OIG

Compendium of Unimplemented Recommendations

May 2017

U.S. Department of Health & Human Services
Office of Inspector General

About the May 2017 Edition

The Compendium of Unimplemented Recommendations (Compendium) is a core publication of the Department of Health and Human Services (HHS or Department) Office of Inspector General (OIG). In this edition, we focus on the top 25 unimplemented recommendations that, in OIG's view, would most positively affect HHS programs in terms of cost savings, program effectiveness and efficiency, and quality improvements and should, therefore, be prioritized for implementation. The recommendations come from OIG audits and evaluations performed pursuant to the Inspector General Act of 1978 (IG Act), as amended. The Appendix of the Compendium includes a broader list of significant unimplemented recommendations from OIG.

The Compendium constitutes OIG's response to a specific requirement of the IG Act, as amended (section 5(a)(3)). It identifies significant recommendations to Congress with respect to problems, abuses, or deficiencies for which corrective actions have not been completed. The 2017 edition also responds to a requirement associated with the Consolidated Appropriations Act of 2014, directing OIG to report its top unimplemented recommendations that, in OIG's opinion, would best protect the integrity of HHS programs if implemented.

In this publication, the top 25 unimplemented recommendations are numbered and generally grouped by the underlying program or operation area. However, they are not internally ranked, and the numbering and grouping do not reflect relative priority among the 25. Each top unimplemented recommendation includes a summary title and narrative, status of the specific recommendation, and a link to the report(s) or source(s) from which the recommendation derived.

The significant unimplemented recommendations described in the body of this Compendium reflect OIG's past and recently issued final reports. As such, the recommendations do not reflect the totality of work we have underway on many issues. Further, OIG regularly follows up with agencies for updates on their progress in implementing recommendations. For the top 25 recommendations, we provide the most current implementation status, as of April 2017. We also note whether one of the top 25 recommendations comes from a report that was issued less than 6 months from April 2017 or before the agency provided OIG with information about its plan to implement the recommendation. This is to account for agencies having up to 6 months from receiving a recommendation to respond to OIG with their plan for implementation.

Implementation of OIG's Recommendations

Under the IG Act, OIG is responsible for making recommendations related to HHS programs and operations. Correspondingly, HHS and its agencies are responsible for responding to those recommendations, including indicating whether recommendations should be implemented. Agencies often may take administrative action to implement an OIG recommendation. However, in some cases

HHS agencies must promulgate regulatory or seek legislative changes for OIG to consider a recommendation implemented. Recommendations for legislative change ultimately require action by Congress. Appendix A lists significant OIG recommendations that require legislative action. Notably, for some recommendations, a combination of administrative, regulatory, or legislative actions may be needed.

Although many OIG recommendations may be implemented by HHS agencies, some require other actors, including States, to take action, as HHS collaborates with them to administer, operate, or oversee federally funded programs, such as Medicaid. Other policymakers, such as the Administration and Congress, may also take actions to address our recommendations. For example, Congress has previously incorporated OIG's recommendations into legislative actions to achieve substantial savings; put public funds to better use; and/or improve quality of care, program integrity, or information systems and processes.

The recommendations in this Compendium derive from final reports. The expected impact of OIG's recommendations varies from direct cost savings to improvements in payment efficiency, program operations, and/or quality and safety. These improvements may not result in direct monetary recoveries, but their impact on ensuring the integrity of HHS programs and the health and welfare of program beneficiaries is just as crucial.

HHS has made progress in implementing many of the recommendations included in this Compendium. However, as of April 2017, OIG has reason to believe that more can and should be achieved. More broadly, OIG continues to focus on several priority areas that require HHS and State improvements, including, for example:

- Protecting beneficiaries from drug abuse, including opioid abuse;
- Ensuring program integrity, quality of care, and safety in programs that serve children, including the Child Care and Development Fund;
- Reducing Medicaid fraud and patient harm, including in the delivery of personal care services;
- Reducing home health fraud; and
- Promoting economy and efficiency in drug pricing and reimbursement.

OIG's ongoing work in these and other critical areas will inform HHS agencies as they seek to strengthen program operations and effectiveness.

For More Information

Report numbers for reports listed in this publication are included in this Compendium and hyperlinked to the text of the reports on our website. The full reports can also be found by entering the report numbers into any major Internet search engine or into the search field on our website. Questions about the Compendium or other publications should be directed to OIG's Office of External Affairs.

Find Us on the Web

OIG's website provides a full range of OIG output, including the Compendium and other key publications, such as the OIG Work Plan, Semiannual Report to Congress, and Top Management and Performance Challenges. The website is at https://oig.hhs.gov.

You may report potential instances of waste, fraud, or abuse related to HHS's programs by phone at 1-800-HHS-TIPS or on our website at https://oig.hhs.gov/fraud/report-fraud/index.asp.

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2. Reimbursement rates for hospital outpatient department procedures should be adjusted to the lower rates for similar procedures conducted in ambulatory surgical centers. (A-05-12-00020)

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8. The disparity in beneficiary coinsurance for outpatient services received at a critical access hospital versus an acute-care hospital should be reduced. (OEI-05-12-00085)

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10. To combat prescription drug abuse, including opioid abuse, CMS should encourage Part D sponsors to implement new authority to restrict certain beneficiaries to a limited number of pharmacies or prescribers. (OEI-02-11-00170)

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16. CMS should facilitate State Medicaid agencies' efforts to screen new and existing providers by ensuring the accessibility and quality of Medicare's Provider Enrollment, Chain and Ownership System data. (OEI-05-13-00520, OEI-04-11-00590, OEI-03-13-00050, and OEI-04-11-00591)

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19. ACF should ensure that its system for automatic noncompetitive renewal of Head Start grantees more accurately predicts grantees' future performance. (OEI-12-14-00650)

20. ACF should take steps to ensure that foster children enrolled in Medicaid receive timely required health screenings. (OEI-07-13-00460)

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22. IHS should implement a quality-focused compliance program for IHS hospitals. (OEI-06-14-00010 and OEI-06-14-00011)

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24. HHS should develop an improper-payment estimate for the Temporary Assistance for Needy Families program and reduce the improper payments estimate for the Medicare Fee-for-Service and Medicaid programs. (A-17-15-52000, A-17-16-52000, and A-17-17-52000)

Health Information Technology

25. ONC and CMS should develop a comprehensive plan to address fraud vulnerabilities in electronic health records. (OEI-01-11-00570)

Selected Abbreviations and Acronyms

ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
ASC	ambulatory surgical center
ASFR	Assistant Secretary for Financial Resources
CAH	critical access hospital
CCDF	Child Care and Development Fund
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CY	calendar year
DRS	designation renewal system
EHR	electronic health records
FDA	Food and Drug Administration
FFS	fee for service
FY	fiscal year
HCBS	home- and community-based services
HHS	Department of Health and Human Services
IHS	Indian Health Service
IG Act	Inspector General Act of 1978
IRF	inpatient rehabilitation facility
IT	information technology
MA	Medicare Advantage
MAC	Medicare Administrative Contractors
NCCI	National Correct Coding Initiative
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health IT
OPPS	outpatient prospective payment system
PECOS	provider enrollment, chain and ownership system
PCS	personal care services
PPS	prospective payment system
SGA	second generation antipsychotics
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
T-MSIS	Transformed Medicaid Statistical Information System

Centers for Medicare & Medicaid Services

Medicare Parts A & B

1. Reimbursement rates for critical access hospital "swing-beds" should be adjusted to the lower rates for similar services provided in skilled nursing facilities.

SUMMARY

Critical access hospitals (CAHs) were established to help ensure that beneficiaries in rural areas gain access to a range of hospital services. CAHs have increasingly employed swing beds, which enable Medicare beneficiaries in inpatient status to transition or "swing" from receiving inpatient services to receiving skilled nursing facility (SNF) services without physically changing beds in the hospital. CAH swing-bed services are reimbursed at 101 percent of the "reasonable cost," while Medicare pays for SNF services provided in SNFs at predetermined daily rates under the SNF prospective payment system (PPS). Our review found that, as swing-bed usage has increased at CAHs, Medicare spending for swing-bed services at CAHs has steadily increased to, on average, almost four times the cost of similar services at alternative facilities, such as SNFs. On the basis of our sample, we estimated that 90 percent of the CAH services could have been provided at alternative facilities within 35 miles. We estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for swing-bed services at CAHs were made using SNF PPS rates.

Recommendation

CMS should seek legislation to adjust critical access hospital swing-bed reimbursement rates to the lower skilled nursing facility prospective payment system rates paid for similar services at alternative facilities.

STATUS

The Centers for Medicare & Medicaid Services (CMS) stated that it disagreed with our recommendation because of concerns with our findings on the availability of skilled nursing services at nearby alternative facilities and our calculation of savings.

SOURCE

Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates (A-05-12-00046: Mar. 2015)

2. Reimbursement rates for hospital outpatient department procedures should be adjusted to the lower rates for similar procedures conducted in ambulatory surgical centers.

SUMMARY

Compared to hospital outpatient departments, ambulatory surgical centers (ASCs) provide surgical services for less cost, in cases in which patients do not require an overnight stay. We found that, from 2007 through 2011, Medicare saved almost $7 billion on surgical procedures that were performed in ASCs instead of outpatient departments. In addition, Medicare could have generated savings up to $15 billion for 2012 through 2017 if Medicare adopted a site-neutral payment policy that reduced outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs. Beneficiaries could also save billions through reduced cost sharing.

Recommendation

CMS should seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system payment rates from budget neutrality adjustments for ambulatory surgical center-approved procedures.

STATUS

CMS has not taken action on this recommendation. CMS noted that the recommended changes "…may raise circularity concerns with respect to the rate calculation process" and that OIG did not provide specific clinical criteria to distinguish patients' risk levels. We continue to recommend changes to hospital's outpatient payment rates and will monitor CMS's progress in implementing our recommendations.

COMPANION RECOMMENDATIONS

- If the legislation described above is enacted, CMS should reduce outpatient prospective payment system (OPPS) payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.
- CMS should thereafter develop and implement a payment strategy in which outpatient departments continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

SOURCE

Medicare and Beneficiaries Could Save Billions If CMS Reduces the Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates (A-05-12-00020: Apr. 2014)

3. Medicare should adopt a hospital transfer payment policy to lower hospital reimbursement for beneficiaries who are discharged early to hospice care.

SUMMARY

Hospital patients are frequently discharged early from inpatient hospital care to hospice care, other hospitals, or post-acute care facilities. Currently, Medicare pays a per diem rate, rather than the prospective payment rate, to hospitals that discharge beneficiaries early to another hospital or post-acute care facility, but pays the full prospective payment rate to hospitals that discharge beneficiaries early to hospice care. Establishing a transfer payment rate policy for early discharges to hospice care would have saved Medicare approximately $602.5 million in 2009 and 2010.

Recommendation

CMS should change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

STATUS

CMS indicated that it would consider making a proposal in the inpatient prospective payment system proposed rule in future rulemaking to address this issue. However, as of April 2017, CMS has not included such a proposal in a proposed or final rule.

SOURCE

Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care (A-01-12-00507: May 2013)

4. CMS and the Agency for Healthcare Research and Quality should take steps to reduce harm to patients in rehabilitation hospitals.

SUMMARY

Over the past several years, OIG has found widespread occurrences of adverse events causing temporary and permanent harm to Medicare beneficiaries across a variety of facility types, including rehabilitation hospitals, nursing facilities, and acute-care hospitals. Beneficiaries have been subjected to prolonged stays and transfers to additional facilities, and, in some cases, adverse events have led to deaths. OIG found an estimated 29 percent of beneficiaries experienced adverse or temporary harm events during stays in rehabilitation hospitals in 2012. Nearly half of adverse or temporary harm events in rehabilitation hospitals appear to have been preventable, much of which is attributable to substandard treatment, failure to provide needed treatment, and inadequate patient monitoring. These results align with results from our prior work on adverse events in nursing facilities and acute-care hospitals. Medicare could save hundreds of millions of dollars annually by reducing the need for costly interventions arising from adverse events in rehabilitation hospitals.

Recommendation

CMS and AHRQ should raise awareness of adverse events in rehabilitation hospitals and work to reduce harm to patients.

STATUS

CMS and the Agency for Healthcare Research and Quality (AHRQ) concurred with this and related recommendations and indicated that they will take steps to address them. CMS will collaborate with AHRQ and other partners to identify and address adverse events in rehabilitation hospitals, including developing a list of potential adverse events in this setting and expanding the current quality assurance and performance improvement guidance to include information specific to rehabilitation hospitals. CMS will also consider using the Quality Improvement Organization Program to assist with quality improvement efforts. AHRQ has already created a crosswalk between OIG's list of adverse events and one of the tools that providers use to report on adverse events. AHRQ plans to collaborate with CMS to revise the list of adverse events in rehabilitation hospitals and update other reporting tools as well. CMS and AHRQ should continue to address adverse events in other settings in accordance with the companion recommendations below.

COMPANION RECOMMENDATIONS

CMS and AHRQ should raise awareness of adverse events in nursing homes and work to reduce harm to patients.

CMS should:

- collaborate with AHRQ to create and promote a list of potential rehabilitation hospital and nursing home events;

- include potential events and information about patient harm in its quality guidance to rehabilitation hospitals and nursing facilities;
- encourage nursing homes to report adverse events to patient safety organizations; and
- instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.

SOURCES

Adverse Events in Inpatient Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries (OEI-06-14-00110: July 2016) and *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (OEI-06-11-00370: Feb. 2014)

5. CMS should reform hospice payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays.

SUMMARY

OIG has identified hospice billing patterns suggesting that Medicare's current payment system may not align with the needs of hospice patients. We found that hospices might be targeting beneficiaries to achieve the greatest financial gains. For example, hospices provided care over longer periods and received much higher Medicare payments for beneficiaries in assisted living facilities than for beneficiaries in other settings. Additionally, for-profit hospices received much higher Medicare payments per beneficiary than did nonprofit hospices. CMS should consider options that tie the specific needs of the beneficiary to payment rates. In areas where billing incentives exist, CMS should improve oversight of incentivized behaviors, such as lengthened inpatient stays or increased billing by for-profit hospices. Adjusting incentives will save Medicare money and safeguard the hospice benefit by ensuring that hospices provide high-quality care to eligible beneficiaries.

Recommendation
CMS should modify the payment system for hospice care in nursing facilities and monitor hospices that depend heavily on nursing facility residents.

STATUS

CMS concurred with our recommendation and stated that it considers its new payment structure, which CMS began using January 1, 2016, as addressing our recommendation. However, in OIG's view, the new structure, which includes a higher base rate for the first 60 days of hospice care and a service intensity add-on for registered nurse and social worker visits that occur in the last 7 days of life, does not resolve all aspects of our recommendation. OIG does not consider the new payment structure to be the best way to align payments with patient needs because it does not address the vulnerability of hospices targeting beneficiaries to achieve the greatest financial gains.

SOURCE

Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities (OEI-02-14-00070: Jan. 2015)

6. CMS should change the way Medicare pays skilled nursing facilities for therapy services to reduce costs and align services with beneficiary needs.

SUMMARY

OIG, the Medicare Payment Advisory Commission, and others have raised longstanding concerns about Medicare's SNF payment system. These concerns focus on: (1) SNF billing, (2) the method of paying for therapy, and (3) the extent to which Medicare payments exceed SNFs' costs for therapy. OIG found that Medicare payments for therapy greatly exceeded SNFs' costs for therapy. Combined with the current method of paying for therapy, this large difference between therapy payments and costs creates a strong financial incentive for SNFs to bill for higher levels of therapy than necessary. Under this system, SNFs increasingly billed for the highest level of therapy even though beneficiaries' characteristics remained largely unchanged. Increases in SNF billing, particularly for the highest level of therapy, resulted in a combined $1.1 billion in Medicare payments in fiscal years (FYs) 2012 and 2013, despite beneficiary characteristics remaining nearly identical. OIG findings demonstrate the need for CMS to reevaluate the Medicare SNF payment system. Although CMS could implement several of OIG's recommendations under existing authority, CMS would need additional statutory authority to reduce Medicare's base payment rate for therapy.

Recommendation

CMS should evaluate the extent to which Medicare payment rates for therapy should be reduced, change the method for paying for therapy, adjust Medicare payments to eliminate any increases that are unrelated to beneficiary characteristics, and strengthen oversight of skilled nursing facility billing.

STATUS

CMS concurred with our recommendation to evaluate the extent to which Medicare payment rates for therapy should be reduced. However, CMS stated that additional statutory authority would be required for the agency to address this recommendation. CMS also concurred with our recommendation to change the method of paying for therapy and stated that it is studying and evaluating SNF therapy payment options. CMS also concurred with our recommendations to adjust payments once it determines that payment increases are unrelated to beneficiaries' characteristics and to strengthen oversight of SNF billing.

SOURCE

The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated (OEI-02-13-00610: Sept. 2015)

7. CMS should increase protections for beneficiaries under the "2-midnight policy" that applies to hospitals' decisions about a beneficiary's inpatient or outpatient admission status.

SUMMARY

Beneficiaries and Medicare often face different hospital costs depending on inpatient or outpatient admission status, even when a hospital provides similar services to treat similar conditions. Such differences can create substantial inequity for patient costs and access to services. Medicare implemented a "2-midnight policy" (i.e., a policy based on the number of midnights the patient is expected to spend in the hospital) to standardize hospital decisions about inpatient versus outpatient admission status. OIG's report on the 2-midnight policy found that an increasing number of beneficiaries in outpatient stays pay more in cost sharing and have less access to SNF services than they would as inpatients. This is because access to SNF services typically requires 3 days of inpatient admission status. Additionally, hospitals continue to vary in how they use inpatient and outpatient stays. OIG found that hospitals continue to bill Medicare for many short inpatient stays that are potentially inappropriate – Medicare paid hospitals three times as much, on average, for short inpatient stays as it paid for short outpatient stays, although the stays were for similar reasons. To address these concerns, CMS should explore ways to protect beneficiaries and increase its oversight of hospital billing under the 2-midnight policy. Beneficiary cost-sharing liabilities for inpatient and outpatient hospital services and the "3-day rule" for SNF eligibility are prescribed in statute; therefore, CMS may need additional statutory authority to increase protections for beneficiaries.

Recommendation

CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for skilled nursing facility services so that beneficiaries receiving similar hospital care have similar access to these services, and explore methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients.

STATUS

CMS concurred with our recommendation to study how to make cost sharing for beneficiaries' hospital stays more equitable and improve access to post-hospital care for beneficiaries with similar needs. However, CMS stated that revising payment policies would require statutory change. CMS has taken steps within its statutory authority to reduce beneficiary cost sharing, such as by establishing Comprehensive Ambulatory Payment classifications under the OPPS, which establishes a single copayment for beneficiaries rather than paying a copayment each time a service is sought. CMS also concurred with our companion recommendation to target hospitals with high or increasing numbers of short inpatient stays, and it has revised the way its Quality Improvement Organizations select hospitals for review to reflect the recommendations in this report. We issued the report to CMS less than 6 months from the time of publication of this Compendium. As such, we anticipate that CMS will provide OIG with more information about its plan to implement the recommendation by June 2017.

COMPANION RECOMMENDATIONS

CMS should:

- conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy, and
- identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy.

SOURCE

Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy (OEI-02-15-00020: Dec. 2016)

8. The disparity in beneficiary coinsurance for outpatient services received at a critical access hospital versus an acute-care hospital should be reduced.

SUMMARY

CAHs are small hospitals that are reimbursed by Medicare at 101 percent of their "reasonable costs." Beneficiaries who receive care at CAHs pay higher coinsurance amounts than those who receive services at acute-care hospitals. Beneficiaries who receive services at acute-care hospitals pay coinsurance amounts based on OPPS rates. In 2012, OIG found that coinsurance amounts at CAHs cost beneficiaries approximately $1.5 billion of the estimated $3.2 billion paid for CAH outpatient services, nearly half the costs for outpatient services at CAHs. Under OPPS, beneficiaries paid 22 percent of costs at acute-care hospitals. Additionally, for 10 outpatient services frequently provided at CAHs, beneficiaries paid between 2 and 6 times the amount in coinsurance than they would have for the same services at acute-care hospitals.

Recommendation

CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at critical access hospitals.

STATUS

CMS did not indicate whether it concurred or did not concur with the recommendation. OIG continues to recommend that CMS seek legislative authority to modify how coinsurance is calculated for outpatient services at CAHs. Without this legislative change, beneficiaries will continue to pay more—in terms of both the percentage of final costs and the total amounts—than outpatient beneficiaries at hospitals paid under the OPPS.

SOURCE

Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals (OEI-05-12-00085: Oct. 2014)

Medicare Parts C & D

9. CMS should prevent enrollment of unlawfully present beneficiaries in Medicare Advantage organizations and Part D sponsors.

SUMMARY

We conducted audits to determine whether CMS made payments to Medicare Advantage (MA) organizations for unlawfully present beneficiaries – individuals who are not U.S. citizens or nationals, or otherwise are not lawfully present in the United States. We also determined whether CMS accepted prescription drug event records submitted by sponsors on behalf of unlawfully present beneficiaries. We found that CMS made improper payments to MA organizations totaling more than $26 million for unlawfully present beneficiaries for CYs 2010 through 2012. CMS did not have policies and procedures to notify MA organizations of the unlawful-presence information in its data systems. In addition, CMS accepted prescription drug event records totaling almost $29 million in unallowable gross drug costs on behalf of unlawfully present beneficiaries during CYs 2009 and 2011. CMS did not have a policy for Part D that included internal controls to identify and disenroll unlawfully present beneficiaries and automatically reject prescription drug event records associated with them.

Recommendation

CMS should implement policies and procedures to notify Medicare Advantage organizations of unlawful-presence information and thereby prevent enrollment in Medicare Advantage organizations, prevent enrollment of unlawfully present beneficiaries in Part D, disenroll beneficiaries already enrolled, automatically reject prescription drug event records, and recoup any improper payments.

STATUS

CMS is developing and implementing policies and procedures to avoid enrollment of unlawful beneficiaries. In the Part D review, CMS stated there was no effective way to fully recover the improper payments in question, without first implementing the appropriate policies and procedures, including the relevant system changes.

COMPANION RECOMMENDATIONS

CMS should:

- identify and recoup improper payments made to MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented,
- recoup $26 million in improper payments in accordance with legal requirements, and
- reopen and revise final payment determinations for CYs 2009 through 2011 to remove prescription drug costs for unlawfully present beneficiaries.

SOURCES

Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries during 2009 through 2011 (A-07-12-06038: Oct. 2013) and *Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 through 2012* (A-07-13-01125: Apr. 2014)

10. To combat prescription drug abuse, including opioid abuse, CMS should encourage Part D sponsors to implement new authority to restrict certain beneficiaries to a limited number of pharmacies or prescribers.

SUMMARY

OIG has historically found that Medicare Part D prescription drug coverage is vulnerable to fraud, waste, and abuse, and limited safeguards exist. We analyzed beneficiary usage patterns for HIV drugs, because their expense and psychoactive effects can make them vulnerable to misuse. We found that almost 1,600 Part D beneficiaries who received HIV drugs had questionable patterns of usage in 2012. Of these beneficiaries, 213 obtained HIV drugs from 6 or more pharmacies, and 179 had at least 6 prescribers. OIG also found that nearly 1 in 3 beneficiaries received commonly abused opioids, and Part D spending for these drugs exceeded $4 billion in 2015. Misuse of opioids has serious financial and human costs, including deaths from overdoses. OIG recommends that CMS encourage implementation of the new Medicare Part D beneficiary "lock in" authority under the Comprehensive Addiction and Recovery Act of 2016 (CARA). "Lock in" would restrict certain beneficiaries to a limited number of pharmacies or prescribers when warranted and reduce inappropriate use of opioids among Medicare beneficiaries and Part D fraud. This policy would aid beneficiaries being harmed by overprescribing and address beneficiaries who are "doctor shopping" or intentionally seeking unnecessary prescriptions.

Recommendation
CMS should restrict certain beneficiaries to a limited number of pharmacies or prescribers.

STATUS

CMS concurred with this recommendation and sought legislative authority to implement it. CARA provides Part D sponsors the authority to establish drug management programs for at-risk beneficiaries. In November 2016, CMS held a teleconference to gather input from stakeholders prior to rulemaking on important topics that will significantly influence the implementation of this program. CMS should continue to take steps to encourage Part D sponsors to establish lock-in programs.

COMPANION RECOMMENDATIONS

CMS should:

- expand sponsors' drug utilization review programs;
- expand sponsors' use of beneficiary-specific controls;
- expand the Overutilization Monitoring System to include additional drugs susceptible to fraud, waste, and abuse;
- limit the ability of certain beneficiaries to switch plans; and
- increase monitoring of beneficiaries' utilization patterns.

SOURCE

Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs (OEI-02-11-00170: Aug. 2014)

11. CMS should collect comprehensive data from Part D plan sponsors to improve its oversight of their efforts to identify and investigate potential fraud and abuse.

SUMMARY

OIG has identified weaknesses in the use of data to identify vulnerabilities, as well as in oversight, by all parties responsible for protecting Part D. Specifically, OIG has made numerous recommendations focused on: (1) the need to more effectively collect and analyze program data to quickly identify and resolve program vulnerabilities and prevent fraud, waste, and abuse before they occur; and (2) the need to increase and strengthen oversight to ensure appropriate payments, prevent fraud, and protect beneficiaries. While progress has been made, OIG's ongoing investigations and data analyses confirm that Part D remains vulnerable to fraud. By collecting comprehensive data on potential fraud and abuse incidents identified by plan sponsors, CMS could more effectively prevent emerging fraud schemes and share these data to target audits of plan sponsors. In 2016, OIG presented an overview of OIG investigations, numerous reports and recommendations, and legal guidance related to Part D in our portfolio, *Ensuring the Integrity of Medicare Part D* (OEI-03-15-00180).

Recommendation
CMS should amend regulations to require Part D plan sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse.

STATUS

CMS did not initially concur with the recommendation and did not intend to seek authority to require plan sponsors to refer all potential fraud and abuse incidents for possible investigation. However, in subsequent discussions with OIG, CMS indicated that it would consider an appropriate threshold for required reporting of potential fraud and abuse incidents.

SOURCES

Summary of recommendations from five reports related to ensuring the integrity of Medicare Part D: *Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse* (OEI-03-13-00030: Mar. 2014); *Medicare Advantage Organizations' Identification of Potential Fraud and Abuse* (OEI-03-10-00310: Feb. 2012); *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* (OEI-03-07-00380: Oct. 2008); *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse* (OEI-03-08-00420: Oct. 2009); and *Retail Pharmacies with Questionable Part D Billing* (OEI-02-09-00600: May 2012)

Medicaid

12. CMS and States should strengthen program integrity of Medicaid personal care services to ensure beneficiaries receive safe, quality care.

SUMMARY

Medicaid personal care services (PCS) provide nonmedical assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so they can remain in their homes and communities. OIG's work examining the PCS program has found significant and persistent compliance, payment, and fraud vulnerabilities. Beneficiaries are at risk of being exposed to substandard or otherwise harmful care. For the past 8 years, OIG has identified program integrity for Medicaid home- and community-based services (HCBS), particularly PCS, as a top management concern for the Department. To address program vulnerabilities and protect beneficiaries, OIG has made recommendations that would prevent untrustworthy or unqualified PCS attendants from serving Medicaid beneficiaries; help CMS and States detect potential fraud, waste, or quality of care concerns more quickly; and provide better enforcement tools when rules are not followed.

Recommendation

Improve CMS's and States' ability to monitor billing and care quality by requiring States to either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.

STATUS

OIG has worked with CMS to explore actions that it can take to address vulnerabilities in the delivery of PCS. In addition to requiring States to enroll or register all PCS attendants, OIG has recommended that CMS establish minimum Federal qualifications and screening standards for PCS workers, including minimum age requirements and background checks; require that PCS claims identify the dates of service and the PCS attendant who provided the service; and consider whether additional controls are needed to ensure that PCS provided to beneficiaries are allowed under program rules and are, in fact, provided. CMS issued a Request for Information (RFI) entitled *Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services* (Nov. 2016). The RFI sought stakeholder comments, information, and data on policy options that CMS can consider to address issues affecting HCBS, including PCS. CMS has indicated that implementing OIG's recommendations would require regulatory change and is currently analyzing the comments it received from the RFI to determine potential policy options. Depending on the actions CMS chooses to take, OIG's four outstanding recommendations could be resolved.

COMPANION RECOMMENDATIONS

CMS should:

- establish minimum Federal qualifications and screening standards for PCS workers, including background checks;
- require that PCS claims identify the dates of service and the PSC attendant who provided the service; and
- consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.

SOURCE

Summary of recommendations from*: Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services* (Oct. 2016), and *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (OIG-12-12-01: Nov. 2012).

TESTIMONY

https://oig.hhs.gov/testimony/docs/2017/grimm-testimony-05022017.pdf

13. CMS should ensure that State Medicaid agencies do not claim unallowable and unsupported costs related to providing services under home- and community-based services waiver programs.

SUMMARY

States may obtain CMS approval to operate Medicaid HCBS waiver programs to meet the needs of people who prefer to get long-term-care services and support in their homes or communities rather than in institutional settings. While States with approved HCBS waiver programs may claim Federal reimbursement, our audits determined that State Medicaid agencies claimed unallowable room-and-board costs and certain other unallowable and unsupported costs. As a result, States claimed unallowable and unsupported Federal Medicaid reimbursement for services under their HCBS waiver programs. Our audits also found that States did not always ensure that: (1) PCS provided under the HCBS waiver program met program requirements, (2) only eligible beneficiaries received additional services, and (3) unapproved costs were excluded when determining payment rates under the HCBS waiver programs.

Recommendation

CMS should share the findings of our home- and community-based services waiver program audits with all State agencies, share (at CMS's discretion) the other findings of our home and community-based services waiver program audits with all State agencies, and encourage all State agencies to review their procedures for calculating and claiming costs under their home and community-based services waiver programs.

STATUS

CMS concurred with our recommendations and indicated that it continues to provide guidance to States on their procedures for calculating and claiming costs under HCBS waiver programs.

SOURCE

State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program (A-07-16-03212: Oct. 2016)

14. CMS should work with State Medicaid programs to review the use of second-generation antipsychotic drugs prescribed to children.

SUMMARY

Second-generation antipsychotics (SGAs) are a class of drugs used to treat psychiatric disorders, such as schizophrenia, bipolar disorder, and psychotic depression. However, SGAs can have serious side effects, and little clinical research has been conducted on the safety of treating children with these drugs. OIG's review of select States found that medical reviewers identified quality-of-care concerns in the medical records associated with 67 percent of claims for SGA drugs prescribed to children. In 53 percent of claims, Medical reviewers identified the lack of monitoring as the most common issue. The high percentage of claims with quality-of-care concerns indicates a greater need to ensure the quality of care provided to children receiving SGAs and paid for by Medicaid.

Recommendation

CMS should work with State Medicaid programs to perform utilization reviews on the use of second-generation antipsychotic drugs prescribed to children.

STATUS

CMS concurred with the recommendation and stated it would work with States through the Medicaid Drug Utilization Review Program to monitor children's use of antipsychotic drugs. CMS indicated that it also collaborated with the National Association of Medicaid Directors and the American Drug Utilization Review Society to host a national teleconference for program directors of Medicaid drug utilization reviews to share their strategic efforts on antipsychotic drug monitoring in children.

SOURCE

Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns (OEI-07-12-00320: Mar. 2015)

15. CMS should ensure that Medicaid data are complete, accurate, and timely.

SUMMARY

To help prevent inappropriate Medicaid payments, protect patients, and reduce time-consuming and expensive activities to correct errors, stakeholders must have access to complete, accurate, and timely national Medicaid data. The Transformed Medicaid Statistical Information System (T-MSIS) is a national database of Medicaid and Children's Health Insurance Program (CHIP) information covering a broad range of user needs, including program integrity. OIG found that States' early implementation of T-MSIS has raised questions about the completeness and accuracy of T-MSIS data upon national implementation. We also found that States are not reporting data for all contracted managed care entities, as required. We recommended that CMS establish a deadline for the availability of complete, accurate, and timely T-MSIS data. This deadline may be different than a compliance deadline when States are capable of sending data to CMS in T-MSIS format. Additionally, we recommended that CMS monitor encounter data to ensure States report all required encounter data.

Recommendation

CMS should ensure that Medicaid data are complete, accurate, and timely. This can be achieved through CMS's monitoring of State-submitted managed care encounter data and by implementing the national Transformed Medicaid Statistical Information System.

STATUS

CMS concurred with our recommendations and indicated that all States are working toward T-MSIS implementation with the goal of every State submitting data in 2017. CMS stated that it is working with States to ensure that encounter data includes data from all contracted managed care entities and has correct plan identifiers.

SOURCES

Not All States Reported Medicaid Managed Care Encounter Data as Required (OEI-07-13-00120: July 2015) and *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* (OEI-05-12-00610: Sept. 2013)

Medicare and Medicaid

16. CMS should facilitate State Medicaid agencies' efforts to screen new and existing providers by ensuring the accessibility and quality of Medicare's Provider Enrollment, Chain and Ownership System data.

SUMMARY

To promote efficiency and reduce provider burden, State Medicaid agencies are allowed to substitute Medicare screening results for their own results when applying enhanced screening to new and existing providers. However, many States reported that they did not take advantage of this option because of difficulties accessing and using Medicare data and concerns about the completeness and accuracy of that data. OIG has repeatedly found Medicare's provider enrollment data system, the Provider Enrollment, Chain and Ownership System (PECOS), to be incomplete, inconsistent, and inadequate. OIG found that, for nearly all providers, owner names in PECOS did not match those on record with the State Medicaid agencies. Medicare and Medicaid information for the same providers did not match. In 2013, OIG found that provider data were inconsistent between PECOS and the National Plan and Provider Enumeration System for 97 percent of records. Addresses were the source of most inaccuracies and inconsistencies.

Recommendation
CMS should enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data.

STATUS

CMS concurred with the recommendation and indicated that it is taking actions to address provider enrollment vulnerabilities identified by OIG. CMS updated guidance in May 2016 on how States can access and use Medicare's data, and the option for States to submit their provider enrollment data to CMS to match against Medicare data. In addition, CMS has improved PECOS data through ongoing data cleanup activities, enhanced system functionality, and system integration efforts. CMS also indicated it will continue to work with Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse to ensure that complete and accurate enrollment information is entered into PECOS.

COMPANION RECOMMENDATIONS

CMS should:

- monitor Medicare contractors to determine whether they are verifying information on enrollment and revalidation applications, as required;
- ensure that PECOS contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements;
- increase coordination with State Medicaid programs on collecting and verifying provider ownership information in Medicare and Medicaid; and

- develop a central system in which States can submit and access screening results from other States.

SOURCES

Summary of recommendations from four reports related to provider enrollment issues: *Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented* (OEI-05-13-00520: May 2016); *Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* (OEI-04-11-00590: May 2016); *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* (OEI-03-13-00050: Apr. 2016); and *Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* (OEI-04-11-00591: May 2016)

TESTIMONY

https://www.oig.hhs.gov/testimony/docs/2016/maxwell-testimony05242016.pdf.

Marketplaces

17. CMS should implement computerized Marketplace systems to maintain confirmed enrollee and payment information.

SUMMARY

CMS operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments for the Federal and State-based marketplaces. We found that CMS's internal controls for calculating and authorizing financial assistance payments, the bulk of which were manual and not automated, were not effective.

Recommendation

CMS should correct internal control deficiencies by implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on qualified health plan issuers' attestations in calculating payments.

STATUS

CMS concurred with our recommendations. By May 2016, CMS transitioned issuers in the Federal marketplace to an automated system that calculates payment amounts and enrollment numbers, replacing the manual calculation method with a more precise, policy-based method. CMS has not yet transitioned issuers in the State marketplaces to the automated system, but has indicated that it expects to do so in 2018.

COMPANION RECOMMENDATION

- CMS should correct internal control deficiencies by implementing a computerized system so that State marketplaces can submit enrollee eligibility data.

SOURCE

CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers under the Affordable Care Act (A-02-14-02006: June 2015)

Administration for Children and Families

18. ACF should ask States administering Child Care and Development Fund grant funds to examine the effectiveness of their program integrity and fraud-fighting activities.

SUMMARY

The Child Care and Development Fund (CCDF) block grant program is a Federal-State partnership that helps eligible, low-income families pay for childcare at a provider of their choice. CCDF is the third largest block grant program administered by the Federal Government. Nearly 1.5 million children receive a childcare subsidy from the CCDF program each month. In prior work on the CCDF program, OIG identified fraud, found improper payments, and exposed health and safety concerns at childcare facilities. In 2016, OIG found that States differed in the number and types of activities they planned to conduct to ensure program integrity. In addition, many States reported no results or not knowing the results of their CCDF program integrity efforts. Finally, not all States performed important antifraud activities, and few States notified the Administration on Children and Families (ACF) and other States about suspected fraud.

Recommendation
ACF should request that States examine the effectiveness of their program integrity and fraud-fighting activities.

STATUS

ACF concurred with our recommendation and stated that it plans to use a grantee internal controls self-assessment tool to assist States in examining the effectiveness of their program integrity and fraud-fighting efforts. The ACF self-assessment process will consider the costs and benefits and overall success of States' efforts. Further, ACF will coordinate with States to examine policies and procedures to strengthen program integrity efforts.

COMPANION RECOMMENDATIONS

ACF should:

- examine with States the benefits of expanding program integrity and fraud-fighting activities,
- establish routine communication to share program integrity and fraud-fighting best practices, and
- determine the feasibility of requiring all States to report information about the results of their program integrity and fraud-fighting activities.

SOURCE

More Effort Is Needed to Protect the Integrity of the Child Care and Development Fund Block Grant Program (OEI-03-16-00150: July 2016)

19. ACF should ensure that its system for automatic noncompetitive renewal of Head Start grantees more accurately predicts grantees' future performance.

SUMMARY

The Head Start grant program is the largest Federal investment in early childhood education, serving more than 1 million children. The Improving Head Start for School Readiness Act of 2007 required ACF to begin awarding 5-year grants rather than the indefinite-term grants used in the past. It also required grantees who do not provide high-quality and comprehensive services to recompete for renewal. In late 2011, ACF began assessing grantees through the Designation Renewal System (DRS) to determine which grantees would be required to recompete for renewal. In 2016, OIG found that grantees that were automatically renewed noncompetitively had performed significantly better than other grantees on only one of six selected performance measures. ACF must ensure that it accurately identifies the grantees best suited for automatic renewal.

Recommendation

ACF should monitor the performance of Head Start grantees to verify that those designated for automatic noncompetitive renewal perform better than their peers.

STATUS

ACF concurred with the recommendation and stated that it has taken steps to redesign and improve performance measures in Head Start monitoring. These actions include issuing revised performance standards and implementing a robust monitoring system that focus on quality as well as compliance. OIG encouraged ACF to ensure that DRS data comparisons accurately reflect those grantees deserving of noncompetitive renewal and those designated for recompetition. ACF stated that, in summer 2017, it will roll out a new plan for monitoring grantees using higher program performance standards. As part of this effort, it will consider the historical performance of a grantee and the grantees' prior audit findings and noncompliance as identified in the OIG report.

COMPANION RECOMMENDATION

- ACF should take additional steps to increase the number of applicants for recompeted grants.

SOURCE

Head Start Grant Recompetition: Early Implementation Results Suggest Opportunities for Improvement (OEI-12-14-00650: Aug. 2016)

20. ACF should take steps to ensure that foster children enrolled in Medicaid receive timely required health screenings.

SUMMARY

Health screenings are essential because children in foster care often experience chronic medical, developmental, and mental health issues. States' ability to ensure that foster children enrolled in Medicaid receive needed health services is critical to the well-being of these children. The Social Security Act requires each State to develop a plan for ongoing oversight and coordination of health services for children in foster care, including initial and periodic health screenings. A series of previous OIG reports on the use of Medicaid services by children in foster care revealed that all children did not receive required medical, vision, and hearing screenings. In 2015, we found that nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening. ACF is responsible for monitoring States' foster care programs, including States' oversight and coordination of health services for children. OIG found that ACF reviews of these programs do not assess whether screenings are given according to the timeframes specified in State plans.

Recommendation

ACF should expand the scope of the Child and Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans.

STATUS

ACF stated that it is monitoring State performance during its current round of foster care program reviews to assess whether the approach OIG recommends is appropriate for the next round of reviews.

SOURCE

Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings (OEI-07-13-00460: Mar. 2015)

Food and Drug Administration

21. FDA should ensure that food facilities correct serious violations identified during FDA inspections.

SUMMARY

Each year, more than 300,000 Americans are hospitalized and 5,000 die from contaminated foods and beverages. The Food and Drug Administration (FDA) safeguards the Nation's food supply by ensuring that food is free of disease-causing organisms, chemicals, or other harmful substances. Recent high-profile outbreaks of foodborne illness, however, have raised serious questions about FDA's inspections process. When FDA identifies significant violations, an "official action indicated" (OAI) classification is issued, which warrants regulatory action, including a warning letter, a regulatory meeting, or a seizure or injunction. OIG recommends that FDA take appropriate action against facilities with OAI violations. In FY 2007, FDA took regulatory action against only 46 percent of the facilities with initial OAI classifications, either lowering the classification or taking no regulatory action for the other facilities.

Recommendation
FDA should ensure that violations are corrected for all facilities that receive "official action indicated" classifications.

STATUS

FDA concurred with our recommendation. In 2017, FDA reported that it is investigating the extent to which its database reporting tools can reconcile inspection data and compliance actions, along with the results from subsequent follow-up inspections, to demonstrate that the actions achieved the desired result. OIG continues to recommend use of a tracking system that identifies all inspections classified as OAI, what—if any—follow-up actions were taken by FDA, and whether the violations are corrected.

COMPANION RECOMMENDATIONS

FDA should:

- take appropriate actions against facilities with OAI classifications, particularly those that have histories of violations; and
- consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.

SOURCE

FDA Inspections of Domestic Food Facilities (OEI-02-08-00080: Apr. 2010)

Indian Health Service

22. IHS should implement a quality-focused compliance program for IHS hospitals.

SUMMARY

The Indian Health Service (IHS) provides health services to 567 federally recognized tribes of American Indians and Alaska Natives and directly operates 28 acute-care hospitals. IHS hospitals face longstanding challenges that affect their ability to provide quality care and comply with Medicare standards, including ensuring access to needed care, maintaining clinical competence, recruiting and retaining essential staff, and keeping patients safe despite outdated buildings and equipment. Further, IHS has few sources of information on its hospitals' performance and a limited capacity to provide clinical support. OIG found that IHS may be missing opportunities to improve the quality of care at its hospitals because of limited oversight and inadequate compliance with quality standards set for all hospitals that receive Medicare payments. IHS monitors hospitals through its Area Offices, which have insufficient information about the quality of care and degree of oversight at hospitals. Staffing and funding shortages at Area Offices also limit the clinical support and guidance they can provide. Hospitals with limited resources struggle to implement information technology (IT) improvements and update electronic health record (EHR) systems.

Recommendation

IHS should implement a quality-focused compliance program to better monitor and ensure the quality of care provided by IHS hospitals.

STATUS

IHS concurred with our recommendation. To develop a quality-focused compliance program, HHS health quality experts should work with IHS to enhance the quality of care at its hospitals. IHS plans to establish a new office in its headquarters that will focus on standardizing processes and procedures across the IHS system of care. Moreover, IHS is pursuing new initiatives to assess its hospitals for compliance and provide technical assistance where needed. The HHS Office of the Secretary also established an Executive Council on Quality Health Care, holding biweekly meetings with agency heads across the Department to identify opportunities to assist IHS in its improvement efforts.

COMPANION RECOMMENDATIONS

- IHS should:
    - continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts;
    - establish standards and expectations for how Area Offices/Governing Boards oversee and monitor hospitals and monitor adherence to those standards;

    - continue to seek new meaningful ways to monitor hospital quality through the use of outcomes and/or process measures; and
    - conduct a needs assessment culminating in an agency-wide strategic plan with actionable initiatives and target dates.
- CMS should assist IHS in its oversight efforts by conducting more frequent surveys of hospitals, informing IHS leadership of deficiency citations, and continuing to provide technical assistance and training.
- The Office of the Secretary should, as part of the newly formed Executive Council, lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's longstanding challenges.

SOURCES

Indian Health Services Hospitals: More Monitoring Needed to Ensure Quality Care (OEI-06-14-00010: Oct. 2016), and *Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care* (OEI-06-14-00011: Oct. 2016)

HHS-wide

23. HHS should have a department-wide system to share information about problematic grantees.

SUMMARY

Since 2007, OIG has identified grants management as a top management challenge for HHS, the largest grant-making agency in the Federal Government. Until 2007, the HHS Office of Grants maintained a list to alert other awarding agencies to the potential risks of awarding funds to specified grantees. Suspended in 2007, pending a major redesign, the list has yet to be reinstated. As such, awarding agencies lack a mechanism to share with each other information about problematic grantees, thereby impairing the Department's ability to assess risks posed by new grant applicants. OIG recommended that the Assistant Secretary for Financial Resources (ASFR) establish such a tool. OIG recently reported that grant officials cited limitations in the sources of information and communication they use to mitigate grantee risks. For example, National External Audit Review Center (NEARC) memorandums contain important information about grantee risks, but not all awarding agencies receive them. ASFR should ensure that grant officials have timely access to grantee information that they can use in pre-award assessments and to mitigate grantee risks.

Recommendation
ASFR should establish a department-wide source of adverse information from audits of grantees.

STATUS

ASFR concurred with our recommendation and reported that an enterprise-wide Audit Resolution System is being developed that will allow awarding agencies to obtain audit report findings from sources such as OIG and the Government Accountability Office. OIG continues to encourage and monitor ASFR's efforts to disseminate adverse grantee information from audits of grantees.

SOURCE

HHS Oversight of Grantees Could Be Improved Through Better Information Sharing (OEI-07-12-00110: Sept. 2015)

24. HHS should develop an improper-payment estimate for the Temporary Assistance for Needy Families program and reduce the improper payments estimate for the Medicare Fee-for-Service and Medicaid programs.

SUMMARY

OIG conducted audits to: (1) determine whether HHS complied with the Improper Payments Elimination and Recovery Act of 2010 (IPERA), as amended, for FY 2016, in accordance with the related Office of Management and Budget (OMB) guidance; (2) evaluate HHS's assessment of the level of risk and the quality of the improper-payment estimates and methodology for high-priority programs;[1] and (3) assess HHS's performance in reducing and recapturing improper payments. We found that HHS did not fully comply with the IPERA, as amended, requirements for FY 2016. Specifically, HHS did not publish an improper-payment rate for the Temporary Assistance for Needy Families (TANF) program. OMB has determined TANF to be a risk susceptible program. While HHS did not report an improper-payment estimate of less than 10 percent for the Medicare Fee-for-Service (FFS) or Medicaid programs, it began the Departmentwide risk assessments for payments to employees and charge card payments at several Operating Divisions.

Recommendation
HHS should address and reduce improper payments in the Temporary Assistance for Needy Families, Medicare Fee-for-Service, and Medicaid programs.

STATUS

HHS reported in its FY 2016 Agency Financial Report a number of actions to address improper payments for the TANF and Medicare FFS programs, including assisting States in reducing improper payments in the TANF program. HHS also has several corrective actions for the Medicare FFS program that focus on specific service areas with high error rates, such as home health and Inpatient Rehabilitation Facility (IRF) claims. In addition, HHS performs risk assessments on other programs and payment streams, including payments to employees and charge card payments, to determine if they are susceptible to significant improper payments.

SOURCES

HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2014, FY 2015, and FY 2016 (A-17-15-52000: May 2015; A-17-16-52000: May 2016; A-17-17-52000: May 2017)

[1] A high-priority program is one that has improper payments of greater than $750 million (OMB Circular A-123 Appendix C, Figure 1).

Health Information Technology

25. ONC and CMS should develop a comprehensive plan to address fraud vulnerabilities in electronic health records.

SUMMARY

EHRs replace traditional paper medical records with computerized recordkeeping to document and store patient health information. Experts in health IT caution that EHR technology can make it easier to commit fraud. For example, OIG found that, although the Office of the National Coordinator for Health IT (ONC) contracted with RTI International to develop a list of recommended safeguards for EHR technology, HHS did not directly address all of these safeguards through certification criteria or meaningful use requirements. We found that nearly all hospitals with EHR technology had audit functions recommended by RTI International, but these hospitals may not be using them to their full extent. HHS needs to address the risks that EHRs pose to the integrity of Federal health programs. OIG found that hospitals were individually employing their own EHR fraud and abuse safeguards to varying degrees.

Recommendation:
ONC and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in electronic health records.

STATUS

CMS and ONC concurred with the recommendation. CMS stated that it continues to work with ONC to implement a comprehensive plan to detect and reduce fraud. In December 2015, CMS published a fact sheet entitled: "Electronic Health Records Provider Fact Sheet," which gives providers information to recognize, report, and prevent fraud, waste, and abuse associated with EHRs. However, OIG believes that HHS still needs to develop a more comprehensive plan to address fraud vulnerabilities in EHRs.

SOURCE

Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology (OEI-01-11-00570: Dec. 2013)

Appendix A: Legislative Recommendations

This Appendix collates OIG unimplemented recommendations listed in this document that address identified vulnerabilities though legislative changes. Items with an asterisk (*) represent Top 25 unimplemented recommendations (the number of the corresponding top recommendation is indicated in the "HHS Area" column). If the "Savings" field is blank, either the cost savings is not specified in the report(s) or the unimplemented recommendation(s) does not include cost savings.

HHS Area	Recommendation	Savings	Report Title/Link
CMS* (#1)	CMS should seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF rates.	Estimated savings of $4.1 billion over a 6-year period	*Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates* **(A-05-12-00046)**
CMS* (#2)	CMS should seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.	Estimated savings of up to $15 billion over a 6-year period	*Medicare and Beneficiaries Could Save Billions If CMS Reduces the Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates* **(A-05-12-00020)**
CMS* (#3)	CMS should change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.	Estimated savings of $602.5 million over a 2-year period	*Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care* **(A-01-12-00507)**
CMS* (#6)	To support a legislative change to the way Medicare pays for therapy provided by SNFs, CMS should evaluate the extent to which Medicare payment rates for therapy should be reduced.		*The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated* **(OEI-02-13-00610)**
CMS* (#7)	To support legislative changes to make beneficiary cost-sharing for hospital services and access to SNF care more equitable, CMS should: • explore methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients, and • analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services.		*Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* **(OEI-02-15-00020)**

HHS Area	Recommendation	Savings	Report Title/Link
CMS* (#8)	CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs.		*Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals* (OEI-05-12-00085)
CMS	CMS should seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission and other hospital ownership arrangements, such as affiliated hospital groups.	Estimated savings of $318 million[2]	*Medicare and Beneficiaries Could Realize Substantial Savings if the DRG Window Were Expanded* **(OEI-05-12-00480)**
CMS	We recommend that CMS: • seek legislative authority to remove Necessary Provider CAHs' permanent exemption from the distance requirement, thus allowing CMS to reassess these CAHs, and • seek legislative authority to revise the CAH Conditions of Participation to include alternative location-related requirements.	Estimated savings of $449 million[3]	*Most Critical Access Hospitals Would Not Meet the Location Requirements if Required To Re-enroll in Medicare* **(OEI-05-12-00080)**
CMS	We recommend that CMS develop and implement a system that allows CMS to collect the information necessary to fully comply with Medicare requirements that prohibit payments for Medicare service rendered to incarcerated beneficiaries and, if necessary, seek the appropriate legislation and funding.		*Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2013 and 2014* **(A-07-15-01158)**
CMS	CMS should improve handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.		*Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals* **(OEI-02-10-00340)**
CMS	CMS should work with Congress to set Federal Upper Limit amounts that more closely approximate acquisition costs.		*Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices* **(OEI-03-05-00110)**
CMS	CMS should work with Congress to require manufacturers of first generics to submit monthly average sales price (ASP) data during initial generic availability.		*Medicare Payments for Newly Available Generic Drugs* **(OEI-03-09-00510)**

[2] The estimated $308 million in savings is based on OIG's analysis of claims for services provided just prior to the window or provided at affiliated hospitals during the window in 2011.

[3] Medicare and beneficiaries would have saved $449 million if CMS had decertified CAHs that were 15 or fewer miles from the nearest hospitals in 2011.

HHS Area	Recommendation	Savings	Report Title/Link
CMS	CMS should consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both ASPs and average manufacturer prices (AMPs).		*Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011* **(OEI-03-12-00670)**
CMS	CMS should seek legislative authority or administratively require rural health clinic applicants to document need and impact on access to health care in rural underserved areas.		*Status of the Rural Health Clinic Program* **(OEI-05-03-00170)**
CMS	CMS should seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification.		*Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight* **(OEI-06-05-00260)**
CMS	CMS should seek legislative change to prevent States from using State Supplementary Payments to shift Medicare Part B premium costs for full benefit dual eligibles to the Federal Government.		*Iowa Has Shifted Medicare Cost-Sharing For Dual Eligibles to the Federal Government* **(OEI-07-13-00480)**
CMS	CMS should seek legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.		*Least Costly Alternative Policies: Impact On Prostrate Cancer Drugs Covered Under Medicare Part B* **(OEI-12-12-00210)**
CMS	CMS should seek a legislative change to directly require all manufacturers of Part B drugs to submit ASPs.		*Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs* **(OEI-12-13-00040)**
FDA	FDA should seek statutory authority to impose civil monetary penalties on companies that do not comply with registration requirements.		*Dietary Supplements: Companies May Be Difficult to Locate in an Emergency* **(OEI-01-11-00211)**
FDA	FDA should seek statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.		*FDA Inspections of Domestic Food Facilities* **(OEI-02-08-00080)**
FDA	FDA should seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading.		*Dietary Supplements: Structure/ Function Claims Fail To Meet Federal Requirements* **(OEI-01-11-00210)**
FDA	FDA should seek legislative authority to enforce FDA assessment plans.		*FDA Lacks Comprehensive Data to Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety* **(OEI-04-11-00510)**

Appendix B: Significant Unimplemented Recommendations

This Appendix summarizes significant unimplemented recommendations. This list includes the top 25 unimplemented recommendations, which are designated below with an asterisk (*) (the number of the corresponding top recommendation is indicated in the "HHS Area" column). The recommendations represent opportunities to achieve expected impact through costs savings, improvements in program effectiveness and efficiency, and increased quality of care and safety of beneficiaries. The recommendations are generally grouped by the HHS program area and agency. The "Savings" field below denotes the cost savings specified in the report(s) that contains the unimplemented recommendation(s). If the "Savings" field is blank, either the cost savings is not specified in the report(s) or the unimplemented recommendation(s) does not include cost savings.

HHS Area	Recommendation	Savings	Report Title/Link
Medicare Parts A & B* (#1)	CMS should seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.	Estimated savings of $4.1 billion over a 6-year period	*Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates* A-05-12-00046 **(Mar. 2015)**
Medicare Parts A & B* (#2)	• CMS should seek legislation that would exempt the reduced expenditures as a result of lower outpatient PPS payment rates from budget neutrality adjustments for ASC-approved procedures. • If the legislation described above is enacted, CMS should reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments. • CMS should thereafter develop and implement a payment strategy in which outpatient departments continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.	Estimated savings of up to $15 billion over a 6-year period	*Medicare and Beneficiaries Could Save Billions If CMS Reduces the Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates* A-05-12-00020 **(Apr. 2014)**
Medicare Parts A & B* (#3)	CMS should change its regulations or pursue a legislative change, if necessary, to establish a	Estimated savings of	*Medicare Could Save Millions by Implementing a*

HHS Area	Recommendation	Savings	Report Title/Link
	hospital transfer payment policy for early discharges to hospice care.	$602.5 million over a 2-year period.	*Hospital Transfer Payment Policy for Early Discharges to Hospice Care* A-01-12-00507 **(May 2013)**
Medicare Parts A & B* (#4)	CMS and AHRQ should: • raise awareness of adverse events in rehabilitiation hospitals and work to reduce harm to patients; and • raise awareness of adverse events in nursing homes and work to reduce harm to patients. CMS should: • collaborate with AHRQ to create and promote a list of potential rehabilitation hospital and nursing home events; • include potential events and information about patient harm in its quality guidance to rehabilitation hospitals and nursing facilities; • encourage nursing homes to report adverse events to patient safety organizations; and • instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.		*Adverse Events in Inpatient Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* OEI-06-14-00110 **(July 2016)** *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* OEI-06-11-00370 **(Feb. 2014)**
Medicare Parts A & B* (#5)	CMS should: • modify the payment system for hospice care in nursing facilities; and • monitor hospices that depend heavily on nursing facility residents.		*Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities* OEI-02-14-00070 **(Jan. 2015)**
Medicare Parts A & B* (#6)	CMS should: • evaluate the extent to which Medicare payment rates for therapy should be reduced; • change the method for paying for therapy; • adjust Medicare payments to eliminate any increases that are unrelated to beneficiary characteristics; and • strengthen oversight of SNF billing.		*The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated* OEI-02-13-00610 **(Sept. 2015**)
Medicare Parts A & B* (#7)	CMS should: • analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF		*Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* OEI-02-15-00020 **(Dec.**

HHS Area	Recommendation	Savings	Report Title/Link
	services so that beneficiaries receiving similar hospital care have similar access to these services, and explore methods for protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients; • conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy; and • identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy.		**2016)**
Medicare Parts A & B* (#8)	CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs.		*Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals* OEI-05-12-00085 **(Oct. 2014)**
Medicare Parts A & B	CMS should: • educate hospitals on billing outpatient Right Heart Catheterizations (RHCs) performed during the same patient encounter as heart biopsies and recover any overpayments Medicare made subsequent to our audit period; • educate hospitals on how to appropriately bill for RHCs performed during the same patient encounter as heart biopsies, which could have resulted in savings totaling an estimated $7.6 million over a 2-year period; • identify claims in the years subsequent to our audit period that did not meet Medicare payment requirements and recover any associated overpayments; and • notify providers of potential overpayments so they can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and	Estimated savings of $7.6 million over a 2-year period	*Hospitals Nationwide Generally Did Not Comply With Medicare Requirements for Billing Outpatient Right Heart Catheterizations With Heart Biopsies* A-01-13-00511 **(Mar. 2017)**

HHS Area	Recommendation	Savings	Report Title/Link
	identify and track any returned overpayments as having been made in accordance with this recommendation.		
Medicare Parts A & B	We recommend that CMS direct its Medicare contractors, to the maximum extent feasible, to initiate recoupment activities: • against the 481 unlawfully present beneficiaries on whose behalf Medicare made $9,267,392 in improper payments; and • for improper payments made after our audit period on behalf of any beneficiaries who are detected to be unlawfully present.		*Medicare Improperly Paid Millions of Dollars for Unlawfully Present Beneficiaries for 2013 and 2014* A-07-15-01159 **(Sept. 2016)**
Medicare Parts A & B	We recommend that CMS: • establish a cumulative payment threshold—taking into consideration costs and potential program integrity benefits—above which a clinician's claims would be selected for review; and • implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.	Estimated savings of $358.8 million for CY 2013	*Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements* A-09-14-02033 **(Oct. 2016)**
Medicare Parts A & B	We recommend that CMS: • direct Medicare contractors to initiate recoupment for $415,069 in improper payments associated with the 332 claims whose dates of service were after the individuals' dates of death; • confirm that the $11,450 in improper payments associated with the 95 claims that we identified have been recouped; and • review the accuracy of the beneficiary dates of death in the Common Working File and Enrollment Database to determine whether any of the $1,480,913 relating to the 1,047 claims with conflicting date-of-death information were improper payments, and if so, direct Medicare contractors to initiate recoupment for the identified amounts.		*Medicare's Policies and Procedures Identified Almost All Improper Claims Submitted for Deceased Individuals and Recouped Almost All Improper Payments Made for These Claims for January 2013 Through October 2015* A-07-16-05089 **(Oct. 2016)**

HHS Area	Recommendation	Savings	Report Title/Link
Medicare Parts A & B	We recommend that CMS: • develop and implement a system that allows CMS to collect the information necessary to fully comply with Medicare requirements that prohibit payments for Medicare service rendered to incarcerated beneficiaries and, if necessary, seek the appropriate legislation and funding; • review the $34,588,984 in claims to determine which portion, if any, was not claimed in accordance with Medicare requirements and direct Medicare contractors to recoup any ensuing improper payments; and • identify improper payments made on behalf of incarcerated beneficiaries after our audit period and ensure that Medicare contractors recoup those payments.		*Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2013 and 2014* A-07-15-01158 **(Oct. 2016)**
Medicare Parts A & B	We recommend that CMS: • ensure that Medicare contractors recover the $1,488,165 in identified overpayments for the sampled claims; • revise the length-of-stay edit to take into account the mechanical ventilation start date for claims with a potential length of 4 days or fewer, which could result in savings of an estimated $3,709,139 over a 2-year period; and • provide additional guidance to hospitals on the correct billing of mechanical ventilation claims with a potential procedure length of 5 days, which could result in savings of an estimated $15,853,359 over a 2-year period.	Estimated savings of $19.6 million over a 2-year period	*Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation* A-09-14-02041 **(June 2016)**
Medicare Parts A & B	We recommend that the nursing home implement its newly developed policies and procedures requiring that: • its nursing staff follow residents' care plans; and • the director of nursing or a designee conduct reviews to ensure that the nursing staff follows residents' care		*West Carroll Care Center Did Not Always Follow Care Plans for Residents Who Were Later Hospitalized With Potentially Avoidable Urinary Tract Infections* A-06-14-00073 **(June 2016)**

HHS Area	Recommendation	Savings	Report Title/Link
	plans.		
Medicare Parts A & B	CMS should ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements.		*Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011* A-07-12-01113 **(Jan. 2013)**
Medicare Parts A & B	CMS should require that all immediate jeopardy complaint surveys evaluate compliance with the Conditions of Participation on quality assurance and performance improvement.		*Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events* OEI-01-08-00590 **(Oct. 2011)**
Medicare Parts A & B	CMS should: • monitor hospices that depend heavily on nursing facility residents; and • modify the payment system for hospice care in nursing facilities.		*Medicare Hospices That Focus on Nursing Facility Residents* OEI-02-10-00070 **(July 2011)**
Medicare Parts A & B	CMS should consider pursuing rulemaking to expand the price substitution policy.	Estimated savings of $6 million[4]	*Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2013* OEI-03-14-00520 **(Feb. 2015)**
Medicare Parts A & B	Office of Medicare Hearings and Appeals (OMHA) and CMS should: • identify and clarify Medicare policies that are unclear and are interpreted differently; and • standardize case files and make them electronic. CMS should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary. OMHA should develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly.		*Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals* OEI-02-10-00340 **(Nov. 2012)**
Medicare Parts A & B	CMS should use the Medicare Appeals System to monitor contractor performance.		*The First Level of the Medicare Appeals Process,*

[4] Medicare could have saved almost $6 million if CMS had expanded its price substitution criteria to include drug codes with complete AMP data in a single quarter or certain codes with partial AMP data in 2013.

HHS Area	Recommendation	Savings	Report Title/Link
			2008–2012: Volume, Outcomes, and Timeliness OEI-01-12-00150 **(Oct. 2013)**
Medicare Parts A & B	We recommend that CMS: • seek legislative authority to remove Necessary Provider CAHs permanent exemption from the distance requirement, allowing CMS to reassess these CAHs; and • seek legislative authority to revise the CAH Conditions of Participation to include alternative location-related requirements.	Estimated savings of $449 million[5]	*Most Critical Access Hospitals Would Not Meet the Location Requirements if Required To Re-enroll in Medicare* OEI-05-12-00080 **(Aug. 2013)**
Medicare Parts A & B	CMS should amend current regulations to decrease the Part B payment rates for dispensing and supplying fees to rates similar to those of other payers, such as Part D and Medicaid.		*Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs* A-06-12-00038 **(Sept. 2014)**
Medicare Parts A & B	CMS should adjust the estimated number of evaluation and management (E&M) services within global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, or use the financial results of the audit, in conjunction with other information, during the annual updates of the physician fee schedule.	Estimated savings of $97.6 million per year[6]	*Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005* A-05-07-00077 **(Apr. 2009)**
Medicare Parts A & B	CMS should adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $49 million, or use the results of this audit during the annual update of the physician fee schedule.	Estimated savings of $49 million[7]	*Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* A-05-09-00053 **(May 2012)**
Medicare Parts A & B	CMS should seek legislative authority to expand the diagnostic related group window to include:	Estimated savings of	*Medicare and Beneficiaries Could Realize Substantial*

[5] Medicare and beneficiaries would have saved $449 million if CMS had decertified CAHs that were 15 or fewer miles from the nearest hospitals in 2011.
[6] Estimate based on CY 2005 data.
[7] Estimate based on CY 2007 data.

HHS Area	Recommendation	Savings	Report Title/Link
	• additional days prior to the inpatient admission; and • other hospital ownership arrangements, such as affiliated hospital groups.	$318 million[8]	*Savings if the DRG Window Were Expanded* OEI-05-12-00480 **(Feb. 2014)**
Medicare Parts A & B	CMS should adjust the estimated number of E&M services within cardiovascular global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $14.6 million, or use the results of this audit during the annual update of the physician fee schedule.	Estimated savings of $14.6 million[9]	*Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* A-05-09-00054 **(May 2012)**
Medicare Parts A & B	CMS should: • reinstate beneficiary deductibles and coinsurance (and notifications of amounts paid on their behalf) as a means of controlling utilization; and • periodically evaluate the national fee schedule to ensure that reimbursement is aligned with the prices that physicians pay for clinical laboratory tests.	Estimated savings of $23.8 billion over 10 years[10]	*Follow-up Report to "Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests"* A-09-93-00056 **(Jan. 1996)** *Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests* A-09-89-00031 **(Jan. 1990)**
Medicare Parts A & B	We recommend that CMS: • direct the Medicare contractors to recover the $4,574,228 in identified overpayments for incorrectly billed claims that are within the 3-year recovery period; • work with the Medicare contractors to notify providers of potential overpayments outside of the 3-year recovery period, which we estimate to be as much as $1,767,213 for our audit period; • review the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stays of 1 to 2 days, which could save as much as $2,054,306; and	Estimated savings of $3.8 million over a 3-year period	*Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance with Medicare Requirements* A-09-14-02037 **(Feb. 2016)**

[8] The estimated $318 million in savings is based on OIG's analysis of claims for services provided just prior to the window or provided at affiliated hospitals during the window in 2011.

[9] Estimate based on CY 2007 data.

[10] The Congressional Budget Office's December 2008 "Budget Options Volume I – Healthcare" (p. 159) estimated savings of $23.8 billion over 10 years from reinstating standard deductible and coinsurance requirements, with annual savings of $2.4 billion by 2014.

HHS Area	Recommendation	Savings	Report Title/Link
	• strengthen controls related to Medicare Severity-Diagnosis Related Groups for stem cell transplants.		
Medicare Parts A & B	CMS should conduct additional analysis to determine the extent to which financial incentives influence long-term-care hospital readmission decisions.		*Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals* OEI-04-12-00490 **(June 2014)**
Medicare Parts A & B	CMS should implement policies and procedures to detect and recoup improper payments when entitlement termination information is received on previously paid Medicare claims, and identify these types of improper payments after our audit period but before implementation of policies and procedures and ensure that Medicare contractors recoup the improper payments.		*Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012* A-07-13-01127 **(Apr. 2014)**
Medicare Parts A & B	CMS should seek legislative change to prevent States from using State Supplementary Payments to shift Medicare Part B premium costs for full benefit dual eligibles to the Federal Government.		*Iowa Has Shifted Medicare Cost-Sharing For Dual Eligibles to the Federal Government* OEI-07-13-00480 **(Apr. 2014)**
Medicare Parts A & B	CMS should modify the payment system for hospice care in nursing facilities, seeking statutory authority, if necessary.		*Medicare Hospices That Focus on Nursing Facility Residents* OEI-02-10-00070 **(July 2011)**
Medicare Parts A & B	CMS should: • facilitate access to information necessary to ensure accurate coverage and reimbursement determination; and • assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes.		*Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents* OEI-07-08-00150 **(May 2011)**
Medicare Parts A & B	CMS should implement claims processing edits or improve edits to prevent inappropriate payments.		*Questionable Billing for Polysomnography Services* OEI-05-12-00340 **(Oct. 2013)**
Medicare Parts A & B	CMS should: • increase its oversight of hospice general inpatient (GIP) claims and review Part D payments for drugs for hospice		*Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*

HHS Area	Recommendation	Savings	Report Title/Link
	beneficiaries; • establish additional enforcement remedies for poor hospice performance; • ensure that a physician is involved in the decision to use GIP; • conduct prepayment reviews for lengthy GIP stays; • follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care; and • increase surveyor efforts to ensure that hospices meet care planning requirements.		OEI-02-10-00491 **(Mar. 2016)**
Medicare Parts A & B	CMS should: • provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care; and • instruct surveyors to strengthen their review of election statements and certifications of terminal illness.		*Hospices Should Improve Their Election Statements and Certifications of Terminal Illness* OEI-02-10-00492 **(Sept. 2016)**
Medicare Parts A & B	CMS should seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification.		*Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight* OEI-06-05-00260 **(Apr. 2007)**
Medicare Parts A & B	CMS should take appropriate action regarding physicians we identified as having inappropriate or questionable billing.		*Questionable Billing for Medicare Electrodiagnostic Tests* OEI-04-12-00420 **(Apr. 2014)**
Medicare Parts A & B	CMS should instruct Medicare contractors to increase monitoring of outlier payments.		*Medicare Hospital Outlier Payments Warrant Increased Scrutiny* OEI-06-10-00520 **(Nov. 2013)**
Medicare Parts A & B	CMS should develop an alternative mechanism, such as having contractors perform additional prepay and post-pay reviews, to ensure that suppliers maintain the required documentation for the specific medical equipment and supply	Estimated savings of $316.4 million[11]	*Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical*

[11] Estimate based on CY 2007 data.

HHS Area	Recommendation	Savings	Report Title/Link
	items that currently use the KX modifier.		*Equipment* A-04-10-04004 **(Apr. 2012)**
Medicare Parts A & B	CMS should monitor compliance with the new therapy assessments.		*Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than $1 Billion in 2009* OEI-02-09-00200 **(Nov. 2012)**
Medicare Parts A & B	CMS should: • reduce the financial incentive for SNFs to use assessments differently when decreasing therapy than when increasing it; and • strengthen the oversight of SNF billing for changes in therapy.		*Skilled Nursing Facility Billing for Changes in Therapy: Improvements Are Needed* OEI-02-13-00611 **(June 2015)**
Medicare Parts A & B	CMS should implement the HHA surety bond requirement.		*Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* OEI-03-12-00070 **(Sept. 2012)**
Medicare Parts A & B	CMS should implement additional claims processing edits or improve edits to ensure that claims are paid appropriately.		*Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims* OEI-04-12-00281 **(Dec. 2014)**
Medicare Parts A & B	We recommend that CMS: • ensure that collections information is consistently recorded in the Audit Tracking and Reporting System; and • collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law.		*Obstacles to Collection of Millions in Medicare Overpayments* A-04-10-03059 **(May 2012)**
Medicare Parts A & B	CMS should distinguish payments in the End Stage Renal Disease base rate between independent and hospital-based dialysis facilities.		*Update: Medicare Payments for End-Stage Renal Disease Drugs* OEI-03-12-00550 **(Mar. 2014)**
Medicare Parts A & B	CMS should clarify the workload definitions in the CMS Analysis, Reporting, and Tracking System to ensure that Zone Program Integrity Contractor's (ZPIC) workload statistics are accurate and that		*Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight* OEI-03-09-00520 **(Nov.**

HHS Area	Recommendation	Savings	Report Title/Link
	ZPICs report their data uniformly.		**2011)**
Medicare Parts A & B	CMS should examine the additional potential impacts of establishing a prescription drug rebate program under Medicare Part B and, if appropriate, seek legislative change.		*Medicare Could Collect Billions If Pharmaceutical Manufacturers Were Required to Pay Rebates for Part B Drugs* OEI-12-12-00260 **(Sept. 2013)**
Medicare Parts A & B	CMS should consider seeking legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.		*Least Costly Alternative Policies: Impact On Prostate Cancer Drugs Covered Under Medicare Part B* OEI-12-12-00210 **(Nov. 2012)**
Medicare Parts A & B	CMS should work with Congress to require manufacturers of first generics to submit monthly average sales price (ASP) data during initial generic availability.		*Medicare Payments for Newly Available Generic Drugs* OEI-03-09-00510 **(Jan. 2011)**
Medicare Parts A & B	CMS should consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both ASPs and average manufacturers prices (AMPs).		*Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011* OEI-03-12-00670 **(Jan. 2013)**
Medicare Parts A & B	CMS should seek a legislative change to directly require all manufacturers of Part B drugs to submit ASPs.		*Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs* OEI-12-13-00040 **(July 2014)**
Medicare Parts A & B	CMS should provide guidance to claims processors about handling [for program integrity purposes] Medicare Summary Notices that are returned as undeliverable.		*Over Four Million Medicare Summary Notices Mailed to Beneficiaries Were Not Delivered in 2012* OEI-03-12-00600 **(Jan. 2014)**
Medicare Parts A & B	CMS should: • explore the possibility of requiring providers to identify on the Part B claims the pharmacies that produced the compounded drugs; and • explore the possibility of conducting descriptive analyses of Part B claims for		*Compounded Drugs Under Medicare Part B: Payment and Oversight* OEI-03-13-00270 **(Apr. 2014)**

HHS Area	Recommendation	Savings	Report Title/Link
	compounded drugs.		
Medicare Parts A & B	CMS should: • define "grievance" for facilities; • provide guidance to facilities on what constitutes a robust process for anonymous grievances; • work with AHRQ to add a question to the Consumer Assessment of Healthcare Providers and Systems to assess beneficiaries' fear of reprisal; and • provide networks with better technical support for the Contact Utility database.		*The ESRD Beneficiary Grievance Process* OEI-01-11-00550 **(Dec. 2013)**
Medicare Parts A & B	CMS should continue working with participating States to: • improve required reporting to ensure that CMS can conduct effective oversight of the program; and • fully implement their background check programs.		*National Background Check Program for Long Term Care Employees: Interim Report* OEI-07-10-00420 **(Jan. 2016)**
Medicare Parts A & B	CMS should link payments to meeting quality-of-care requirements.		*Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements* OEI-02-09-00201 **(Feb. 2013)**
Medicare Parts A & B	CMS should ensure that nursing facilities: • maintain policies related to reporting allegations of abuse or neglect; and • comply with their responsibilities under section 1150B of the Social Security Act.		*Nursing Facilities' Compliance With Federal Requirements for Reporting Allegations of Abuse or Neglect* OEI-07-13 00010 **(Aug. 2014)**
Medicare Parts A & B	CMS should: • determine the relative contribution of each of its quality improvement efforts; and • take additional steps to coordinate, and reduce overlap between, the Quality Improvement Organization (QIO) program and CMS's other quality improvement efforts.		*Quality Improvement Organizations Provide Support to More Than Half of Hospital but Overlap with Other Programs* OEI-01-12-00650 **(Jan. 2015)**

HHS Area	Recommendation	Savings	Report Title/Link
Medicare Parts A & B	CMS should: • take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements; • require hospitals to submit attestations for all their provider-based facilities; • ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews; and • implement systems and methods to monitor billing by all provider-based facilities.		*CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain* OEI-04-12-00380 **(June 2016)**
Medicare Parts A & B	CMS should review providers that submitted nonmatching owner names and take appropriate action.		*Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* OEI-04-11-00591 **(May 2016)**
Medicare Parts A & B	CMS should provide interpretive guidelines for State survey agencies to assess hospital compliance to track and monitor adverse events.		*Adverse Events in Hospitals: Methods for Identifying Events* OEI-06-08-00221 **(Mar. 2010)**
Medicare Parts A & B	CMS should: • examine the variation in workload statistics among benefit integrity contractors and—as appropriate—identify performance issues that need to be addressed, best practices that can be shared, and workload definitions that need to be clarified to ensure that contractors report data uniformly and in the way CMS intends; and • examine trends in workload statistics, determine the causes for the increases and decreases in workload statistics across years, and determine whether these changes align with CMS's benefit integrity goals.		*Medicare Benefit Integrity Contractors' Activities in 2012 and 2013: A Data Compendium* OEI-03-13-00620 **(May 2016)**
Medicare Parts A & B	CMS should: • develop a method for ensuring that beneficiaries who are victims of medical identity theft retain access to		*CMS Response to Breaches and Medical Identity Theft* OEI-02-10-00040 **(Oct. 2012)**

HHS Area	Recommendation	Savings	Report Title/Link
	needed services; and • develop a method for reissuing identification numbers to beneficiaries affected by medical identity theft.		
Medicare Parts A & B	CMS should: • require the National Site Visit Contractor to improve quality assurance oversight and training of site visit inspectors; • ensure that PECOS contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements; • monitor MACs to determine whether they are verifying information on enrollment and revalidation applications as required; and • validate that MACs are appropriately considering site visit results when making enrollment decisions.		*Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* OEI-03-13-00050 **(Apr. 2016)**
Medicare Parts A & B	CMS should seek legislative authority or administratively require rural health clinic applicants to document need and impact on access to health care in rural underserved areas.		*Status of the Rural Health Clinic Program* OEI-05-03-00170 **(Aug. 2005)**
Medicare Parts C & D* (#9)	CMS should: • implement policies and procedures to notify MA organizations of unlawful-presence information and thereby prevent enrollment in MA organizations, prevent enrollment of unlawfully present beneficiaries in Part D, disenroll beneficiaries already enrolled, automatically reject prescription drug event records, and recoup any improper payments; • identify and recoup improper payments made to MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented; • recoup $26 million in improper payments in accordance with legal requirements; and • reopen and revise final payment determinations for CYs 2009 through		*Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2009 through 2011* A-07-12-06038 **(Oct. 2013)** *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries during 2010 through 2012* A-07-13-01125 **(Apr. 2014)**

HHS Area	Recommendation	Savings	Report Title/Link
	2011 to remove prescription drug costs for unlawfully present beneficiaries.		
Medicare Parts C & D* (#10)	CMS should: • restrict certain beneficiaries to a limited number of pharmacies or prescribers; • expand sponsors' drug utilization review programs; • expand sponsors' use of beneficiary-specific controls; • expand the Overutilization Monitoring System to include additional drugs susceptible to fraud, waste, and abuse; • limit the ability of certain beneficiaries to switch plans; and • increase monitoring of beneficiaries' utilization patterns.		*Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs* OEI-02-11-00170 **(Aug. 2014)**
Medicare Parts C & D* (#11)	CMS should: • amend regulations to require Part D plan sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse; • provide Part D plan sponsors with specific guidelines on how to define and count incidents of potential fraud and abuse, related inquiries, and corrective actions; • review data from Part D plan sponsors to determine why certain sponsors reported especially high or low numbers of incidents of potential fraud and abuse, related inquiries, and corrective actions; and • share Part D plan sponsors' data on potential fraud and abuse with all sponsors and law enforcement.		Summary of recommendations from five reports related to ensuring the integrity of Medicare Part D: *Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse* OEI-03-13-00030 **(Mar. 2014)** *Medicare Advantage Organizations' Identification of Potential Fraud and Abuse* OEI-03-10-00310 **(Feb. 2012)** *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* OEI-03-07-00380 **(Oct. 2008)** *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*

HHS Area	Recommendation	Savings	Report Title/Link
			OEI-03-08-00420 **(Oct. 2009)** *Retail Pharmacies with Questionable Part D Billing* OEI-02-09-00600 **(May 2012)**
Medicare Parts C & D	We recommend that CMS implement an edit to reject prescription drug event (PDE) records for Schedule II drugs when the prescriber ID field contains an invalid prescriber ID number and issue specific guidance requiring sponsors to include a valid Drug Enforcement Administration (DEA) number on both standard and nonstandard format PDE records involving Schedule II drugs.		*Schedule II Drugs: Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs* A-14-09-00302 **(Feb. 2011)**
Medicare Parts C & D	CMS should: • add additional data to its contract management system, and improve reports to allow for easier access to contract data that would assist in contract closeout and funds management; and • improve coordination and collaboration with National Institutes of Health.		*CMS Has Not Performed Required Close Outs of Contracts Worth Billions* OEI-03-12-00680 **(Dec. 2015)**
Medicare Parts C & D	CMS should: • evaluate the cost-effectiveness of edits and medical reviews that are designed to ensure appropriate payments for covered uses on Part B drug claims; and • assign a single entity to assist MACs in making coverage determinations.		*MACs Continue to Use Different Methods to Determine Drug Coverage* OEI-03-13-00450 **(Aug. 2016)**
Medicare Parts C & D	We recommend that CMS: • exclude Schedule II refills when calculating payments to sponsors; and • follow up on sponsors and pharmacies with high numbers of refills.		*Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills* OEI-02-09-00605 **(Sept. 2012)**
Medicare Parts C & D	CMS should: • review MA organizations to determine why certain organizations reported high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries; • require MA organizations to report to CMS aggregate data related to their		*Medicare Advantage Organizations' Identification of Potential Fraud and Abuse* OEI-03-10-00310 **(Feb. 2012)**

HHS Area	Recommendation	Savings	Report Title/Link
	Part C and Part D antifraud, waste, and abuse activities; • ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents; and • require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities.		
Medicare Parts C & D	CMS should: • review Part D plan sponsors to determine why certain sponsors have identified especially high or low volumes of potential fraud and abuse incidents; • determine whether the Part D sponsors that identified fraud and abuse initiated inquiries and corrective actions as required by CMS and made referrals for further investigation as recommended by CMS; • require Part D plan sponsors to maintain and routinely report information related to results of sponsors' fraud and abuse programs; and • use this required information to help determine the effectiveness of sponsors' fraud and abuse programs.		*Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* OEI-03-07-00380 **(Oct. 2008)**
Medicare Parts C & D	CMS should require plan sponsors to report all potential fraud and abuse incidents that are referred to law enforcement agencies to Medicare Drug Integrity Contractors (MEDICs) as well.		*Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse* OEI-03-08-00420 **(Oct. 2009)**
Medicare Parts C & D	CMS should require sponsors to refer potential fraud and abuse incidents that may warrant further investigation.		*Retail Pharmacies With Questionable Part D Billing* OEI-02-09-00600 **(May 2012)**
Medicare Parts C & D	We recommend that CMS: • provide the MEDIC with centralized Part C data to enable it to more comprehensively and proactively identify and investigate Part C fraud and abuse;		*MEDIC Benefit Integrity Activities in Medicare Parts C and D* OEI-03-11-00310 **(Jan. 2013)**

HHS Area	Recommendation	Savings	Report Title/Link
	• explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action; • amend regulations to require Part C and Part D plan sponsors to refer potential fraud and abuse incidents to the MEDIC; and • enhance monthly workload-reporting requirements to improve CMS's oversight of the MEDIC's benefit integrity activities.		
Medicare Parts C & D	CMS should cooperate with industry stakeholder efforts to identify a solution to prevent coupons from being used to purchase drugs paid for by Part D.		*Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs* OEI-05-12-00540 **(Sept. 2014)**
Medicare Parts C & D	CMS should: • define Pharmacy Benefit Managers (PBM) as entities that could benefit from formulary decisions; and • establish minimum standards requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the pharmacy and therapeutics (P&T) committee.		*Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions* OEI-05-10-00450 **(Mar. 2013)**
Medicare Parts C & D	CMS should: • determine whether outlier data values submitted by MA organizations reflect inaccurate reporting or atypical performance; and • use appropriate Part C reporting requirements data as part of its reviews of MA organizations' performance.		*CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited* OEI-03-11-00720 **(Mar. 2014)**
Medicaid* (#12)	Improve CMS's and States' ability to monitor billing and care quality by requiring States to either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.		*Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* OIG-12-12-01 **(Nov. 2012)**

HHS Area	Recommendation	Savings	Report Title/Link
	CMS should: • establish minimum Federal qualifications and screening standards for PCS workers, including background checks; • require that PCS claims identify the dates of service and the PSC attendant who provided the service; and • consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.		
Medicaid* (#13)	CMS should: • share the findings of our HCBS waiver program audits with all State agencies; • share (at CMS's discretion) the other findings of our HCBS waiver program audits with all State agencies; and • encourage all State agencies to review their procedures for calculating and claiming costs under their HCBS waiver programs.	Estimated savings of $176.5 million[12]	*State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program* A-07-16-03212 **(Oct. 2016)**
Medicaid* (#14)	CMS should work with State Medicaid programs to perform reviews on the use of SGAs prescribed to children.		*Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns* OEI-07-12-00320 **(Mar. 2015)**
Medicaid* (#15)	CMS should ensure that Medicaid data are complete, accurate, and timely. This can be achieved through CMS's monitoring of State-submitted managed care encounter data and by implementing the T-MSIS.		*Not All States Reported Medicaid Managed Care Encounter Data as Required* OEI-07-13-00120 **(July 2015)** *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* OEI-05-12-00610 **(Sept. 2013)**
Medicaid	CMS should: • monitor States that use the express lane eligibility (ELE) option for Medicaid		*Medicaid Enrollment Using the Express Lane Eligibility Option Did Not Always*

[12] Based on eight HCBS reports from four States from FYs 2007-2013.

HHS Area	Recommendation	Savings	Report Title/Link
	eligibility determinations for compliance with Federal requirements; • provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option; • issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and • ensure that States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.		*Meet Federal Requirements* A-04-15-08043 **(Oct. 2016)**
Medicaid	CMS should: • monitor States that use the ELE option for CHIP eligibility determinations for compliance with Federal requirements; • provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option; • issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and • ensure that States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.		*Children's Health Insurance Program Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Federal Requirements* A-04-15-08045 **(Oct. 2016)**
Medicaid	CMS should: • issue guidance that clarifies requirements and provides further interpretation of the "as needed" language in 42 CFR § 430.30(d)(3) as it relates to the withdrawal of Medicaid funds; • publish regulations that are consistent with the U.S. Department of the Treasury provisions in 31 CFR part 205 and educate States;		*Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds* A-06-14-00068 **(Mar. 2016)**

HHS Area	Recommendation	Savings	Report Title/Link
	• publish and enforce formal guidance based on CMS's instructional email from November 8, 2011, so that States are aware of the appropriate Payment Management System account from which to withdraw or return funds; and • require States to reconcile total Federal Medicaid funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines.		
Medicaid	CMS should issue Medicaid regulations to clarify the requirements of the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.		*Providers Did Not Always Reconcile Patient Records with Credit Balances and Report and Return the Associated Medicaid Overpayments to State Agencies* A-04-14-04029 **(Aug. 2015)**
Medicaid	CMS should: • provide States with definitive guidance for calculating the Medicaid upper payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data; and • require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the Federal share generated by the original payment.	Estimated savings of $3.87 billion over 5 years	*Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers* A-03-00-00216 **(Sept. 2001)**
Medicaid	CMS should work with Congress to set Federal Upper Limit amounts that more closely approximate acquisition costs.		*Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices* OEI-03-05-00110 **(June 2005)**
Medicaid	CMS should require each State Medicaid agency to report all terminated providers.		*CMS Process for Sharing Information about Terminated Providers Needs Improvement* OEI-06-12-00031 **(Mar. 2014)**

HHS Area	Recommendation	Savings	Report Title/Link
Medicaid	CMS should establish a deadline for when national T-MSIS data will be available.		*Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* OEI-05-12-00610 **(Sept. 2013)**
Medicaid	CMS should: • require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits; and • make information about State compliance assurances available to the public.		*Oversight of Quality of Care in Medicaid Home and Community-based Services Waiver Programs* OEI-02-08-00170 **(June 2012)**
Medicaid	CMS should: • identify and share effective strategies with States; • ensure that States pay for services in accordance with their periodicity schedules; • work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid; • develop benchmarks for dental services and require States to create mandatory action plans to meet them; • work with States to analyze the effects of Medicaid payments on access to dental providers; • work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists; • work with States to track children's utilization of required dental services; and • develop a comprehensive plan to increase the number of children who receive required services.		*Most Children With Medicaid in Four States Are Not Receiving Required Dental Services* OEI-02-14-00490 **(Jan. 2016)**
Medicaid	CMS should: • maintain adequate documentation to support the collection of overpayments in accordance with OMB Circular A-50 and CMS Standard Operating Procedures; and		*Medicaid Overpayments—The Centers for Medicare & Medicaid Services Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected*

HHS Area	Recommendation	Savings	Report Title/Link
	• collect the remaining $225.6 million we identified as due the Federal Government.		A-05-11-00071 **(Feb. 2013)**
Medicaid	CMS should ensure that all States appropriately report offset rebate amounts.		*States' Collection of Offset and Supplemental Medicaid Rebates* OEI-03-12-00520 **(Dec. 2014)**
Medicaid	CMS should: • require States to report vision and hearing screenings; • collaborate with States and providers to develop effective strategies to encourage beneficiary participation in screenings; • collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings; and • identify and disseminate promising State practices for increasing children's participation in screenings and providers' delivery of complete medical screenings.		*Most Medicaid Children in Nine States are Not Receiving All Required Preventive Screening Services* OEI-05-08-00520 **(May 2010)**
Medicaid	CMS should work with States to: • ensure that plans are complying with State standards and assess whether additional standards are needed; • ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees; and • assess the number of providers offering appointments and improve the accuracy of plan information.		*Access to Care: Provide Availability in Medicaid Managed Care* OEI-02-13-00670 **(Dec. 2014)**
Medicaid	CMS should: • strengthen its oversight of State standards and ensure that States develop standards for key providers; • strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards; • improve States' efforts to identify and address violations of access standards; and		*State Standards for Access to Care in Medicaid Managed Care* OEI-02-11-00320 **(Sept. 2014)**

HHS Area	Recommendation	Savings	Report Title/Link
	• provide technical assistance and share effective practices.		
Medicaid	CMS should: • work with States to improve the quality of claims data submitted by providers and pharmacies; and • help States obtain better data on ineligible drugs.		*Medicaid Drug Rebate Dispute Resolution Could Be Improved* OEI-05-11-00580 **(Aug. 2014)**
Medicaid	CMS should require the use of claim level methods to identify 340B claims. HRSA should clarify its guidance on preventing duplicate discounts for managed care organization drugs.		*State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates* OEI-05-14-00430 **(June 2016)**
Medicaid	CMS should: • increase coordination with State Medicaid programs on collecting and verifying provider ownership information in Medicare and Medicaid; • work with State Medicaid programs to educated providers on the requirement to report changes of ownership; • require State Medicaid programs to verify the completeness and accuracy of provider ownership information; • work with State Medicaid programs to identify and correct gaps in their collection of all required provider ownership information; • work with State Medicaid programs to review providers that submitted nonmatching owner names and take appropriate action; and • provide guidance to State Medicaid programs on how to verify the completeness and accuracy of provider ownership information.		*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* OEI-04-11-00590 **(May 2016)**
Medicaid	CMS should: • issue guidance to States on how to estimate Medicaid National Correct Coding Initiative (NCCI) cost savings and take steps to ensure that States report as required; • examine whether using NCCI edits on claims paid under managed care is beneficial, and if so, take appropriate		*Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments* OEI-09-14-00440 **(Apr. 2016)**

HHS Area	Recommendation	Savings	Report Title/Link
	action; • take appropriate action to ensure that States fully implement NCCI edits; and • provide technical assistance to States to ensure that they use NCCI edits correctly.		
CMS* (#16)	CMS should: • enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data; • monitor Medicare contractors to determine whether they are verifying information on enrollment and revalidation applications as required; • ensure that PECOS contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements; • increase coordination with State Medicaid programs on collecting and verifying provider ownership information in Medicare and Medicaid; and • develop a central system in which States can submit and access screening results from other States.		Summary of recommendations from four reports related to provider enrollment issues: *Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented* OEI-05-13-00520 **(May 2016)** *Medicaid: Vulnerabilities Related To Provider Enrollment And Ownership Disclosure* OEI-04-11-00590 **(May 2016)** *Enhanced Enrollment Screening Of Medicare Providers: Early Implementation Results* OEI-03-13-00050 **(Apr. 2016)** *Medicare: Vulnerabilities Related To Provider Enrollment and Ownership Disclosure* OEI-04-11-00591 **(May 2016)**
CMS	CMS should update the *State Operations Manual* to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training.		*Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010* OEI-06-09-00270 **(Apr. 2012)**
Marketplaces * (#17)	CMS should: • correct internal control deficiencies by		*CMS's Internal Controls Did Not Effectively Ensure the*

HHS Area	Recommendation	Savings	Report Title/Link
	implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on qualified health plan issuers' attestations in calculating payments; and • correct internal control deficiencies by implementing a computerized system so that State marketplaces can submit enrollee eligibility data.		*Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act* A-02-14-02006 **(June 2015)**
Marketplaces	CMS should: • ensure that acquisition strategies are completed, as required by the Health & Human Services Acquisition Regulations (HHSAR); • assess whether to assign a lead systems integrator for complex IT projects involving multiple contractors; • ensure that contract actions are supported by required documentation; and • ensure that all contracts that are subject to its Contract Review Board requirements undergo these reviews. HHS should revise its guidance to include specific standards for conducting past performance reviews of companies under consideration during contract procurement.		*Federal Marketplace: Inadequacies in Contract Planning and Procurement* OEI-03-14-00230 **(Jan. 2015)**
Marketplaces	The Maryland Department of Health and Mental Hygiene should: • refund $15.9 million to CMS that was misallocated to the establishment grants because it did not prospectively use updated actual enrollment data; • refund $12.5 million to CMS that was misallocated to the establishment grants using a methodology that included a material defect; • immediately amend the Cost Allocation Plan and the Advance Planning Document for July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received;	Estimated savings of $28.4 million[13]	*Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace* A-01-14-02503 **(Mar. 2015)**

[13] Estimate based on data from State FYs 2013 and 2014 (July 1, 2012 through June 30, 2014).

HHS Area	Recommendation	Savings	Report Title/Link
	• develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data; and • oversee operations to ensure: (1) the identification and correction of enrollment projection errors, (2) the use of better or updated enrollment data, and (3) the application of these data to allocate costs.		
Marketplaces	CMS should: • continue to place underperforming Consumer Operated and Oriented Plans (CO-OPs) on enhanced oversight or corrective action plans, in accordance with Federal requirements; • work with State insurance regulators to identify and correct underperforming CO-OPs; • provide guidance or establish criteria to determine when a CO-OP is no longer viable or sustainable; and • pursue available remedies for recovery of funds from terminated CO-OPs, in accordance with the loan agreements.		*Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and May Affect Their Ability to Repay Loans Provided Under the Affordable Care Act* A-05-14-00055 **(July 2015)**
Marketplaces	CMS should: • include all relevant contract costs when it identifies total obligations and expenditures related to the design, development, and operation of the Federal marketplace; and • review all charges submitted by CGI Federal for the Federally facilitated marketplace contract and make a final determination on the appropriate amount to withhold for correcting defects by validating the $267,420 withheld for the fixed fee.		*CMS Did Not Identify All Federal Marketplace Contract Costs and Did Not Properly Validate the Amount to Withhold for Defect Resolution on the Principal Federal Marketplace Contract* A-03-14-03002 **(Sept. 2015)**
Marketplaces	Covered California should: • improve internal controls related to verifying lawful presence and entering applicant information; • improve internal controls related to maintaining and updating eligibility and enrollment data; and • redetermine, if necessary, the eligibility		*Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring that Individuals Were Enrolled in Qualified Health Plans According to Federal*

HHS Area	Recommendation	Savings	Report Title/Link
	of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.		*Requirements* A-09-14-01000 **(June 2014)**
ACF* (#18)	ACF should: • request that States examine the effectiveness of their program integrity and fraud fighting activities; • examine with States the benefits of expanding program integrity and fraud-fighting activities, • establish routine communication to share program integrity and fraud-fighting best practices, and • determine the feasibility of requiring all States to report information about the results of their program integrity and fraud-fighting activities.		*More Effort Is Needed to Protect the Integrity of the Child Care and Development Fund Block Grant Program* OEI-03-16-00150 **(July 2016)**
ACF* (#19)	ACF should: • monitor the performance of Head Start grantees to verify that those designated for noncompetitive renewal perform better than their peers; and • take additional steps to increase the number of applicants for recompeted grants.		*Head Start Grant Recompetition: Early Implementation Results Suggest Opportunities for Improvement* OEI-12-14-00650 **(Aug. 2016)**
ACF* (#20)	ACF should expand the scope of Child and Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans.		*Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings* OEI-07-13-00460 **(Mar. 2015)**
ACF	ACF should: • prepare guidance about supplemental Superstorm Sandy Block Grants (SSBG) documentation requirements; • conduct a post-grant review to identify lessons learned and best practices; and • take additional steps to ensure, within the scope of the legislation, that States are given appropriate time to expand any future supplemental SSBG awards.		*Superstorm Sandy Block Grants: Funds Benefited States' Reconstruction and Social Service Efforts, Though ACF's Guidance Could be Improved* OEI-09-15-00200 **(Sept. 2016)**
FDA* (#21)	FDA should: • ensure that violations are corrected for all facilities that receive OAI		*FDA Inspections of Domestic Food Facilities* OEI-02-08-00080 **(Apr.**

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	classifications; • take appropriate actions against facilities with OAI classifications, particularly those that have histories of violations; and • consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.		**2010)**
FDA	FDA should seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading.		*Dietary Supplements: Structure/ Function Claims Fail To Meet Federal Requirements* OEI-01-11-00210 **(Oct. 2012)**
FDA	FDA should seek statutory authority to impose civil monetary penalties on companies that do not comply with registration requirements.		*Dietary Supplements: Companies May Be Difficult to Locate in an Emergency* OEI-01-11-00211 **(Oct. 2012)**
FDA	FDA should: • develop and implement a plan to identify, develop, validate, and assess Risk Evaluation and Mitigation Strategies (REMS) components; • identify REMS that are not meeting their goals and take appropriate actions to protect the public health; • identify incomplete sponsor assessments and work with sponsors to obtain missing information; • clarify expectations for sponsors' assessments in FDA assessment plans; • seek legislative authority to enforce FDA assessment plans; and • ensure that assessment reviews are timely.		*FDA Lacks Comprehensive Data to Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety* OEI-04-11-00510 **(Feb. 2013)**
FDA	FDA should use its authority to request records in lieu of or in advance of an inspection.		*FDA Has Made Progress on Oversight and Inspections of Manufacturers of Generic Drugs* OEI-01-13-00600 **(May 2015)**

HHS Area	Recommendation	Savings	Report Title/Link
FDA	FDA should: • build capacity in the Document Archiving, Reporting, and Regulatory Tracking System to support postmarketing requirements oversight; and • provide a standardized form for annual status reports, ensure that they are complete, and require sponsors to submit them electronically.		*FDA is Issuing More Postmarketing Requirements but Challenges with Oversight Persist* OEI-01-14-00390 **(July 2016)**
IHS* (#22)	IHS should: • implement a quality-focused compliance program to better monitor and ensure the quality of care provided by IHS hospitals; • continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts; • establish standards and expectations for how Area Offices/Governing Boards oversee and monitor hospitals and monitor adherence to those standards; • continue to seek new meaningful ways to monitor hospital quality through the use of outcomes and/or process measures; and • conduct a needs assessment culminating in an agency-wide strategic plan with actionable initiatives and target dates. CMS should assist IHS in its oversight efforts by conducting more frequent surveys of hospitals, informing IHS leadership of deficiency citations, and continuing to provide technical assistance and training.		*Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care* OEI-06-14-00010 **(Oct. 2016)**
IHS	IHS should: • conduct a needs assessment culminating in an agency-wide strategic plan with actionable initiatives and target dates; and • as part of the Office of Secretary's newly formed Executive Council, lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's		*Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care* OEI-06-14-00011 **(Oct. 2016)**

HHS Area	Recommendation	Savings	Report Title/Link
	longstanding challenges.		
HRSA	HRSA should: • provide more specific guidance about what grantees should address in their quality assurance programs and how they should conduct their periodic assessments; and • establish procedures to independently assess patients' receipt of primary health services and the adequacy of patients' records.		*Quality Assurance and Care Provided at HRSA-Funded Health Centers* OEI-09-06-00420 **(Mar. 2012)**
NIH	NIH should: • develop and disseminate guidance on methods to verify researchers' financial interests; • ensure that grantee institutions are providing adequate oversight of subgrantee compliance with Federal financial conflicts of interest regulations; • ensure that grantee institutions are maintaining proper documentation as outlined in the Federal financial conflict-of-interest regulations; • ensure that grantee institutions take appropriate actions against researchers who do not follow grantee institutions' financial conflict-of-interest policies and procedures; and • develop regulations that address institutional financial conflicts of interest.		*How Grantees Manage Financial Conflicts of Interest in Research Funded by the National Institutes of Health* OEI-03-07-00700 **(Nov. 2009)**
NIH	NIH should promulgate regulations that address institutional financial conflicts of interest.		*Institutional Conflicts of Interest at NIH Grantees* OEI-03-09-00480 **(Jan. 2011)**
NIH	NIH should: • confirm that grants management staff ensure timely submission of required awardee reports; and • revise the NIH Policy Manual and Award Worksheet Report to require a brief narrative documenting awardee progress and stating whether any change in research goals influences		*NIH Postaward Grant Administration and Oversight Could be Improved* OEI-07-11-00190 **(Aug. 2015)**

HHS Area	Recommendation	Savings	Report Title/Link
	continued funding.		
HHS-wide* (#23)	ASFR should establish a department-wide source of adverse information from audits of grantees.		*HHS Oversight of Grantees could be Improved through Better Information-Sharing* OEI-07-12-00110 **(Sept. 2015)**
HHS-wide* (#24)	HHS should address and reduce improper-payments in the TANF, Medicare FFS, and Medicaid programs.		*HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2014, FY 2015, and FY 2016* A-17-15-52000 **(May 2015)** A-17-16-52000 **(May 2016)** A-17-17-52000 **(May 2017)**
HHS-wide	HHS should assess the need for additional actions to meet improper payment rate reduction targets.		*U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Was Not Fully Compliant* A-17-13-52000 **(Mar. 2013)**
HHS-wide	ASFR should: • improve procedures to check for duplicative awards; and • ensure compliance with Small Business Innovation Research Program eligibility requirements.		*Vulnerabilities in the HHS Small Business Innovation Research Program* OEI-04-11-00530 **(Apr. 2014)**
Health IT* (#25)	ONC and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.		*Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology* OEI-01-11-00570 **(Dec. 2013)**
ASPR	ASPR should continue to promote Federal, State, and community collaboration in major disasters. CMS should examine policies and provide guidance regarding flexibility for reimbursement under disaster conditions.		*Hospital Emergency Preparedness and Response During Superstorm Sandy* OEI-06-13-00260 **(Sept. 2014)**
HHS Financial Reports	HHS should: • continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity; and		*Department of Health and Human Services Fiscal Year 2016 Agency Financial Report. Section II. Daniel R. Levinson, Inspector General, OIG Report on the*

HHS Area	Recommendation	Savings	Report Title/Link
	• continue to move forward to prioritize and centralize additional resources in addressing issues related to controls within and surrounding its financial information management systems.		*Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2016 (pp. 59, 60, 61, 71, 72, 76,77 and 79, 70, 75, 76, and 77)* A-17-16-00001 **(Nov. 2016)**
HHS Financial Reports	To improve its financial reporting and related processes, CMS should: • establish a process to perform a claims-level detailed lookback analysis of Medicaid entitlement benefits due and payable to determine the reasonableness of the methodology used to estimate the accrual; • continue to improve the efficiency of the various error rate processes to allow more time to analyze the findings and the development of remediation plans; • continue to implement an integrated financial management system to promote consistency and reliability in accounting and financial reporting; • continue to enhance its process related to the development, documentation, and validation of critical accounting matters and to delegate the responsibility of the centers or offices to provide robust analyses on a routine and recurring basis; and • strengthen oversight and support that will serve to prevent an inordinate backlog of uncertified claims. To improve Medicare information systems controls, CMS should: • continually assess the governance and oversight across its organization units charged with responsibility for configuration management and information security of its Medicare FFS systems and data for both the Central Office and the CMS FFS contractors; • ensure that appropriate segregation of duties is established and maintained for		*CMS Financial Report, Fiscal Year 2015. Audit Opinion Section. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2015 (pp. 118 through 125)* A-17-15-02015 **(Nov. 2015)** A-17-16-02016 **(Nov. 2016)**

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	all systems that support CMS's programs, including Medicare FFS claims and related financial processing at claims processing contractors and virtual data centers, to prevent excessive or inappropriate access; and • have continued implementation of configuration management activities at the Central Office and the Medicare fee-for-service contractors in accordance with CMS' policies and guidance, related monitoring procedures, mitigation of risk, and timely remediation of identified vulnerabilities.		

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