July 2019

Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: OIG's Top Recommendations

U.S. Department of Health & Human Services

Office of Inspector General

About the July 2019 Edition

The *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: OIG's Top Recommendations* is an annual publication of the Department of Health and Human Services (HHS or the 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 public health and safety if implemented. These recommendations come from OIG audits and evaluations performed pursuant to the Inspector General Act of 1978, as amended. This publication is responsive to requirements of the Inspector General Act.[1]

This edition begins with a list of the top 25 unimplemented recommendations, grouped by HHS operating division (OPDIV). For each top 25 recommendation, we then outline key OIG findings and the OPDIV's reported progress in implementing the recommendations. In this edition, we also highlight top 25 recommendations from the 2018 *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations* that were implemented since we published that edition.

In the appendices, we include a list of all unimplemented OIG recommendations that require legislative action. (See Appendix A.) We also include a broader list of OIG's significant unimplemented recommendations described in previous *Semiannual Report(s) to Congress* and the 2018 edition of this publication, as well as significant unimplemented recommendations issued since these publications were issued. (See Appendix B.) Additionally, we include a list of significant recommendations reported in the 2018 edition that were implemented or closed since we published that edition. (See Appendix C.) This edition does not reflect some recent significant recommendations that were issued as the publication was being finalized.

OIG continues to report annually on the *Top Management and Performance Challenges* facing the Department. These challenges arise across HHS programs and cover critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity. We highlight management and performance challenges facing each OPDIV throughout this document.

For more information

More information on OIG's work, including the reports mentioned in this publication, is on our website at https://oig.hhs.gov/. Questions about the *OIG's Top Recommendations* and the lists of legislative and significant unimplemented recommendations should be directed to OIG's Office of External Affairs at Public.Affairs@oig.hhs.gov.

[1] P.L. No. 113-235 (Dec. 16, 2014). The Inspector General Act requires Federal inspectors general to identify significant recommendations described in previous *Semiannual Report(s) to Congress* with respect to problems, abuses, or deficiencies for which corrective action has not been completed.

TABLE OF CONTENTS

Top 25 Unimplemented Recommendations

Centers for Medicare & Medicaid Services (CMS)—Medicare Parts A & B

1. CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for skilled nursing facility (SNF) services so that beneficiaries receiving similar hospital care have similar access to these services.
2. CMS should implement the statutory mandate requiring surety bonds for home health agencies that enroll in Medicare and consider implementing the requirement for other providers.
3. CMS should continue to ensure that medical device-specific information is included on claim forms and require hospitals to use certain condition codes for reporting device replacement procedures.
4. CMS should seek statutory authority to establish additional remedies for hospices with poor performance.[1]
5. CMS should seek legislative authority to comprehensively reform the hospital wage index system.[1]
6. CMS should reevaluate the inpatient rehabilitation facility (IRF) payment system, which could include seeking legislative authority to make any changes necessary to more closely align IRF payment rates and costs.[1]
7. CMS should periodically review claims for replacement positive airway pressure device supplies and take remedial action for suppliers that consistently bill improperly.[1]
8. CMS should consider seeking legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.[1]

CMS—Medicare Parts C & D

9. CMS should collect comprehensive data from plan sponsors, including data on potential fraud and abuse, to improve its oversight of their efforts to identify and investigate potential fraud and abuse.
10. CMS should require Medicare Advantage plans to include ordering and referring provider identifiers in their encounter data.
11. CMS should strengthen oversight of Part D payments for compounded topical drugs to prevent fraud, waste, and abuse while maintaining appropriate access.[1]

CMS—Medicaid

12. CMS should ensure that national Medicaid data are complete, accurate, and timely.
13. CMS and the Health Resources and Services Administration (HRSA) should ensure that States can pay correctly for 340B-purchased drugs billed to Medicaid, by requiring claim-level methods to identify 340B drugs and sharing the official 340B ceiling prices.[1]

14 CMS should require States to either enroll personal care services (PCS) attendants as providers or require PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.

15 CMS should facilitate State Medicaid agencies' efforts to screen new and existing providers by ensuring the accessibility and quality of Medicare's enrollment data.

16 CMS should improve managed care organizations' (MCOs') identification and referral of cases of suspected fraud or abuse.[1]

17 CMS should develop policies and procedures to improve the timeliness of recovering Medicaid overpayments and recover uncollected amounts identified by OIG's audits.[1]

18 CMS should re-evaluate the effects of the healthcare-related tax safe-harbor threshold and the associated 75/75 requirement to determine whether modifications are needed.[1]

Administration for Children and Families (ACF)

19 ACF should develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for children prescribed psychotropic medication.[1]

Food and Drug Administration (FDA)

20 FDA should ensure effective and timely processes related to food facility inspections and food recalls.

Indian Health Service (IHS)

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

22 IHS should assess the continuity of operations programs for all IHS facilities and ensure that each facility has a tested and viable program to respond to and recover from a range of disasters.[1]

National Institutes of Health (NIH)

23 NIH should require security training and security plans for principal investigators and entities and verify that they have fulfilled these requirements before granting them access to genomic data.[1,2]

General Departmental

24 HHS should address issues of non-compliance with the Improper Payments Information Act, as amended, for various programs deemed susceptible to significant improper payments.[1,2]

25 HHS should ensure that all future web application developments incorporate security requirements from an industry recognized web application security standard.[1,2]

Table Note:
[1] Top 25 recommendation is new to this edition.
[2] Recommendation was issued less than 6 months before the date of this publication. OPDIVs are required to submit a Final Management Decision (FMD) within 6 months of report issuance, which indicate whether they concur with the recommendations and any corrective actions they plan to take to implement recommendations. As of the date of this publication, we had not received FMDs for these recommendations, but they were not overdue.

CMS—Medicare Parts A & B

Approximately 38.4 million beneficiaries were enrolled in Medicare Parts A and B in 2018. In 2017, Medicare Parts A and B program payments reached $377 billion. The 2018 Annual Report by Medicare's Board of Trustees estimates that the Trust Fund for Medicare Part A (hospital insurance) will be depleted by 2026. It also projects that spending for Medicare Part B (medical insurance) will grow over 8 percent over the next 5 years, outpacing the U.S. economy. To ensure that Medicare effectively serves beneficiaries well into the future, HHS must foster sound financial stewardship, program integrity, and improved quality of care and health outcomes. This includes helping beneficiaries, clinicians, and providers; protecting Medicare dollars from fraud, waste, and abuse; and implementing prudent payment policies. OIG's work promotes quality of care for Medicare beneficiaries in various settings. OIG also identifies and offers recommendations to reduce improper payments, prevent and deter fraud, and foster economical payment policies across Medicare Part A and B benefits.

Top Management and Performance Challenges Relevant to Medicare Parts A & B: Ensuring Program Integrity in Medicare Fee-for-Service and Effective Administration of Medicare

Protecting the Health and Safety of Vulnerable Populations

Top Unimplemented Recommendations

1 CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services.

Key OIG Findings

Beneficiaries with similar post-hospital care needs have different access to and cost sharing for SNF services depending on whether they were hospital outpatients or inpatients. Additionally, our review of a sample of SNF claims found that many SNFs incorrectly used a combination of inpatient and non-inpatient hospital days to determine whether the 3-night requirement was met, leading to CMS improperly paying an estimated $84.2 million between 2013 and 2015.

Progress in Implementing the Recommendation

In 2014, CMS's Office of the Actuary analyzed counting time spent as an outpatient toward the 3-day inpatient hospital stay requirement for SNF Medicare coverage; its analysis identified potential impacts of a 20-percent uptake in SNF admissions and an increase in Medicare SNF expenditures of $56 billion from 2014 to 2023. CMS still needs to conduct updated analysis about whether, and to what extent, the problem of beneficiaries failing to qualify for Medicare coverage of their SNF services, because some or all of their time spent in the hospital was as an outpatient, continues, as well as reanalyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF Medicare coverage.

Relevant Reports

OEI-02-15-00020 (Dec. 2016); A-05-16-00043 (Feb. 2019)

2 CMS should implement the statutory mandate requiring surety bonds for home health agencies that enroll in Medicare and consider implementing the requirement for other providers.

Key OIG Findings
CMS could have recovered at least $39 million in uncollected overpayments between 2007 and 2011 if it had required home health agencies to obtain $50,000 in surety bonds. Surety bonds could help protect Medicare against fraudulent home health agencies. OIG's historical work has demonstrated that surety bonds would ensure that at least some of the money being dispersed for various services could be recovered.

Progress in Implementing the Recommendation
CMS is currently evaluating its options in implementing a surety bond requirement. CMS has taken other steps to reduce home health service payments. For instance, CMS capped outlier payments in 2010, which resulted in a more than $1 billion-per-year decrease in Medicare payments for home health services nation-wide. However, in fiscal year 2018, Medicare still paid an estimated $3.2 billion in improper payments for home health services.

Relevant Reports
OEI-03-13-00630 (Sept. 2017); OEI-03-12-00070 (Sept. 2012)

3 CMS should continue to ensure that medical device-specific information is included on claim forms and require hospitals to use certain condition codes on claim forms for reporting device replacement procedures.

Key OIG Findings
It is difficult to identify and track Medicare's replacement costs for recalled or prematurely failed medical devices because of the lack of medical device-specific information and certain condition codes on claim forms.

Progress in Implementing the Recommendation
CMS is reviewing its claims policy to determine whether ensuring that device identifiers are included on the next version of claim forms would impose any unnecessary burden on physicians. The X12 Committee, which is the standards-setting organization for claims transactions, issued a draft proposal to add device identifiers to claims.

Relevant Reports
A-05-16-00059 (Mar. 2018); A-01-15-00504 (Sept. 2017)

4 CMS should seek statutory authority to establish additional remedies for hospices with poor performance.

Key OIG Findings
Currently, CMS's only recourse when a hospice is found to have serious deficiencies is to terminate the hospice from the Medicare program, which limits CMS's ability to address performance problems. If CMS cannot effectively address hospices' performance problems, it cannot effectively protect Medicare beneficiaries or the program.

Progress in Implementing the Recommendation
To date, no progress has been reported by CMS. CMS continues to consider this issue.

Relevant Report
OEI-02-16-00570 **(Jul. 2018)**

5 CMS should seek legislative authority to comprehensively reform the hospital wage index system.

Key OIG Findings
OIG identified significant vulnerabilities in the wage index system for Medicare payments. For instance, CMS lacks authority to penalize hospitals that submit inaccurate or incomplete wage data, and Medicare Administrative Contractor (MAC)-limited reviews do not always identify inaccurate wage data. Additionally, wage indexes may not always accurately reflect local labor prices, thus Medicare payments to hospitals and other providers may not be appropriately adjusted to reflect local labor prices.

Progress in Implementing the Recommendation
CMS stated that it will consider whether to recommend including the statutory proposals related to OIG's findings in the President's Budget.

Relevant Report
A-01-17-00500 **(Nov. 2018)**

6 CMS should reevaluate the IRF payment system, which could include seeking legislative authority to make any changes necessary to more closely align IRF payment rates and costs.

Key OIG Findings
Medicare paid IRFs nation-wide $5.7 billion in 2013 for care to beneficiaries that was not reasonable and necessary. These errors occurred, in part, due to IRF payments that are not aligned with cost, which may have provided IRFs with a financial incentive to admit patients inappropriately.

Progress in Implementing the Recommendation
CMS stated that it continuously evaluates the IRF payment system on an annual basis. CMS recently issued the fiscal year 2019 IRF prospective payment system final rule, which updates Medicare policies and payment rates for fiscal year 2019. CMS stated that these changes, specifically the changes to documentation requirements, may potentially decrease the number of improper payments. CMS also stated that it will take OIG's suggestions into account when determining appropriate next steps.

Relevant Report
A-01-15-00500 **(Sept. 2018)**

7 CMS should periodically review claims for replacement positive airway pressure device supplies and take remedial action for suppliers that consistently bill improperly.

Key OIG Findings
Most Medicare claims that durable medical suppliers submitted for replacement positive airway pressure device supplies did not comply with Medicare requirements. Of the 110 claims in our sample, 86 did not comply with Medicare requirements. Additionally, Medicare made an estimated $631 million in overpayments over a two-year period for replacement positive airway pressure device supply claims that did not meet Medicare requirements.

Progress in Implementing the Recommendation
CMS plans to work with Medicare contractors to establish periodic reviews of claims for replacement positive airway pressure device supplies. In addition, for suppliers that consistently submit claims that do not meet Medicare requirements, CMS reported that it will take action, as appropriate.

Relevant Report
A-04-17-04056 **(June 2018)**

8 CMS should consider seeking legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.

Key OIG Findings
If least costly alternative policies, which base the payment amount for a group of clinically comparable products on that of the least costly one, had not been rescinded for Part B drugs, Medicare expenditures for certain prostate cancer drugs would have been reduced by $33.3 million over 1 year (from $264.6 million to $231.3 million). After least costly alternative policies were removed, utilization patterns shifted dramatically in favor of certain costlier products.

Progress in Implementing the Recommendation
CMS has not made any legislative proposals that would potentially implement this recommendation.

Relevant Report
OEI-12-12-00210 (Nov. 2012)

IMPLEMENTED: Top 25 Recommendation from 2018

CMS, as it implements the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), should include stronger program integrity safeguards to modifications of electronic health record (EHR) meaningful use requirements to allow for more consistent verification of the reporting of required measures (A-05-14-00047).

Update: CMS has an audit strategy in place for eligible clinicians in the Merit-Based Incentive Payment System (MIPS) and has hired a contractor to begin work in this area. CMS will conduct audits and data validation in 2019 with respect to the first year of MIPS. These audits will look at data submission of quality measures under MIPS and will also include certain aspects of the "Promoting Interoperability" performance category, which is related to meaningful use of EHR technology.

CMS—Medicare Parts C & D

Approximately 44 million beneficiaries received Medicare Part D benefits and 20 million beneficiaries were enrolled in Medicare Part C in 2018. Part D is a prescription drug benefit provided through private insurance companies—known as Part D plan sponsors. Medicare Advantage (Part C) enrollees receive their coverage through private insurance companies that contract with CMS. OIG's body of work has identified challenges that Medicare Advantage organizations and Part D sponsors face in ensuring program integrity. Among top priorities, OIG is specifically focused on curbing the opioid epidemic through enforcement mechanisms and identifying inappropriate prescribers and beneficiaries at risk of abuse or overdose in the Medicare Advantage and Medicare Part D programs.

Top Management and Performance Challenges Relevant to Medicare Parts C & D: Preventing and Treating Opioid Misuse

Ensuring Value and Integrity in Managed Care and Other Innovative Healthcare Payment and Service Delivery Models

Top Unimplemented Recommendations

9 CMS should collect comprehensive data from plan sponsors, including data on potential fraud and abuse, to improve its oversight of their efforts to identify and investigate potential fraud and abuse.

Key OIG Findings

Plan sponsors may voluntarily report data on potential fraud and abuse to CMS, but they are not required to do so. More than half of Part D plan sponsors did not report such data from 2010 to 2012. As of December 2017, only 60 percent of Part C and D plan sponsors requested access to CMS's electronic system for reporting potential fraud and abuse.

Progress in Implementing the Recommendation

CMS intends to require plan sponsors to report data on potential fraud and abuse and corrective actions taken, and will work with plan sponsors to implement the requirement. CMS previously provided detailed information and guidance to sponsors regarding what constitutes potential fraud and abuse incidents and how to conduct inquiries and respond with appropriate corrective action. The SUPPORT Act also includes provisions that address requirements for Part D plans to share "corrective action plans" with CMS and requires CMS to share information on certain actions it has taken against opioid prescribers. CMS intends to implement these standards through the rulemaking process in a way that is consistent with requirements of the SUPPORT Act.

Relevant Reports

OEI-03-17-00310 (Jul. 2018); OEI-03-13-00030 (Mar. 2014); OEI-02-09-00600 (May 2012); OEI-03-10-00310 (Feb. 2012); OEI-03-08-00420 (Oct. 2009); OEI-03-07-00380 (Oct. 2008)

10 CMS should require Medicare Advantage plans to include ordering and referring provider identifiers in their encounter data.

Key OIG Findings
Ordering and referring provider identifiers are not required in, and were frequently absent from, encounter data. This limits the use of these data for vital program oversight and enforcement activities. It is important that quality of patient care can be tracked by National Provider Identifiers to assess whether ordering or referring providers have determined that services were appropriate for patients.

Progress in Implementing the Recommendation
To date, no progress has been reported by CMS. CMS stated that it would consider this recommendation, but it has not reported taking any action to implement it.

Relevant Reports
OEI-03-15-00060 (Jan. 2018)

11 CMS should strengthen oversight of Part D payments for compounded topical drugs to prevent fraud, waste, and abuse while maintaining appropriate access.

Key OIG Findings
Part D spending for compounded topical drugs has increased exponentially in recent years—from $13.2 million in 2010 to $232.5 million in 2016. OIG identified pharmacies with questionable billing for these drugs, many of which are concentrated in a handful of metropolitan areas. OIG also identified prescribers with concerning order patterns for compounded topical drugs.

Progress in Implementing the Recommendation
CMS issued a memorandum to plan sponsors that clarified Part D policies for coverage of compounded topical drugs and use of utilization management tools. CMS has conducted some analysis of pharmacies and has provided limited training for plan sponsors on compounded topical drugs. However, it has not yet completed followup on the pharmacies and prescribers identified by OIG.

Relevant Reports
OEI-02-16-00440 (Aug. 2018); OEI-02-16-00290 (June 2016)

CMS—Medicaid

Medicaid serves more enrollees than any other Federal healthcare program, and Medicaid spending represents one-sixth of the national healthcare economy. In calendar year 2017, Medicaid had over $361 billion in Federal health expenditures. As of December 2018, Medicaid served over 72 million individuals, including in the Children's Health Insurance Program (CHIP). OIG's work has identified substantial improper payments to providers across a variety of Medicaid services and on behalf of ineligible individuals. OIG has also identified concerns with the completeness and reliability of national Medicaid data. Medicaid has experienced longstanding program integrity vulnerabilities and challenges in ensuring that beneficiaries have access to and receive high-quality care.

Top Management and Performance Challenges Relevant to Medicaid:

Ensuring that HHS Prescription Drug Programs Work as Intended

Ensuring Program Integrity and Effective Administration of Medicaid

Ensuring Value and Integrity in Managed Care and Other Innovative Healthcare Payment and Service Delivery Models

Protecting the Health and Safety of Vulnerable Populations

Top Unimplemented Recommendations

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

Key OIG Findings

Data are essential for detecting fraud, waste, and abuse. However, national Medicaid data have deficiencies that hinder timely and accurate detection. Additionally, problems with Medicaid data have hindered program integrity, research, budgeting, and policy.

Progress in Implementing the Recommendation

All States, the District of Columbia, Puerto Rico, and the Virgin Islands are submitting Transformed Medicaid Statistical Information System (T-MSIS) data. CMS has shifted its T-MSIS efforts to assessing and improving the quality of T-MSIS data. Through one-on-one technical assistance efforts, CMS reviews a State's data quality issues in 23 top-priority areas and then works with the State on addressing them.

Relevant Reports

OEI-05-15-00050 (June 2017); OEI-07-13-00120 (Jul. 2015); OEI-05-12-00610 (Sept. 2013); OEI-02-15-00260 (Jul. 2018)

13 CMS and HRSA should ensure that States can pay correctly for 340B-purchased drugs billed to Medicaid, by requiring claim-level methods to identify 340B drugs and sharing the official 340B ceiling prices.

Key OIG Findings

A lack of transparency regarding both 340B ceiling prices and Medicaid claims associated with 340B-purchased drugs limits State Medicaid agencies' ability to correctly apply their 340B payment policies. Specifically, State Medicaid agencies do not have access to 340B ceiling prices and so cannot create prepay edits for 340B-purchased drugs to prevent overpayments. Moreover, many States are not able to accurately identify specific claims for 340B-purchased drugs because they use methods (e.g., HRSA's Medicaid Exclusion File) that only allow them to identify claims that operate at the broader, provider level. State Medicaid agencies need to know 340B ceiling prices and which Medicaid claims are associated with 340B drugs to ensure that they are correctly paying claims.

Progress in Implementing the Recommendation

CMS stated that it does not have the authority to require States to use claim-level methods to identify 340B claims. However, States may develop their own billing instructions in accordance with requirements in the Public Health Service Act. CMS also stated that it provides technical assistance to States on their Medicaid Drug Rebate Programs, and that it would consider OIG's findings when working with States on this issue in the future. HRSA stated that it would have to seek legislative authority to share 340B ceiling prices with States, but it is working with CMS to determine whether ceiling price data can be released to States through an administrative mechanism.

Relevant Reports

OEI-05-14-00430 (June 2016); OEI-05-09-00321 (June 2011)

14 CMS should require States to either enroll PCS attendants as providers or require PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.

Key OIG Findings
PCS are subject to persistent fraud and beneficiary harm. Furthermore, OIG has raised concerns about the varying standards, and in some cases minimal vetting, for PCS attendants.

Progress in Implementing the Recommendation
CMS continues to have internal deliberations on the feasibility of requiring unique identifiers for PCS attendants and the reflection of their identity on PCS claims. In addition, the Cures Act mandated that States implement an electronic visit verification system for all Medicaid PCS by January 1, 2020.

Relevant Reports
OIG-12-12-01 (Nov. 2012); OEI-12-16-00500 (Dec. 2017)

15 CMS should facilitate State Medicaid agencies' efforts to screen new and existing providers by ensuring the accessibility and quality of Medicare's enrollment data.

Key OIG Findings
State Medicaid agencies reported challenges using provider screening results from Medicare due to incomplete Medicare data. Access to this information would be useful to State agencies to identify providers that it must terminate from Medicaid pursuant to law.

Progress in Implementing the Recommendation
CMS provided training to States on accessing and using data on Medicare provider enrollment screening results held in various CMS data repositories. CMS indicated it has also implemented the Data Exchange System, which is used to share data among CMS and the States on provider terminations, revocations, exclusions, and deaths. Furthermore, CMS improved State access to Medicare provider enrollment data by developing a dedicated Provider Enrollment, Chain, and Ownership System (PECOS) portal for States. CMS is also reviewing National Supplier Contractor supplier data to ensure that all site visit information is appropriately captured in PECOS. Finally, CMS has implemented system edits to ensure the completeness and increase the quality of the Medicare enrollment data within PECOS.

Relevant Reports
OEI-05-13-00520 (May 2016); OEI-04-11-00590 (May 2016); OEI-03-13-00050 (Apr. 2016)

16 CMS should improve MCOs' identification and referral of cases of suspected fraud or abuse.

Key OIG Findings

MCOs are on the front line of ensuring the integrity of Medicaid payments, yet weaknesses exist in their efforts to identify and address fraud and abuse. Although the number of cases varied widely, some MCOs identified and referred few cases of suspected fraud or abuse to the State in 2015, with 13 of the 38 MCOs reviewed referring fewer than 10 cases. Although MCOs took actions against providers suspected of fraud or abuse, they did not typically inform the State, including when MCOs terminated provider contracts for reasons associated with fraud and abuse. Additionally, 4 of the 38 MCOs did not identify and recover a single overpayment. Along with States, MCOs are essential to safeguarding the Medicaid program and taxpayer dollars. It is crucial that all MCOs identify and refer cases of fraud and abuse to the State and ensure that Medicaid dollars are spent appropriately.

Progress in Implementing the Recommendation

CMS is working with States to provide technical assistance and education to identify and share best practices to assist States in improving MCOs' identification and referral of cases of suspected fraud or abuse. Furthermore, CMS is developing a series of educational tool kits to assist States on identifying potential managed care fraud. Finally, CMS is drafting additional regulatory guidance in connection with the Medicaid managed care final rule.

Relevant Report

OEI-02-15-00260 **(Jul. 2018)**

17 CMS should develop policies and procedures to improve the timeliness of recovering Medicaid overpayments and recover uncollected amounts identified by OIG's audits.

Key OIG Findings

CMS had not recovered all overpayments identified in OIG audit reports in accordance with Federal requirements. As of May 2, 2018, CMS had recovered about $909.2 million of the $2.7 billion in Medicaid overpayments identified in the current and prior periods. However, CMS did not collect the remaining $1.8 billion for 84 OIG audit reports. Specifically, CMS had not collected about $1.6 billion in overpayments identified in 77 current period audits and $188.6 million in overpayments identified in 7 prior period audits.

Progress in Implementing the Recommendation

CMS indicated it has issued or is in the process of issuing disallowance letters totaling $383.5 million for 10 audits. CMS has been working to resolve complex policy questions related to 27 audits with $948.6 million in OIG-identified overpayments, and has issued demand letters for $142.8 million related to these audits. CMS has issued or is in the process of issuing either audit compromise letters or disallowance letters totaling $143.5 million for 14 audits. CMS is still reviewing 33 audits totaling $357 million in OIG-identified overpayments. CMS is also exploring options for improving the timeliness of discussions with State officials, obtaining documentation from States, and issuing disallowance letters.

Relevant Report

A-05-17-00013 **(Dec. 2018)**

18 CMS should re-evaluate the effects of the healthcare-related tax safe-harbor threshold and the associated 75/75 requirement to determine whether modifications are needed.

Key OIG Findings
States may use revenue from permissible healthcare-related taxes to fund a portion of the non-Federal share of Medicaid expenditures. CMS will deem a tax impermissible if the taxpayer is held-harmless for the tax payments. A taxpayer is held harmless if the tax exceeds 6 percent of net patient revenues and at least 75 percent of the tax is returned to at least 75 percent of the taxpayers through supplemental Medicaid payments (known as the 75/75 requirement). A "safe harbor" is created if the tax is 6 percent or less. In that case, the 75/75 requirement does not apply.

Our review of hospital tax programs for seven States found that non-disproportionate share supplemental payments exceeded 75 percent of hospital tax payments in each year for all States, except for 2 years in one State and 1 year for another State. However, because the tax rate was less than the 6-percent safe-harbor threshold, the programs could return more than 75 percent of the tax payments to more than 75 percent of taxpayers without violating the hold-harmless requirement.

Progress in Implementing the Recommendation
CMS concurred with our recommendation and stated that it will evaluate the effects of the healthcare-related-tax threshold and the associated 75/75 requirement to determine whether modifications are needed.

Relevant Report
A-03-16-00202 **(Nov. 2018)**

IMPLEMENTED: Top 25 Recommendation from 2018

CMS should pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid drug rebate program (OEI-03-17-00100).

Update: In April 2019, the President signed the Medicaid Services Investment and Accountability Act of 2019, which gave the Secretary new enforcement authorities related to misclassified drugs in the Medicaid drug rebate program. Specifically, if a manufacturer does not correct a misclassification identified by the Secretary, the Secretary may now unilaterally correct the misclassification, and may also assess civil monetary penalties against the manufacturer or exclude the drug from eligibility for Federal reimbursement.

Administration for Children and Families (ACF)

ACF programs focus on promoting the economic and social well-being of families, children, individuals, and communities. Among ACF's vital programs, CCDF—the third-largest block grant program administered by the Federal Government—provides subsidies to approximately 1.4 million children to receive child care every month. Head Start—the largest Federal investment in early childhood education—also promotes school readiness to more than 1 million low-income children through education, health, social, and other services. Safeguarding funds for these programs is crucial to ensure that the funds are used efficiently, effectively, and for their intended purposes. OIG's portfolio of ACF work has focused on ensuring program integrity, quality of care, and safety in ACF's grants programs that provide critical health and human services to children, families, and communities. OIG is undertaking an expansive body of work examining the health and safety of unaccompanied children in the care of ACF's Office of Refugee Resettlement (ORR).

Top Management and Performance Challenges Relevant to ACF:
Protecting the Integrity of HHS Grants

Protecting the Health and Safety of Vulnerable Populations

Top Unimplemented Recommendations

19 ACF should develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for children prescribed psychotropic medication.

Key OIG Findings
In the five States we reviewed, one in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring. State requirements for psychotropic medication oversight in these States did not always incorporate suggested professional practice guidelines for treatment planning and medication monitoring.

Progress in Implementing the Recommendation
ACF plans to undertake several actions to improve States' compliance, including requesting that States report on successes and challenges in addressing psychotropic medication use requirements in their Child and Family Services Plans, as well as assessing related findings in its State Child and Family Services Reviews. Additionally, ACF stated that the topic of oversight of psychotropic medications will be addressed with its constituency group of State foster care managers.

Relevant Report
OEI-07-15-00380 **(Sept. 2018)**

IMPLEMENTED: Top 25 Recommendations from 2018

ACF should resolve recurring Head Start Single Audit Findings (A-02-16-02009; A-06-17-07003; A-09-16-01004; A-06-16-00019).

Update: ACF implemented several recommendations in 2018, including providing training to Head Start grantees on preparing corrective action plans; instituting reorganizational changes; dedicating a team to resolve all audits as soon as possible; entering into a new Audit Resolution Processing System; and tracking audit findings and resolving the issues through quarterly reports that indicate open audit findings.

ACF should request that States examine the effectiveness of their program integrity and fraud-fighting activities in their Child Care Development Fund programs (OEI-03-16-00150).

Update: To implement this recommendation, ACF undertook several actions, including rolling out a Fraud Risk Assessment Tool as part of a webinar series and completing revisions of its Grantee Internal Controls Self-Assessment instrument.

Food and Drug Administration (FDA)

FDA is tasked with ensuring the safety and security of foods and medical products in the U.S. (including drugs, biological products, and medical devices) and overseeing the complex drug and medical device supply. With an annual budget of approximately $5.4 billion in 2018, FDA is responsible for the oversight of more than $2.5 trillion in consumption of food, medical products, and tobacco. FDA-regulated products account for approximately 20 percent of all U.S. consumer spending. OIG has a long history of work focused on a wide range of FDA topics related to food safety, drug products, and medical devices. OIG's work on food safety has highlighted systemic and persistent public health and safety issues.

Top Management and Performance Challenge Relevant to FDA:
Ensuring the Safety of Food, Drugs, and Medical Devices

Top Unimplemented Recommendations

20 FDA should ensure effective and timely processes related to food facility inspections and food recalls.

Key OIG Findings

Deficiencies exist in FDA's oversight of recall initiation, monitoring of recalls, and the recall information captured and maintained in FDA's electronic recall data system. Additionally, FDA did not take advisory or enforcement action in response to 22 percent of significant inspection violations identified from 2011 to 2015. When FDA did take action, it commonly relied on facilities to voluntarily correct violations and rarely used administrative tools provided by the Food Safety Modernization Act. Moreover, FDA did not issue warning letters within the expected timeframe to almost half of the facilities it inspected during 2011–2015. In some cases, its inaction led to facilities continuing to operate under conditions that were harmful to public health. Furthermore, FDA consistently failed to conduct timely followup inspections to ensure that facilities corrected significant inspection violations.

Progress in Implementing the Recommendation

FDA implemented plans to audit and monitor its recall program across all regulated product areas and identified priorities that optimize its policies and procedures for recalling products that pose a public health risk. Additionally, FDA established the Strategic Coordinated Oversight of Recall Execution, a team of FDA senior leaders that examines cases that present significant hazards to human health and makes decisions pertaining to challenging high-risk food-recall cases. In regard to food facility inspections, FDA developed a report to monitor food facilities that warrant followup. The report will allow it to more efficiently track compliance activities resulting from inspections.

Relevant Reports

A-01-16-01502 (Dec. 2017); OEI-02-14-00420 (Sept. 2017)

Indian Health Service (IHS)

IHS, with an estimated annual budget of $6 billion, is the largest HHS program serving the American Indian and Alaska Native (AI/AN) community, providing or funding healthcare services to about 2.2 million AI/ANs in 573 federally recognized tribes nation-wide. IHS faces longstanding challenges that hinder its ability to provide quality care, ensure sound management of Federal funds, and comply with Medicare standards. OIG continues to focus on improving the quality of care delivered by IHS, its management, and its infrastructure. OIG has also reviewed the use of funds across HHS programs that serve the AI/AN community. OIG continues to issue new recommendations, including recommendations issued as this publication was being finalized.

Top Management and Performance Challenge Relevant to IHS: Ensuring Quality and Integrity in Programs Serving AI/AN Populations

Top Unimplemented Recommendations

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

Key OIG Findings

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.

Progress in Implementing the Recommendation

IHS implemented a new Quality Framework and established an Office of Quality, with the goal of tracking compliance and quality efforts through a new accountability dashboard under development. These efforts establish a vision and course of action for improving care provided by IHS facilities. IHS has also established contracts with the Joint Commission Resources to provide consultation services to IHS hospitals to meet accreditation standards. Additionally, IHS is working in partnership with CMS to reduce all-cause harm, improve and sustain compliance, and improve transitions in care.

Relevant Report

OEI-06-14-00010 (Oct. 2016)

22 IHS should assess the continuity of operations programs for all IHS facilities and ensure that each facility has a tested and viable program to respond to and recover from a range of disasters.

Key OIG Findings
One of the two IHS hospitals we reviewed lacked an effective continuity of operations program and disaster recovery plan. In addition, the hospital did not have an alternate recovery facility with the appropriate system hardware, space, infrastructure, and personnel to support information system recovery activities.

Progress in Implementing the Recommendation
IHS continues to assess its contingency planning options. IHS stated that the procurement of alternate recovery facilities and the hospital's updated contingency plans are still in process.

Relevant Report
A-18-16-30540 (Nov. 2017)

National Institutes of Health (NIH)

NIH, the nation's medical research agency, is the largest grant-making agency in HHS. It invests nearly $39 billion annually in medical research. It is made up of 27 different Institutes and Centers, each with its own specific research agenda, often focusing on particular diseases or body systems. Recently, numerous congressional committees have expressed concerns about potential threats to the integrity of taxpayer-funded research and intellectual property, including the theft of intellectual property and its diversion to foreign entities. OIG is undertaking a body of work focused on intellectual property and cybersecurity protections, compliance with Federal requirements and NIH policies for grants and contracts, and the integrity of grant application and selection processes.

Top Management and Performance Challenge Relevant to NIH:
Protecting HHS Data, Systems, and Beneficiaries from Cybersecurity Threats

Protecting the Integrity of HHS Grants

Top Unimplemented Recommendations

23 NIH should require security training and security plans for principal investigators (PIs) and entities and verify that they have fulfilled these requirements before granting them access to genomic data.

Key OIG Findings
NIH did not consider the risk presented by foreign PIs when permitting access to U.S. genomic data. We found that NIH did not: (1) assess the risks to national security when permitting access to foreign PIs, (2) ensure that Data Access Committee members and the Genomic Data Sharing Policy keep current with emerging threats to national security, and (3) verify that foreign PIs had completed information security training or verify whether foreign PIs had a security plan.

Progress in Implementing the Recommendation
Since the report was issued in February 2019, no progress has been reported in implementing the recommendations. As of the date of this publication, we had not received an FMD for this recommendation, but it was not overdue.

Relevant Report
A-18-18-09350 **(Feb. 2019)**

General Departmental

In fiscal year 2018, HHS reported a total of approximately $1.1 trillion in expenditures and awarded $109 billion in grants (excluding CMS). HHS is the largest grant-making agency in the Federal government. Ensuring program integrity and responsible stewardship across HHS programs is vital, and operating an infrastructure that minimizes risk and provides oversight for the protection of resources remains a challenge. OIG has examined the operation of financial management and administrative infrastructure across the Department.

Top Management and Performance Challenges Relevant Across the Department: Improving Financial and Administrative Management and Reducing Improper Payments

Ensuring Program Integrity in Medicare Fee-for-Service and Effective Administration of Medicare

Protecting HHS Data, Systems, and Beneficiaries from Cybersecurity Threats

Top Unimplemented Recommendations

24 HHS should address issues of non-compliance with the Improper Payments Information Act, as amended, for various programs deemed susceptible to significant improper payments.

Key OIG Findings

HHS did not fully comply with all improper payment reporting required under the Improper Payments Information Act of 2002. Specifically, in fiscal year 2018, HHS did not report an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program and the Medicaid, CHIP, and Foster Care programs did not meet their improper payment reduction targets.

Progress in Implementing the Recommendation

Although HHS does not measure and report improper payments for TANF, as required, it uses a multi-faceted approach to support States in improving TANF program integrity and to prevent improper payments. CMS uses data from the Payment Error Rate Measurement program to measure and monitor the States' improper payment rates in Medicaid and CHIP, as well as the progress of their corrective action plans to address the root causes of improper payments. As of the date of this publication, we had not received an FMD for this recommendation, but it was not overdue.

Relevant Reports

A-17-19-52000 **(May 2019)**

25 HHS should ensure that all future web application developments incorporate security requirements from an industry recognized web application security standard.

Key OIG Findings
Security controls across eight HHS OPDIVs needed improvements to more effectively detect and prevent certain types of cyberattacks. During testing, we identified vulnerabilities in configuration management, access control, data input controls, and software patching. We determined that cybersecurity of publicly accessed websites could be improved through the utilization of secure coding standards. Cybersecurity enhancements after application deployment are less effective and more costly.

Progress in Implementing the Recommendation
Since the report was issued in March 2019, no progress has been reported in implementing the recommendations. As of the date of this publication, we had not received an FMD for this recommendation, but it was not overdue.

Relevant Report
A-18-18-08500 (March 2019)

IMPLEMENTED: Top 25 Recommendation from 2018

The Office of the Assistant Secretary for Financial Resources (ASFR) should establish a department-wide source for adverse information from audits of grantees so that grant officials can use it in pre-award assessments and to mitigate risk (OEI-07-12-00110).

Update: In October 2018, HHS established an enterprise-wide Audit Tracking and Analysis System, which automates the assignment of single audit findings and tracks the status of single-audit resolution activities across HHS.

Appendix A: Unimplemented Legislative Recommendations

This appendix identifies OIG unimplemented recommendations that require legislative change to implement or that might best be addressed by legislation. It includes several of OIG's top 25 unimplemented recommendations [indicated below]. The recommendations are grouped by HHS operating division. Some recommendations also include estimated cost savings that we believe would be generated if the specific recommendation(s) were implemented.

Centers for Medicare & Medicaid Services (CMS)

Recommendation	Relevant Report(s)
CMS should seek statutory authority to establish additional remedies for hospices with poor performance. **Top 25 Recommendation #4**	*Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio* **OEI-02-16-00570 (Jul. 2018)**
CMS should seek legislative authority to comprehensively reform the hospital wage index system. **Top 25 Recommendation #5**	*Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments* **A-01-17-00500 (Nov. 2018)**
CMS should seek legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances. **Top 25 Recommendation #8**	*Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B* **OEI-12-12-00210 (Nov. 2012)**
CMS should require the use of claim-level methods to identify 340B claims. **Top 25 Recommendation #13**	*State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates* **OEI-05-14-00430 (June 2016)**
CMS should seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system (PPS) payment rates from budget neutrality adjustments for procedures approved by ambulatory surgical centers. **Estimated Savings: 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)**
CMS should seek legislation to adjust critical access hospital (CAH) swing-bed reimbursement rates to the lower SNF rates. **Estimated Savings: $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 SNF PPS Rates* **A-05-12-00046 (Mar. 2015)**

Recommendation	Relevant Report(s)
CMS should seek legislative authority to: • remove Necessary Provider CAHs' permanent exemption from the distance requirement, allowing CMS to reassess these CAHs; and • revise the CAH Conditions of Participation to include alternative location-related requirements. **Estimated Savings: $449 million in 2011**[2]	*Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-enroll in Medicare* OEI-05-12-00080 **(Aug. 2013)**
CMS should seek legislative authority to expand the diagnosis-related group window to include additional days prior to the inpatient admission and other hospital ownership arrangements, such as affiliated hospital groups. **Estimated Savings: $318 million**[3]	*Medicare and Beneficiaries Could Realize Substantial Savings if the Diagnosis Related Group Window Were Expanded* OEI-05-12-00480 **(Feb. 2014)**
CMS should take all necessary actions, including seeking legislative authority, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A. **Estimated Savings: $223.1 million**	*Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays* A-09-17-03035 **(Nov. 2018)**
CMS should seek a legislative change that would provide the agency flexibility to determine when non-covered versions of a drug should be included in Part B payment amount calculations.	*Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries* OEI-12-17-00260 **(Nov. 2017)**
CMS should explore ways of protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients and use the results of these analyses to seek needed legislative authority to implement these changes.	*Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* OEI-02-15-00020 **(Dec. 2016)**
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)**

[2]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.

[3]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.

Recommendation	Relevant Report(s)
CMS should seek legislation to eliminate the lump-sum payment option for all power mobility devices.	*Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices* A-05-15-00020 **(May 2017)**
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 **(Nov. 2012)**
CMS should consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both average sales prices (ASPs) and average manufacturer prices (AMPs).	*Comparison of ASPs and AMPs: An Overview of 2011* OEI-03-12-00670 **(Jan. 2013)**
CMS should work with Congress to require manufacturers of first generics to submit monthly ASP data during initial generic availability.	*Medicare Payments for Newly Available Generic Drugs* OEI-03-09-00510 **(Jan. 2011)**
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)**
CMS should seek legislative authority or administratively require rural health clinic applicants to document need and impact on access to healthcare in rural underserved areas.	*Status of the Rural Health Clinic Program* OEI-05-03-00170 **(Aug. 2005)**
CMS should set firm deadlines for marketplaces to fully develop system functionality for verifying applicants' eligibility and resolving inconsistencies, assess potential enforcement mechanisms to ensure that marketplaces meet those deadlines, and, if such mechanisms are identified, seek legislative authority to establish them.	*CMS Did Not Provide Effective Oversight to Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs* A-09-16-01002 **(Sept. 2017)**
CMS should seek a legislative change that would provide the agency flexibility to determine when noncovered versions of a drug should be included in Part B payment amount calculations.	*Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries* OEI-12-17-00260 **(Nov. 2017)**
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)**
CMS should evaluate the extent to which Medicare payment rates for therapy should be reduced.	*The Medicare Payment System for SNFs Needs to Be Reevaluated* OEI-02-13-00610 **(Sept. 2015**)

Recommendation	Relevant Report(s)
CMS should ensure that the Medicare Drug Integrity Contractor (MEDIC) has the ability to require medical records from prescribers of Part D drugs not under contract with plan sponsors, obtaining legislative authority, if necessary.	*The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness* OEI-03-17-00310 **(Jul. 2018)**

Food and Drug Administration (FDA)

Recommendation	Relevant Report(s)
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 **(Feb. 2013)**
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 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 should consider seeking 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 **(Apr. 2010)**

Health Resources and Services Administration (HRSA)

Recommendation	Relevant Report(s)
HRSA should share 340B ceiling prices with States. **Top 25 Recommendation #13**	*State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs* OEI-05-09-00321 **(June 2011)**

Appendix B: Significant Unimplemented Recommendations

This appendix includes a list of significant unimplemented recommendations compiled from audit and evaluation reports of HHS-OIG. The recommendations represent opportunities to achieve expected impact through cost savings, improvements in program effectiveness and efficiency, and increased quality of care and safety of program beneficiaries.

This appendix includes significant recommendations described in previous *Semiannual Report(s) to Congress* and the 2018 edition of this publication. It also includes significant recommendations issued since these publications were issued. The recommendations describe problems, abuses, or deficiencies for which corrective action has not been completed. The recommendations are generally grouped by HHS operating division. It includes OIG's top 25 unimplemented recommendations [indicated below]. Note that the recommendations in this appendix include the exact wording from the associated audits or evaluations, some of which is paraphrased in the top 25 recommendation summaries. Some recommendations also include estimated cost savings that we believe would be generated if the specific recommendation(s) were implemented. The hyperlinks below provide more information on the report(s) relevant to each recommendation.

Centers for Medicare & Medicaid Services (CMS)—Medicare Parts A & B

Recommendation	Relevant Report(s)
CMS should: • ensure that when SNF claims are being processed for payment, the Common Working File (CWF) qualifying inpatient hospital stay edit for SNF claims is enabled and operating properly to identify SNF claims ineligible for Medicare reimbursement; • require hospitals to provide a written notification to beneficiaries whose discharge plans include post-hospital SNF care, clearly stating how many inpatient days of care the hospital provided and whether the 3-day rule for Medicare coverage of SNF stays has been met (if necessary, CMS should seek statutory authority to do so); • require SNFs to obtain from the hospital or beneficiary, at the time of admission, a copy of the hospital's written notification to the beneficiary and retain it in the beneficiary's medical record (if necessary, CMS should seek statutory authority to do so); • require SNFs to provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met (if necessary, CMS should seek statutory authority to do so);	*CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met* A-05-16-00043 **(Feb. 2019)**

Recommendation	Relevant Report(s)
• educate hospitals about the importance of explicitly communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent SNF care for Medicare reimbursement so that beneficiaries understand their potential financial liability related to SNF care; and • educate SNFs about their responsibility to submit accurate and valid claims for payment that are supported with documentation that clearly shows that the SNF services qualify for reimbursement. **Top 25 Recommendation #1** **Estimated Savings: $84.2 million**	
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; • identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy; • analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services; and • explore ways of protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients. **Top 25 Recommendation #1**	*Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* OEI-02-15-00020 **(Dec. 2016)**
CMS should implement the home health agency surety bond requirement. **Top 25 Recommendation #2**	*Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* OEI-03-12-00070 **(Sept. 2012)**
CMS should: • identify strategies to increase MACs' collection of Zone Program Integrity Contractors (ZPICs) and Unified Program Integrity Contractors (UPICs) referred overpayments; and • implement the surety bond requirement for home health providers and consider the feasibility of implementing surety bonds for other providers based on their level of risk. **Top 25 Recommendation #2**	*Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPIC and Program Safeguard Contractors* OEI-03-13-00630 **(Sept. 2017)**

Recommendation	Relevant Report(s)
CMS should: • continue to work with the Accredited Standards Committee to ensure that the device identifier is included on the next version of claim forms; and • require hospitals to use condition codes 49 or 50 on claims for reporting a device replacement procedure if the procedure resulted from a recall or premature failure independent of whether there was a device provided at no cost or with a credit. **Top 25 Recommendation #3**	*Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely Failed Devices* A-01-15-00504 **(Sept. 2017)**
CMS should: • (assuming the OIG recommendation requiring the use of condition codes 49 and 50 is implemented) instruct its Medicare contractors to implement a postpayment process to followup with any hospital that submits a claim for certain cardiac device replacement procedures with condition code 49 or 50 but no value code FD to determine whether an adjustment claim should be submitted; and • consider studying alternatives to implementing edits to eliminate the current Medicare requirements for reporting device credits, for instance, by reducing inpatient PPS and outpatient PPS payments for device-intensive procedures. **Top 25 Recommendation #3**	*Hospitals Did Not Comply with Medicare Requirements for Reporting Certain Cardiac Device Credits* A-05-16-00059 **(Mar. 2018)**
CMS should: • analyze claims data to inform the survey process; • analyze deficiency data to inform the survey process; • seek statutory authority to establish additional, intermediate remedies for poor hospice performance; • develop other claims-based information and include it on Hospice Compare; • include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies; • work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers; • ensure that a physician is involved in the decisions to start and continue general inpatient care; • analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns; • take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns;	*Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio* OEI-02-16-00570 **(Jul. 2018)**

Recommendation	Relevant Report(s)
• increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate; • implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled; • develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D; • assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs; • adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care; and • modify the payments for hospice care in nursing facilities. **Top 25 Recommendation #4**	
CMS should seek legislative authority to comprehensively reform the hospital wage index system. **Top 25 Recommendation #5**	*Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments* A-01-17-00500 **(Nov. 2018)**
CMS should reevaluate the IRF payment system, which could include: • conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices, • studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them; and • considering the high error rate found in this report and Comprehensive Error Rate Testing reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute-care PPS system. **Top 25 Recommendation #6**	*Many Inpatient Rehabilitation Facilities Stays Did Not Meet Medicare Requirements* A-01-15-00500 **(Sept. 2018)**
CMS should work with Medicare contractors to establish periodic reviews of claims for replacement positive airway pressure device supplies and take remedial action for suppliers that the contractors find consistently bill claims that do not meet Medicare	*Most Medicare Claims for Replacement Positive Airway Pressure Device Supplies Did*

Recommendation	Relevant Report(s)
requirements. **Top 25 Recommendation #7** **Estimated Savings: $631.2 million**	*Not Comply with Medicare Requirements* A-04-17-04056 **(June 2018)**
CMS should consider seeking legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances. **Top 25 Recommendation #8**	*Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B* OEI-12-12-00210 **(Nov. 2012)**
CMS should: • revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational; and • ensure that the PECOS data contain the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements. **Top 25 Recommendation #15**	*Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* OEI-03-13-00050 **(Apr. 2016)**
CMS should: • study reinstating the coinsurance and deductible provisions for laboratory services 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.	*Followup 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)**
CMS should seek legislation that would exempt the reduced expenditures as a result of lower outpatient PPS payment rates from budget neutrality adjustments for ambulatory surgical center (ASC)-approved procedures. **Estimated Savings: 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 ASC-Approved Procedures to ASC Payment Rates* A-05-12-00020 **(Apr. 2014)**
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: $4.1 billion over a 6-year period**	*Medicare Could Have Saved Billions at CAHs If Swing-Bed Services Were Reimbursed Using the SNF PPS Rates* A-05-12-00046 **(Mar. 2015)**
CMS should seek legislative authority to:	*Most CAHs Would Not Meet*

Recommendation	Relevant Report(s)
• remove Necessary Provider CAHs' permanent exemption from the distance requirement, allowing CMS to reassess these CAHs; and • revise the CAH Conditions of Participation to include alternative location-related requirements. **Estimated Savings: $449 million in 2011[4]**	*the Location Requirements if Required to Re-enroll in Medicare* **OEI-05-12-00080 (Aug. 2013)**
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: $318 million[5]**	*Medicare and Beneficiaries Could Realize Substantial Savings if the Diagnostic Related Group Window Were Expanded* **OEI-05-12-00480 (Feb. 2014)**
CMS should: • direct the durable medical equipment MACs to correct the CWF edits to fully prevent or detect overpayments to suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies items provided during inpatient stays; and • take all necessary actions, including seeking legislative authority, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A. **Estimated Savings: $223.1 million**	*Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays* **A-09-17-03035 (Nov. 2018)**
CMS should adjust the estimated number of evaluation and management (E&M) services within eye 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: $97.6 million per year[6]**	*Nationwide Review of E&M Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005* **A-05-07-00077 (Apr. 2009)**
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.	*Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* **A-05-09-00053 (May 2012)**

[4] 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.

[5] 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.

[6] Estimate based on calendar year 2005 data.

Recommendation	Relevant Report(s)
Estimated Savings: $49 million[7]	
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 calendar year 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: $14.6 million**[8]	*Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* A-05-09-00054 **(May 2012)**
CMS should: • direct the Medicare contractors to recover the $66,309,751 in identified improper payments; and • strengthen its system edits to prevent improper payments for specimen validity tests and instruct the Medicare contractors to educate providers on properly billing for specimen validity and urine drug tests, which could result in savings of an estimated $12,146,760 over a 5-year period. **Estimated Savings: $12.1 million over a 5-year period**	*Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests* A-09-16-02034 **(Feb. 2018)**
CMS should seek legislation to eliminate the lump-sum payment option for all power mobility devices. If such legislation had been in place during CY 2011 through CY 2014, Medicare could have saved at least an additional $10,245,539. **Estimated Savings: $10.2 million**	*Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices* A-05-15-00020 **(May 2017)**
CMS should expand the price-substitution policy. **Estimated Savings: $2.7 million**[9]	*Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices* OEI-03-18-00120 **(Aug. 2018)**
CMS should recover $2,344,680 in overpayments made to eligible professionals after they switched programs and recover $291,222 in payments made to the sampled eligible professionals who did not meet meaningful use requirements.	*Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments that Did Not Comply with Federal Requirements* A-05-14-00047 **(June 2017)**

[7] Estimate based on calendar year 2007 data.
[8] Estimate based on calendar year 2007 data.
[9] If CMS had expanded its price-substitution criteria to include certain other Part B drugs in 2016, Medicare and its beneficiaries could have saved up to an additional $2.7 million over 1 year.

Recommendation	Relevant Report(s)
CMS should work with its contractors to educate chiropractors on the training materials that are available to them.	*Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services* A-09-16-02042 **(Feb. 2018)**
CMS should seek a legislative change that would provide the agency flexibility to determine when non-covered versions of a drug should be included in Part B payment amount calculations.	*Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries* OEI-12-17-00260 **(Nov. 2017)**
CMS should take immediate action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Among other things, CMS should: • implement procedures to compare Medicare claims for emergency room treatment with claims for SNF services to identify incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs and periodically provide the details of this analysis to the Survey Agencies for further review; and • continue to work with the HHS Office of the Secretary to receive the delegation of authority to impose the civil monetary penalties and exclusion provisions of section 1150B of the Social Security Act.	*Early Alert: CMS Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at SNFs Are Identified and Reported in Accordance with Applicable Requirements* A-01-17-00504 **(Aug. 2017)**
CMS should make better use of data analytics to ensure the integrity of hospital-reported quality data and the resulting payment adjustments.	*CMS Validated Hospital Inpatient Quality Reporting Program Data, But Should Use Additional Tools to Identify Gaming* OEI-01-15-00320 **(Apr. 2017)**
CMS should provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care.	*Hospices Should Improve Their Election Statements and Certifications of Terminal Illness* OEI-02-10-00492 **(Sept. 2016)**
CMS should: • raise awareness of adverse events in rehabilitation hospitals and work to reduce harm to patients; • collaborate with the Agency for Healthcare Research and Quality (AHRQ) to create and promote a list of potential rehabilitation hospital events; and • include information about potential events and patient harm in its quality guidance to rehabilitation hospitals.	*Adverse Events in Inpatient Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* OEI-06-14-00110 **(Jul. 2016)**

Recommendation	Relevant Report(s)
CMS should: • take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements; and • require hospitals to submit attestations for all their provider-based facilities.	*CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain* **OEI-04-12-00380 (June 2016)**
CMS should follow up on inappropriate general inpatient care stays, inappropriate Part D payments, and hospices that provided poor-quality care.	*Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care* **OEI-02-10-00491 (Mar. 2016)**
CMS should continue working with participating States to fully implement their background check programs.	*National Background Check Program for Long-Term-Care Employees: Interim Report* **OEI-07-10-00420 (Jan. 2016)**
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 SNFs Needs to Be Reevaluated* **OEI-02-13-00610 (Sept. 2015)**
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.	*SNF Billing for Changes in Therapy: Improvements Are Needed* **OEI-02-13-00611 (June 2015)**
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)**
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 CAHs* **OEI-05-12-00085 (Oct. 2014)**
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)**

Recommendation	Relevant Report(s)
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)**
CMS should: • explore the possibility of requiring providers to identify on the Part B claim the pharmacy that produced the compounded drug; and • explore the possibility of conducting descriptive analyses of Part B claims for compounded drugs.	*Compounded Drugs Under Medicare Part B: Payment and Oversight* OEI-03-13-00270 **(Apr. 2014)**
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 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)**
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)**
CMS should distinguish payments in the end-stage renal disease (ESRD) base rate between independent and hospital-based dialysis facilities.	*Update: Medicare Payments for ESRD Drugs* OEI-03-12-00550 **(Mar. 2014)**
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)**
CMS should instruct Medicare contractors to increase monitoring of outlier payments.	*Medicare Hospital Outlier Payments Warrant Increased Scrutiny* OEI-06-10-00520 **(Nov. 2013)**
CMS should use the Medicare Appeals System to monitor Medicare contractor performance.	*The First Level of the Medicare Appeals Process, 2008–2012: Volume, Outcomes, and Timeliness* OEI-01-12-00150 **(Oct. 2013)**

Recommendation	Relevant Report(s)
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)**
CMS should consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both ASPs and AMPs.	*Comparison of ASPs and AMPs: An Overview of 2011* OEI-03-12-00670 **(Jan. 2013)**
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)**
CMS should monitor compliance with the new therapy assessments.	*Inappropriate Payments to SNFs Cost Medicare More Than $1 Billion in 2009* OEI-02-09-00200 **(Nov. 2012)**
CMS should: • standardize case files and make them electronic; and • improve the 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 **(Nov. 2012)**
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)**
CMS should facilitate access to information necessary to ensure accurate coverage and reimbursement determination.	*Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents* OEI-07-08-00150 **(May 2011)**
CMS should work with Congress to require manufacturers of first generics to submit monthly ASP data during initial generic availability.	*Medicare Payments for Newly Available Generic Drugs* OEI-03-09-00510 **(Jan. 2011)**
CMS should seek legislative authority or administratively require rural health clinic applicants to document need and impact on access to healthcare in rural underserved areas.	*Status of the Rural Health Clinic Program* OEI-05-03-00170 **(Aug. 2005)**

Recommendation	Relevant Report(s)
CMS should conduct periodic postpayment reviews for telehealth claim edits that cannot be implemented, implement all telehealth claim edits, and offer education and training to practitioners on Medicare telehealth requirements.	*CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements* A-05-16-00058 **(Apr. 2018)**
CMS should take steps to ensure that no resident is counted as more than one full-time employee. This could include implementing policies and procedures to analyze Intern and Resident Information System data or requiring MACs to determine whether residents claimed by hospitals in their jurisdiction were claimed as more than one full-time employee.	*CMS Did Not Always Ensure Hospitals Complied With Medicare Reimbursement Requirements for Graduate Medical Education* A-02-17-01017 **(Nov. 2018)**
CMS should finalize the implementation of automated ASP-related procedures by using AMP-related processes as a model, and subsequently require all manufacturers to submit ASPs through the automated system.	*Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs* OEI-12-13-00040 **(Jul. 2014)**

CMS—Medicare Parts C & D

Recommendation	Relevant Report(s)
CMS should: • 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. **Top 25 Recommendation #9**	*Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse* OEI-03-13-00030 **(Mar. 2014)**
CMS should: • review MAOs to determine why certain organizations reported high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries; and • ensure that all MAOs are responding appropriately to potential fraud and abuse incidents. **Top 25 Recommendation #9**	*MAOs' Identification of Potential Fraud and Abuse* OEI-03-10-00310 **(Feb. 2012)**

Recommendation	Relevant Report(s)
CMS should: • 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; and • use this required information to help determine the effectiveness of sponsors' fraud and abuse programs. **Top 25 Recommendation #9**	*Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* **OEI-03-07-00380 (Oct. 2008)**
CMS should: • require plan sponsors to report Part C and Part D fraud and abuse incidents and the corrective actions taken to address them to a centralized system; • provide the MEDIC centralized access to all Part C encounter data; • require that Part C and Part D providers and pharmacies enroll in Medicare; • clarify the MEDIC's authority to require records from pharmacies, pharmacy benefit managers, and other entities under contract with Part C and Part D plan sponsors; • ensure that the MEDIC has the ability to require medical records from prescribers of Part D drugs not under contract with plan sponsors, obtaining legislative authority, if necessary; and • establish measures to assess the MEDIC's effectiveness. **Top 25 Recommendation #9**	*The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness* **OEI-03-17-00310 (Jul. 2018)**
CMS should: • require Medicare Advantage organizations (MAOs) to submit ordering and referring provider identifiers for applicable records; and • ensure that MAOs submit rendering provider identifiers for applicable records. **Top 25 Recommendation #10**	*Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed* **OEI-03-15-00060 (Jan. 2018)**
CMS should: • conduct additional analysis on compounded topical drugs; • conduct training for Part D sponsors on fraud schemes and safety concerns related to compounded topical drugs; and • follow up on pharmacies with questionable Part D billing and the prescribers associated with these pharmacies. **Top 25 Recommendation #11**	*Questionable Billing for Compounded Topical Drugs in Medicare Part D* **OEI-02-16-00440 (Aug. 2018)**
CMS should: • evaluate the cost-effectiveness of edits and medical reviews that	*MACs Continue to Use Different Methods to*

Recommendation	Relevant Report(s)
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.	*Determine Drug Coverage* OEI-03-13-00450 **(Aug. 2016)**
CMS should improve coordination and collaboration with NIH.	*CMS Has Not Performed Required Closeouts of Contracts Worth Billions* OEI-03-12-00680 **(Dec. 2015)**
CMS should: • implement policies and procedures to notify MAOs of unlawful-presence information and thereby prevent their enrollment in MAOs, prevent enrollment of unlawfully present beneficiaries in Part D, disenroll such beneficiaries already enrolled, automatically reject such prescription drug event records, and recoup any improper payments; • identify and recoup improper payments made to MAOs for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented; and • recoup $26 million in improper payments in accordance with legal requirements.	*Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries during 2010 Through 2012* A-07-13-01125 **(Apr. 2014)** *Medicare Improperly Paid MAOs Millions of Dollars for Unlawfully Present Beneficiaries for 2009 Through 2011* A-07-12-06038 **(Oct. 2013)**
CMS should: • determine whether outlier data values submitted by MAOs reflect inaccurate reporting or atypical performance; and • use appropriate Part C reporting requirements data as part of its reviews of MAOs' 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)**
CMS should: • define pharmacy benefit managers 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 Medicare Part D Pharmacy and Therapeutics committee; and • oversee compliance with Federal Pharmacy and Therapeutics committee conflict-of-interest requirements and guidance.	*Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions* OEI-05-10-00450 **(Mar. 2013)**
CMS should 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 for further action involving inappropriate services.	*Medicare Drug Integrity Contractor (MEDIC) Benefit Integrity Activities in Medicare Parts C and D* OEI-03-11-00310 **(Jan. 2013)**

Recommendation	Relevant Report(s)
CMS should: • 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)**
CMS should hold sponsors more accountable for inaccuracies in the bids.	*Medicare Part D Reconciliation Payments for 2006 and 2007* OEI-02-08-00460 **(Sep. 2009)**
CMS should: • require sponsors to use methods CMS deems reasonable to allocate rebates across plans; and • ensure that sponsors appropriately report the fees that pharmacy benefit managers collect from manufacturers.	*Concerns with Rebates in the Medicare Part D Program* OEI-02-08-00050 **(Mar. 2011)**
CMS should: • enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate; • address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage; and • provide beneficiaries with clear, easily accessible information about serious violations by MAOs.	*Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* OEI-09-16-00410 **(Sep. 2018)**

CMS—Medicaid

Recommendation	Relevant Report(s)
CMS should monitor encounter data to ensure that States report data for all managed care entities. **Top 25 Recommendation #12**	*Not All States Reported Medicaid Managed Care Encounter Data as Required* OEI-07-13-00120 **(Jul. 2015)**
CMS should establish a deadline for when national Transformed Medicaid Statistical Information System data will be available. **Top 25 Recommendation #12**	*Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* OEI-05-12-00610 **(Sept. 2013)**
CMS should require the use of claim-level methods to identify 340B claims. **Top 25 Recommendation #13**	*State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates* OEI-05-14-00430 **(June 2016)**

Recommendation	Relevant Report(s)
CMS should: • improve MCO identification and referral of cases of suspected fraud or abuse; • increase MCO reporting of corrective actions taken against providers suspected of fraud or abuse to the State; • clarify the information MCOs are required to report regarding providers that are or otherwise leave the MCO network; • identify and share best practices about payment retention policies and incentives to increase recoveries; • improve coordination between MCOs and other State program integrity entities; • standardize reporting of referrals across all MCOs in the State; • ensure that MCOs provide complete, accurate, and timely encounter data; and • monitor encounter data and impose penalties on States for submitting inaccurate or incomplete encounter data. **Top 25 Recommendations #12 and #16**	*Weaknesses Exist in Medicaid MCO's Efforts to Identify and Address Fraud and Abuse* **OEI-02-15-00260 (Jul. 2018)**
CMS should 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. **Top 25 Recommendation #14**	*PCS: Trends, Vulnerabilities, and Recommendations for Improvement* **OIG-12-12-01 (Nov. 2012)**
CMS should require State Medicaid programs to verify the completeness and accuracy of provider ownership information. **Top 25 Recommendation #15**	*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* **OEI-04-11-00590 (May 2016)**
CMS should: • help States implement fingerprint-based criminal background checks for all high-risk providers; • help States overcome challenges in conducting site visits, • enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data; • develop a central system by which States can submit and access screening results from other States; • strengthen minimum standards for fingerprint-based criminal background checks and site visits; and • work with States to develop a plan to complete their revalidation screening in a timely way. **Top 25 Recommendation #15**	*Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented* **OEI-05-13-00520 (May 2016)**

Recommendation	Relevant Report(s)
CMS should develop policies and procedures to improve the timeliness of recovering Medicaid overpayments, and recover uncollected amounts identified during OIG's audit. **Top 25 Recommendation #17**	*CMS Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits* A-05-17-00013 **(Dec. 2018)**
CMS should re-evaluate the effects of the healthcare-related tax safe-harbor threshold and the associated 75/75 requirement to determine whether modifications are needed. **Top 25 Recommendation #18**	*Although Hospital Tax Programs in Seven States Complied with Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated* A-03-16-00202 **(Nov. 2018)**
CMS should provide States with definitive guidance for calculating the Medicaid upper payment limit, which should include using facility-specific upper payment limits that are based on actual cost report data. **Estimated Savings: $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)**
CMS should improve its Drug Data Reporting for Medicaid System to minimize inconsistent data submissions and track potential classification errors for followup.	*Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates* OEI-03-17-00100 **(Dec. 2017)**
CMS should provide additional technical assistance to help Medicaid agencies fully utilize Medicaid payment suspensions as a program integrity tool.	*Challenges Appear to Limit States' Use of Medicaid Payment Suspensions* OEI-09-14-00020 **(Sept. 2017)**
CMS should take appropriate action to ensure that States fully implement National Correct Coding Initiative edits.	*Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments* OEI-09-14-00440 **(Apr. 2016)**
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; • 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	*Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds* A-06-14-00068 **(Mar. 2016)**

Recommendation	Relevant Report(s)
• require States to reconcile total Federal Medicaid funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines.	
CMS should: • 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 track children's utilization of required dental services; and • ensure that States pay for services in accordance with their periodicity schedules.	*Most Children with Medicaid in Four States Are Not Receiving Required Dental Services* **OEI-02-14-00490 (Jan. 2016)**
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)**
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)**
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; and • improve States' efforts to identify and address violations of access standards.	*State Standards for Access to Care in Medicaid Managed Care* **OEI-02-11-00320 (Sept. 2014)**
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)**
CMS should require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits.	*Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs* **OEI-02-08-00170 (June 2012)**

Recommendation	Relevant Report(s)
CMS should instruct all State agencies to review, revise, develop, and implement policies and procedures to monitor the school district administrative claiming and school-based health services programs in their States.	*Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling to Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures* A-07-18-04107 **(Dec. 2018)**
CMS should: • take action against States that do not meet the Deficit Reduction Act of 2005 requirement to collect rebates on physician-administered drugs; and • ensure that all State agencies are accurately identifying and collecting physician-administered drug rebates owed by manufacturers.	*States' Collection of Medicaid Rebates for Physician-Administered Drugs* OEI-03-09-00410 **(June 2011)**
CMS should: • work with States to recoup any potentially inappropriate Federal reimbursement for drugs that CMS determines were not FDA-approved and did not meet the criteria for an exception; • continue to improve its reporting system to prevent inappropriate reimbursement for drugs that are not FDA-approved; and • work with States to ensure that they prevent inappropriate reimbursement for drugs that are not FDA-approved and do not meet the criteria for an exception.	*One Percent of Drugs With Medicaid Reimbursement Were Not FDA-Approved* OEI-03-17-00120 **(May 2019)**

CMS—General

Recommendation	Relevant Report(s)
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; • 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	*Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace* A-01-14-02503 **(Mar. 2015)**

Recommendation	Relevant Report(s)
or updated enrollment data, and (3) the application of these data to allocate costs. **Estimated Savings: $28.4 million**[10]	
CMS should: • continue to enhance the data analysis on Medicaid claims-level data to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program; • establish a process to perform a claims-level detailed look-back analysis on the Medicaid Entitlement Benefits Due and Payable to determine the reasonableness of the methodology utilized to record the approximately $34.1 billion accrual. • consider whether there are portions of the manual journal voucher process to record MAC data at the Central Office that should be configured as routine systemic entries within the system; • continue to adhere to established policies and procedures to ensure that the Statement of Social Insurance model methodology and related calculation and estimate are reviewed at a level of sufficient precision; and • consider additional opportunities to further reduce improper payments which are consistent with the organization's objectives of improving payment accuracy levels; and • continually assess the governance and oversight across its organizational units charged with responsibility for configuration management and information security of its information technology systems and data, at both the Central Office and the CMS Medicare fee-for-service contractors.	Summary of recommendations from the *Report on the Financial Statement Audit of CMS for Fiscal Year 2018* **A-17-18-53000** **CMS Financial Report Fiscal Year 2018 (Nov. 2018)** (See pp. 42 and 47)
CMS should set firm deadlines for marketplaces to fully develop system functionality for verifying applicants' eligibility and resolving inconsistencies, assess potential enforcement mechanisms that would ensure that marketplaces meet those deadlines, and, if such mechanisms are identified, seek legislative authority to establish them.	*CMS Did Not Provide Effective Oversight to Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs* **A-09-16-01002 (Sept. 2017)**

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

Recommendation	Relevant Report(s)
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; and • correct internal control deficiencies by implementing a computerized system so that State marketplaces can submit enrollee eligibility data.	*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)**
CMS should 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)**
CMS should ensure that critical security updates are applied to Internet-facing systems regularly and follow vendor-provided security recommendations for configuring software.	*OIG Penetration Test of CMS's Network* A-18-17-08200 **(Apr. 2018)**
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.	*IHS Hospitals: More Monitoring Needed to Ensure Quality Care* OEI-06-14-00010 **(Oct. 2016)**

Administration for Children and Families (ACF)

Recommendation	Relevant Report(s)
ACF should: • develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication; and • help States strengthen their requirements for oversight of psychotropic medication by incorporating professional practice guidelines for monitoring children at the individual level. **Top 25 Recommendation #19**	*Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication* OEI-07-15-00380 **(Sept. 2018)**
ACF should proactively monitor Head Start grantee performance results to verify that those grantees designated for automatic, noncompetitive renewal perform better than their peers.	*Head Start Grant Recompetition: Early Implementation Results Suggest Opportunities for Improvement* OEI-12-14-00650 **(Aug. 2016)**
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.	*Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings* OEI-07-13-00460 **(Mar. 2015)**
ACF should examine with States the benefit of expanding 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 **(Jul. 2016)**

Food and Drug Administration (FDA)

Recommendation	Relevant Report(s)
FDA should establish set timeframes, through its Strategic Coordinated Oversight of Recall Execution initiative, to: • discuss the possibility of a voluntary recall with a firm; and • initiate use of its mandatory recall authority after it has made the determination that the legal standard for use of that authority has been met and a firm is not willing to voluntarily conduct a recall. **Top 25 Recommendation #20**	*FDA's Food-Recall Process Did Not Always Ensure the Safety of the Nation's Food Supply* A-01-16-01502 **(Dec. 2017)**

Recommendation	Relevant Report(s)
FDA should take appropriate action against all facilities with significant inspection violations. **Top 25 Recommendation #20**	*Challenges Remain in FDA's Inspections of Domestic Food Facilities* **OEI-02-14-00420 (Sept. 2017)**
FDA should provide technical assistance: • on requirements regarding direct purchase statements; • regarding the exchange of drug product tracing information for sales to 340B-covered entities that use 340B contract pharmacies; and • regarding exempt products.	*Drug Supply Chain Security: Wholesalers Exchange Most Tracing Information* **OEI-05-14-00640 (Sept. 2017)**
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 (Jul. 2016)**
FDA should: • develop and implement a plan to identify, develop, validate, and assess Risk Evaluation and Mitigation Strategy (REMS) components; • identify REMS that are not meeting their goals and take appropriate actions to protect the public health; • 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 REMS Improve Drug Safety* **OEI-04-11-00510 (Feb. 2013)**
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 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 should consider seeking 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 (Apr. 2010)**

Health Resources and Services Administration (HRSA)

Recommendation	Relevant Report(s)
HRSA should clarify its guidance on preventing duplicate discounts for MCO drugs. **Top 25 Recommendation #13**	*State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates* **OEI-05-14-00430 (June 2016)**
HRSA should share 340B ceiling prices with States. **Top 25 Recommendation #13**	*State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs* **OEI-05-09-00321 (June 2011)**

Indian Health Service (IHS)

Recommendation	Relevant Report(s)
IHS should: • implement a quality-focused compliance program to support Federal requirements for healthcare programs; • 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 and Governing Boards oversee and monitor hospitals and monitor adherence to those standards; and • continue to seek new meaningful ways to monitor hospital quality through the use of outcomes and/or process measures. **Top 25 Recommendation #21**	*IHS Hospitals: More Monitoring Needed to Ensure Quality Care* **OEI-06-14-00010 (Oct. 2016)**
IHS should: • deem a risk of the lack of continuity of operations to be unacceptable and take immediate action to assess all IHS facilities and ensure that each facility has a tested and viable continuity of operations program to respond to and recover from a range of disasters; and • identify all hospitals with unsupported networking equipment and implement a system development life cycle plan to ensure hardware and software replacement before end-of-life. **Top 25 Recommendation #22**	*Two IHS Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls* **A-18-16-30540 (Nov. 2017)**

Recommendation	Relevant Report(s)
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 the 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 longstanding challenges.	*IHS Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care* OEI-06-14-00011 **(Oct. 2016)**

National Institutes of Health (NIH)

Recommendation	Relevant Report(s)
NIH should: • work with an organization with national security expertise and knowledge of international risk areas to assess the impact of the potential misuse of genomic data provided to foreign principal investigators; • develop and implement mechanisms to ensure that the Genomic Data Sharing Policy keeps current with emerging threats to national security; and • make security training and security plans a requirement that principal investigators and entities must fulfill before being permitted access to genomic data, and develop additional internal controls to verify that foreign principal investigators and entities have fulfilled those requirements. **Top 25 Recommendation #23**	*Opportunities Exist for the NIH To Strengthen Controls in Place to Permit and Monitor Access to Its Sensitive Data* A-18-18-09350 **(Feb. 2019)**
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 should develop and disseminate guidance on methods to verify researchers' financial interests.	*How Grantees Manage Financial Conflicts of Interest in Research Funded by the NIH* OEI-03-07-00700 **(Nov. 2009)**

General Departmental

Recommendation	Relevant Report(s)
HHS should: • continue to work with the Office of Management and Budget and other stakeholders to develop and implement an approach to reporting on TANF improper payments in fiscal year 2019; • first focus on developing and implementing an approach to reporting on TANF improper payments, as this process will aid in identifying root causes of TANF improper payments; • develop and publish corrective action plans after implementing an approach; • along with ACF, continue working with States to: (1) provide technical assistance and training related to policy updates; and (2) support the Foster Care program in reaching its overall reduction target through appropriate implementation of corrective action plans at the State level; • proactively take action throughout the fiscal year to achieve its established improper payment reduction targets; • continue to explore a vehicle to conduct recovery audits that will fit into the larger Medicare Part C program in fiscal year 2019; and • analyze the viability of issuing a contract that is cost-beneficial to the program. **Top 25 Recommendation #24**	*HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for Fiscal Year 2018* A-17-19-52000 **(May 2019)**
HHS should: • continue to develop and refine their financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity; and • continue to strengthen oversight of remediation activities to limit new deficiencies and improve internal control over financial information systems.	Summary of recommendations from *OIG Report on the Financial Statement Audit of HHS for Fiscal Year 2018 (A-17-18-00001)* **HHS Fiscal Year 2018 Agency Financial Report (Nov. 2018)** (See pp. 53–54, 63–64, and 68)
HHS should address factors that may limit the Office for Human Research Protection's (OHRP) ability to operate independently.	*OHRP Generally Conducted Its Compliance Activities Independently, But Changes Would Strengthen Its Independence* OEI-01-15-00350 **(Jul. 2017)**
ASFR should: • ensure compliance with Small Business Innovation Research Program eligibility requirements; and • improve procedures to check for duplicative awards.	*Vulnerabilities in the HHS Small Business Innovation Research Program* OEI-04-11-00530 **(Apr. 2014)**

Recommendation	Relevant Report(s)
HHS should: • ensure compliance with Small Business Innovation Research Program eligibility requirements; and • improve procedures to check for duplicative awards.	*Vulnerabilities in the HHS Small Business Innovation Research Program* OEI-04-11-00530 **(Apr. 2014)**
The Office of the National Coordinator for Health Information Technology 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)**
The Office of the Assistant Secretary for Preparedness and Response, the Centers for Disease Control and Prevention (CDC), and CMS should continue to help hospitals sustain preparedness for emerging infectious diseases by coordinating guidance and providing practical advice for all hospitals.	*Hospitals Reported Improved Preparedness for Emerging Infectious Diseases After the Ebola Outbreak* OEI-06-15-00230 **(Oct. 2018)**

Appendix C: Implemented and Closed Significant Recommendations Reported in 2018 Edition

This appendix identifies significant recommendations described in the 2018 edition of the *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations* that were implemented or closed for other reasons since the publication was issued. OIG may close recommendations that were not implemented for a range of reasons; for example, the underlying problem may have been solved in a different way, a program change may make a recommendation no longer relevant, or OIG may conduct new work on the same issue and make a new, "superseding" recommendation to address the problem. The recommendations listed below are generally grouped by HHS operating division. We have indicated which recommendations below were on the 2018 top 25 list and legislative recommendations. The status of each recommendation is also included. The hyperlinks below provide more information on the report(s) relevant to each recommendation.

Centers for Medicare & Medicaid Services (CMS)—Medicare Parts A & B

Recommendation	Relevant Report(s)	Status
As CMS implements the Medicare Access and CHIP Reauthorization Act, any modifications to the EHR meaningful use requirements should include stronger program integrity safeguards that allow for more consistent verification of the reporting of required measures so that CMS can ensure that eligible professionals are using EHR technology consistent with CMS's goal of Advancing Care Information under the Merit-based Incentive System. **2018 Top 25 Recommendation #8**	*Medicare Paid Hundreds of Millions in EHR Incentive Payments that Did Not Comply with Federal Requirements* A-05-14-00047 **(June 2017)**	Implemented
CMS should modify the payment system for hospice care in nursing facilities. **2018 Legislative Recommendation**	*Medicare Hospices That Focus on Nursing Facility Residents* OEI-02-10-00070 **(Jul. 2011)**	Closed: superseded by recommendations in OEI-02-16-00570.
CMS should: • educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing	*Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services* A-09-16-02042 **(Feb. 2018)**	First recommendation implemented. Second and third recommendations closed: CMS took action toward achieving the goals of

Recommendation	Relevant Report(s)	Status
non-Medicare-covered services; • identify chiropractors with aberrant billing patterns or high service-denial rates, select a statistically valid random sample of services provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and request that the chiropractors refund the amounts overpaid by Medicare; and • establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.		the recommendations that OIG determined to be sufficient to close the recommendations.
CMS should: • share best practices across ZPICs and UPICs and address challenges that hinder their identification of overpayments; • work with ZPICs, UPICs, and MACs to create a standard report format both for overpayment referral reports and overpayment collection reports; and • require ZPICs, UPICs, and MACs to use a unique identifier for each overpayment.	*Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPIC and Program Safeguard Contractors* **OEI-03-13-00630 (Sept. 2017)**	Implemented
CMS should 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)**	Implemented
CMS should 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)**	Implemented
CMS should examine the variation in workload statistics among benefit integrity	*Medicare Benefit Integrity Contractors' Activities in*	Implemented

Recommendation	Relevant Report(s)	Status
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.	*2012 and 2013: A Data Compendium* OEI-03-13-00620 **(May 2016)**	
CMS should require the National Site Visit Contractor to improve quality assurance oversight and training of site visit inspectors.	*Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* OEI-03-13-00050 **(Apr. 2016)**	Implemented
CMS should: • increase its oversight of hospice general inpatient care claims and review Part D payments for drugs for hospice beneficiaries; • establish additional enforcement remedies for poor hospice performance; • ensure that a physician is involved in the decision to use general inpatient care; and • conduct prepayment reviews for lengthy general inpatient care stays.	*Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care* OEI-02-10-00491 **(Mar. 2016)**	Closed: superseded by recommendations in OEI-02-16-00570.
CMS should continue working with participating States to improve required reporting to ensure that CMS can conduct effective oversight of the program.	*National Background Check Program for Long Term Care Employees: Interim Report* OEI-07-10-00420 **(Jan. 2016)**	Implemented
CMS should determine the relative contribution of each of its quality improvement efforts.	*Quality Improvement Organizations Provide Support to More Than Half of Hospitals but Overlap with Other Programs* OEI-01-12-00650 **(Jan. 2015)**	Closed: CMS took action toward achieving the goal of the recommendation that OIG determined sufficient for closing the recommendation.
CMS should: • reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays; • develop and adopt claims-based measures of quality; and	*Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities* OEI-02-14-00070 **(Jan. 2015)**	Closed: superseded by recommendations in OEI-02-16-00570.

Recommendation	Relevant Report(s)	Status
• make hospice data publicly available for beneficiaries.		
CMS should instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.	*Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* OEI-06-11-00370 **(Feb. 2014)**	Implemented
CMS should develop a method for ensuring that beneficiaries who are victims of medical identity theft retain access to needed services.	*CMS Response to Breaches and Medical Identity Theft* OEI-02-10-00040 **(Oct. 2012)**	Implemented
CMS should clarify the workload definitions in the CMS Analysis, Reporting, and Tracking System to ensure that ZPICs' workload statistics are accurate and that ZPICs report their data uniformly.	*ZPICs' Data Issues Hinder Effective Oversight* OEI-03-09-00520 **(Nov. 2011)**	Implemented

CMS—Medicare Parts C & D

Recommendation	Relevant Report(s)	Status
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.	*CMS Has Not Performed Required Closeouts of Contracts Worth Billions* OEI-03-12-00680 **(Dec. 2015)**	Implemented
CMS should: • restrict certain beneficiaries to a limited number of pharmacies or prescribers; • expand sponsors' use of beneficiary-specific controls; and • limit the ability of certain beneficiaries to switch plans.	*Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs* OEI-02-11-00170 **(Aug. 2014)**	Implemented
CMS should: • 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 MEDICS's benefit integrity activities.	*MEDIC Benefit Integrity Activities in Medicare Parts C and D* OEI-03-11-00310 **(Jan. 2013)**	First recommendation closed: superseded by recommendation in OEI-03-13-00030. Second recommendation implemented.

Recommendation	Relevant Report(s)	Status
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.	*Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* OEI-03-07-00380 **(Oct. 2008)**	Closed: superseded by recommendation in OEI-03-13-00030.

CMS—Medicaid

Recommendation	Relevant Report(s)	Status
CMS should • pursue a means to manufacturers to correct inaccurate classification data reported to the Medicaid drug rebate program, including a potential legislative change; and • follow up with manufacturers associated with potentially misclassified drugs identified in this report to determine whether current classifications are correct. **2018 Top 25 Recommendation #11** **2018 Legislative Recommendation**	*Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates* OEI-03-17-00100 **(Dec. 2017)**	Implemented
CMS should 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.	*Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers* A-03-00-00216 **(Sept. 2001)**	Implemented
CMS should issue guidance to States on how to estimate Medicaid National Correct Coding Initiative cost savings and take steps to ensure that States report as required.	*Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments* OEI-09-14-00440 **(Apr. 2016)**	Implemented
CMS should help States obtain better data on ineligible drugs.	*Medicaid Drug Rebate Dispute Resolution Could Be Improved* OEI-05-11-00580 **(Aug. 2014)**	Implemented

Recommendation	Relevant Report(s)	Status
CMS should: • maintain adequate documentation to support the collection of overpayments in accordance with the Office of Management and Budget's Circular A-50 and CMS Standard Operating Procedures; and • collect the remaining $225.6 million we identified as due the Federal Government.	*CMS Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected* A-05-11-00071 **(Feb. 2013)**	Closed due to issuance of followup audit in 2018 (A-05-17-00013).
CMS should work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid.	*Most Children with Medicaid in Four States Are Not Receiving Required Dental Services* OEI-02-14-00490 **(Jan. 2016)**	Implemented
CMS should: • require States to report vision and hearing screenings; and • collaborate with States and providers to develop effective strategies to encourage beneficiary participation in Early and Periodic Screening, Diagnostic, and Treatment screenings.	*Most Medicaid Children in Nine States are Not Receiving All Required Preventive Screening Services* OEI-05-08-00520 **(May 2010)**	First recommendation closed: CMS conducted an assessment identifying an undue State burden to reporting vision and hearing screenings, and OIG agreed to close the recommendation. Second recommendation implemented.
CMS should: • consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided; • promulgate regulations to reduce significant variation in States' PCS laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants; and • promulgate regulations to reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified	*PCS: Trends, Vulnerabilities, and Recommendations for Improvement* OIG-12-12-01 **(Nov. 2012)**	First recommendation implemented. Second and third recommendations closed: CMS's analysis and discussions with stakeholders concluded that States should retain discretion on supervision parameters and establishing provider qualifications for PCS attendants, and OIG agreed to close the recommendation.

Recommendation	Relevant Report(s)	Status
PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.		
CMS should increase coordination with State Medicaid programs on collecting and verifying provider ownership information in Medicare and Medicaid.	*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* OEI-04-11-00590 **(May 2016)**	Implemented

CMS—General

Recommendation	Relevant Report(s)	Status
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)**	First recommendation closed: CMS demonstrated that the additional obligations and expenditures identified by the audit were not for services directly related to the operation of the Federal Marketplaces, and OIG agreed to close the recommendation. Second recommendation implemented.
CMS should: • ensure that acquisition strategies are completed, as required by the HHS Acquisition Regulation; • assess whether to assign a lead systems integrator for complex information technology projects involving multiple contractors; and • ensure that contract actions are supported by required documentation.	*Federal Marketplace: Inadequacies in Contract Planning and Procurement* OEI-03-14-00230 **(Jan. 2015)**	Implemented

Administration for Children and Families (ACF)

Recommendation	Relevant Report(s)	Status
ACF should request that States examine the effectiveness of their program integrity and fraud-fighting activities in their CCDF programs. **2018 Top 25 Recommendation #17**	*More Effort is Needed to Protect the Integrity of the CCDF Block Grant Program* OEI-03-16-00150 **(Jul. 2016)**	Implemented
ACF should: • review its staffing levels and determine whether resources are aligned efficiently, and adjust as needed, to ensure that the audit resolution process is conducted in accordance with Federal requirements, including the requirement to issue management decisions to grantees within 6 months; • provide training to Head Start grantees on implementing corrective action plans with sufficient information for ACF to determine whether corrective actions are adequate to resolve audit findings; • strengthen its policies and procedures to include monitoring of Head Start grantees and conducting site visits, when feasible, to ensure that grantees implement appropriate corrective actions to resolve audit findings; and • include in the letters sent to Head Start grantees specific dates for correcting deficiencies noted in the audit reports when corrective actions have not been completed. **2018 Top 25 Recommendation #18**	*ACF Region II Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance with Federal Requirements* A-02-16-02009 **(Feb. 2018)**	First and second recommendation implemented. Third and fourth recommendations closed: ACF took action toward achieving the goals of these recommendations that OIG determined to be sufficient to close the recommendations.

Recommendation	Relevant Report(s)	Status
ACF should: • include in the letters sent to AI/AN Head Start grantees specific dates for correcting deficiencies noted in the audit reports when corrective actions have not been completed. • review its staffing levels and determine whether resources are aligned efficiently, and adjust as needed, to ensure that the audit resolution process is conducted in accordance with Federal requirements; • ensure that management decisions are issued to AI/AN Head Start grantees within the 6-month timeframe; and • strengthen its policies and procedures to include monitoring of AI/AN Head Start grantees and conducting site visits, when feasible, to ensure that grantees actually implement corrective actions to resolve audit findings. **2018 Top 25 Recommendation #18**	*ACF Did Not Always Resolve AI/AN Head Start Grantees' Single Audit Findings in Accordance with Federal Requirements* A-06-17-07003 **(Dec. 2017)**	Second and third recommendations implemented. First recommendation closed: the recommendation is no longer relevant due to a program change. Fourth recommendation closed: ACF took action toward achieving the goal of the recommendation that OIG determined to be sufficient for closing the recommendation.
ACF should review its staffing levels and determine whether resources are aligned efficiently, and adjust as needed, to ensure that management decisions are issued to Head Start grantees within the required 6-month timeframe. **2018 Top 25 Recommendation #18**	*ACF Region X Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance with Federal Requirements* A-09-16-01004 **(Dec. 2017)**	Implemented
ACF should: • take additional steps to ensure, within the scope of the legislation, that States are given appropriate time to expand any future supplemental Superstorm Sandy Block Grant (SSBG) awards; • conduct a post-grant review to identify lessons learned and best practices; and • prepare guidance about supplemental SSBGs documentation requirements.	*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)**	Implemented

Recommendation	Relevant Report(s)	Status
ACF should 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)**	Implemented

FDA

Recommendation	Relevant Report(s)	Status
FDA should: • take appropriate actions against facilities with Official Action Indicated classifications, particularly those that have histories of violations; and • ensure that violations are corrected for all facilities that receive Official Action indicated classification.	*FDA Inspections of Domestic Food Facilities* OEI-02-08-00080 **(Apr. 2010)**	Closed: superseded by recommendations in OEI-02-14-00420.

General Departmental

Recommendation	Relevant Report(s)	Status
ASFR should establish a department-wide source for adverse information from audits of grantees. **2018 Top 25 Recommendation #23**	*HHS Oversight of Grantees could be Improved through Better Information-Sharing* OEI-07-12-00110 **(Sept. 2015)**	Implemented

U.S. Department of Health & Human Services

Office of Inspector General