U.S. Department of Health & Human Services

Office of Inspector General

Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations

July 2018

About the July 2018 Edition

The *Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs: Top Unimplemented Recommendations* is an annual publication of the Department of Health and Human Services (HHS or the Department) Office of Inspector General (OIG).[1] 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. The unimplemented recommendations come from OIG audits and evaluations performed pursuant to the Inspector General Act of 1978, as amended.

This edition begins with a list of the top 25 unimplemented recommendations. The top 25 unimplemented recommendations are grouped by HHS operating division (OPDIV). For each OPDIV, we also outline the top unimplemented recommendations, key OIG findings, and the OPDIV's reported progress in implementing the recommendations. Additionally, this edition includes a list of all unimplemented OIG recommendations that require legislative action, as well as a broader list of OIG's significant unimplemented recommendations described in previous *Semiannual Report(s) to Congress*. This publication is responsive to requirements of the Inspector General Act.[2]

OIG continues to report annually on the Top 10 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 the management and performance challenges facing each OPDIV throughout the document.

For more information

More information on OIG's work, including the reports mentioned in this publication, are on our website at https://oig.hhs.gov/. Questions about the *Top Unimplemented 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] This publication was previously known as the *Compendium of Unimplemented Recommendations*.

[2] 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 seek legislative authority to change Medicare's method for paying for therapy in skilled nursing facilities (SNFs).
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 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.
4. CMS should take steps to tie payment for hospice care to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.
5. CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at critical access hospitals (CAHs).
6. 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 to require hospitals to use certain condition codes on claims for reporting device replacement procedures.
7. CMS should continue coordinating with the Agency for Healthcare Research and Quality (AHRQ) to raise awareness of adverse events in rehabilitation hospitals and work to reduce harm to patients.
8. CMS, as it implements the Medicare Access and Children's Health Insurance Program (CHIP) 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.

CMS—Medicare Parts C & D

9. CMS should collect comprehensive data from Part D 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 (MA) plans to include ordering and referring provider identifiers in their encounter data.

CMS—Medicaid

11. CMS should pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid drug rebate program.
12. CMS should ensure that national Medicaid data are complete, accurate, and timely.

13 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.

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

15 CMS should work with States to ensure that plans' networks are adequate and ensure timely access to care for Medicaid managed care enrollees.

16 CMS should require each State Medicaid agency to report all terminated providers.

Administration for Children and Families (ACF)

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

18 ACF should resolve recurring Head Start Single Audit Findings.

Food and Drug Administration (FDA)

19 FDA should use its Strategic Coordinated Oversight of Recall Execution (SCORE) initiative to establish set timeframes, expedite decisionmaking and move recall cases forward, and improve electronic recall data.

20 FDA should take appropriate action against all food facilities with significant inspection violations.

Indian Health Service (IHS)

21 IHS should conduct a needs assessment culminating in an agency-wide strategic plan with actionable initiatives and target dates.

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

General Departmental

23 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.

24 HHS should address and reduce improper payments in the Temporary Assistance for Needy Families (TANF) and Medicaid programs.

25 The Office of the National Coordinator for Health IT (ONC) and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.

CMS—Medicare Parts A & B

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 and program integrity. This includes helping beneficiaries and providers; protecting Medicare dollars from fraud, waste, and abuse; and implementing prudent payment policies. OIG's Medicare oversight work is focused on identifying and offering recommendations to reduce improper payments, prevent and deter fraud, and foster economical payment policies.

Top Management and Performance Challenges Relevant to Medicare Parts A &B: Ensuring Program Integrity in Medicare

Improving Care for Vulnerable Populations

Top Unimplemented Recommendations

1 CMS should seek legislative authority to change Medicare's method for paying for therapy in SNFs.

Key OIG Findings
SNFs increasingly billed for the highest level of therapy even though beneficiary characteristics remained largely the same.

Progress in Implementing the Recommendation
CMS is targeting SNFs that rarely bill for changes in therapy or frequently use therapy assessments incorrectly for education and claims review.

Relevant Report
OEI-02-13-00610 **(Sept. 2015)**

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.

Progress in Implementing the Recommendation
Since CMS capped outlier payments in 2010, Medicare payments for home health services have decreased across the country by more than $1 billion per year.

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

3 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.

Progress in Implementing the Recommendation
CMS is promoting more prudent payment policies. For example, Medicare stopped paying certain new hospital-owned, off-campus, "provider-based" departments that charge higher hospital rates than freestanding facilities that perform the same services for less.

Relevant Report
OEI-02-15-00020 **(Dec. 2016)**

4 CMS should take steps to tie payment for hospice care to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.

Key OIG Findings
Hospices may target beneficiaries in assisted living facilities who have certain diagnoses because they typically offer the hospices the greatest financial gain.

Progress in Implementing the Recommendation
Medicare Administrative Contractors have targeted their monitoring of hospices that rely heavily on nursing facility residents and examine whether these hospices are meeting Medicare requirements.

Relevant Report
OEI-02-10-00070 **(July 2011)**

5 CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs.

Key OIG Findings
Medicare beneficiaries paid higher coinsurance costs for outpatient services received at CAHs than what they would have paid at hospitals under the outpatient payment program.

Progress in Implementing the Recommendation
CMS stated it would consider a proposal to modify how coinsurance is calculated for outpatient services received at CAHs, but this was not included in the fiscal year (FY) 2019 President's Budget.

Relevant Report
OEI-05-12-00085 **(Oct. 2014)**

6 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 to require hospitals to use certain condition codes on claims 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 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.

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

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

Key OIG Findings
Twenty-nine percent of Medicare beneficiaries experienced a temporary harm or adverse event during rehabilitation hospital stays.

Progress in Implementing the Recommendation
CMS continues to raise awareness about adverse events and reducing harm to patients in rehabilitation hospitals. CMS has adopted several measures for the Inpatient Rehabilitation Facilities Quality Reporting Program, with public reporting on its website beginning late 2018.

Relevant Report
OEI-06-14-00110 **(July 2016)**

8 CMS, as it implements MACRA, should include stronger program integrity safeguards to modifications of EHR meaningful use requirements to allow for more consistent verification of the reporting of required measures.

Key OIG Findings
From May 2011 through June 2014, CMS inappropriately paid an estimated $729 million in EHR incentive payments to otherwise eligible professionals who did not meet meaningful use requirements.

Progress in Implementing the Recommendation
CMS implemented targeted risk-based audits to strengthen the integrity of the EHR Incentive Program. Additionally, CMS implemented edits to ensure that eligible professionals who switch programs during a payment year receive payment under only one EHR incentive program.

Relevant Report
A-05-14-00047 **(June 2017)**

CMS—Medicare Parts C & D

Approximately 43 million beneficiaries received Medicare Part D benefits and 19.8 million beneficiaries were enrolled in Medicare Part C in 2017. 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 who contract with CMS or States. OIG's body of work has identified challenges that MA organizations and Part D sponsors face in ensuring program integrity. 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:

Curbing the Opioid Epidemic

Ensuring Integrity in Managed Care and Other Programs Delivered Through Private Insurers

Top Unimplemented Recommendations

9 CMS should collect comprehensive data from Part D 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

More than half of Part D plan sponsors did not report data on potential fraud and abuse from 2010 to 2012.

Progress in Implementing the Recommendation

CMS 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.

Relevant Reports

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 MA plans to include ordering and referring provider identifiers in their encounter data.

Key OIG Findings

Provider identifiers were frequently absent from encounter data. This limits the use of these data for vital program oversight and enforcement activities.

Progress in Implementing the Recommendation

CMS is working to validate the completeness and accuracy of MA encounter data. For example, CMS reported that it plans to address potential errors by reviewing submission instructions and consider requiring provider identifiers in the future.

Relevant Report

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

CMS—Medicaid

Medicaid serves more enrollees than any other Federal health care program and represents one-sixth of the national health care economy. In FY 2017, Medicaid had $373 billion in Federal expenditures and served over 74 million individuals (including 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 high-quality care. Protecting Medicaid from fraud, waste, and abuse takes on heightened urgency as it continues to grow in spending and the number of beneficiaries served.

Top Management and Performance Challenges Relevant to Medicaid: Ensuring Program Integrity in Medicaid

Improving Care for Vulnerable Populations

Top Unimplemented Recommendations

11 CMS should pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid drug rebate program.

Key OIG Findings

OIG found that Medicaid may have lost $1.3 billion in rebates for 10 potentially misclassified drugs from 2012 to 2016. CMS does not have explicit legal authority to require manufacturers to update classification data in the Medicaid drug rebate program.

Progress in Implementing the Recommendation

CMS is considering methods to improve its efforts to compel manufacturers to correct inaccurate drug classification data. The methods could include, for example, seeking legislative authority to compel manufacturers to submit accurate data and/or enhance its enforcement authority.

Relevant Report

OEI-03-17-00100 **(Dec. 2017)**

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

Key OIG Findings

Data is an essential tool for detecting fraud, waste, and abuse. However, national Medicaid data has 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

CMS is working with State Medicaid agencies to improve the completeness, accuracy, and timely submission of national Medicaid data, including convening a technical panel to make recommendations to improve data quality.

Relevant Reports
OEI-05-15-00050 (June 2017); OEI-07-13-00120 (July 2015); OEI-05-12-00610 (Sept. 2013)

13 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 is subject to persistent fraud and beneficiary harm. Furthermore, OIG has raised concerns about the varying standards, and in some cases minimal vetting, for PCS providers.

Progress in Implementing the Recommendation
CMS issued an information bulletin indicating that all PCS claims must adhere to requirements and must provide all relevant documentation.

Relevant Report
OIG-12-12-01 (Nov. 2012)

14 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 the data on Medicare provider enrollment screening results held in various CMS data repositories.

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

15 CMS should work with States to ensure that plans' networks are adequate and ensure timely access to care for Medicaid managed care enrollees.

Key OIG Findings
Significant vulnerabilities were identified in Medicaid provider availability (a key indicator for access to care), which raises questions about the ability of plans, States, and CMS to ensure that access-to-care standards are met.

Progress in Implementing the Recommendation
CMS published a toolkit for ensuring provider network adequacy and service availability as a resource guide to assist States in ensuring access to care.

Relevant Reports
OEI-02-13-00670 (Dec. 2014); OEI-02-11-00320 (Sept. 2014)

16 CMS should require each State Medicaid agency to report all terminated providers.

Key OIG Finding

CMS's process for sharing information on terminated providers needs improvement to make it more useful to State Medicaid agencies in identifying providers that must be terminated pursuant to Federal law.

Progress in Implementing the Recommendation

CMS procured a Data Exchange System to collect and disseminate Medicaid termination data.

Relevant Report

OEI-06-12-00031 **(Mar. 2014)**

Administration for Children and Families (ACF)

Among ACF's vital programs, CCDF—the third largest block grant program administered by the Federal Government—provides subsidies to nearly 1.5 million children to receive child care every month. Head Start—the largest Federal investment in early childhood education—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 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.

Top Management and Performance Challenge Relevant to ACF: Protecting the Integrity of Public Health and Human Services Grants

Top Unimplemented Recommendations

17 ACF should request that States examine the effectiveness of their program integrity and fraud-fighting activities in their CCDF programs.

Key OIG Findings

OIG's CCDF work has identified fraud, found improper payments, and exposed health and safety concerns at child care facilities. In addition, OIG audits have identified weaknesses in some States' fiscal controls that put CCDF funds at risk.

Progress in Implementing the Recommendation

ACF has mobilized its technical assistance network to ensure States have policies and practices in place to support high-quality services for children and families and prevent improper payments. For instance, in FY 2017, ACF provided technical assistance to 33 States on topics including improper payment reviews and fraud prevention measures and policies. Additionally, ACF plans to use its *Grantee Internal Controls Self-Assessment* instrument to assist States in examining the effectiveness of their CCDF program integrity and fraud fighting efforts.

Relevant Report

OEI-03-16-00150 **(July 2016)**

18 ACF should resolve recurring Head Start Single Audit Findings.

Key OIG Findings

OIG found that ACF did not always resolve Head Start grantees' recurring audit findings in accordance with Federal requirements and ACF policies and procedures. For instance, for some grantees, ACF did not issue audit determination letters in a timely manner, establish specific dates for grantees to correct all audit report deficiencies, or always follow up with grantees to ensure that they took corrective actions to resolve audit findings.

Progress in Implementing the Recommendation

ACF will continue to explore alternative approaches to staffing challenges and include corrective action plans and training, as appropriate, in other trainings and contacts with Head Start grantees.

Relevant Reports

A-02-16-02009 (Feb. 2018); A-06-17-07003 (Dec. 2017); A-09-16-01004 (Dec. 2017); A-06-16-00019 (Sept. 2017)

Food and Drug Administration (FDA)

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

FDA has the continuing challenge of 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. 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 Unimplemented Recommendations

19 FDA should use its SCORE initiative to establish set timeframes, expedite decisionmaking and move recall cases forward, and improve electronic recall data.

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.

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 SCORE, 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.

Relevant Report
A-01-16-01502 **(Dec. 2017)**

20 FDA should take appropriate action against all food facilities with significant inspection violations.

Key OIG Findings
FDA did not always act to ensure that food facilities corrected significant inspection violations. Additionally, the actions that FDA took in response to violations were not always timely and did not always result in corrections of violations.

Progress in Implementing the Recommendation
FDA developed a report to monitor food facilities that warrant followup. The reports will allow it to more efficiently track compliance activities resulting from inspections.

Relevant Report
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 health care services to about 2.2 million AI/ANs in 567 Federally recognized tribes across the Nation. IHS faces longstanding challenges that hinder its ability to provide quality care and comply with Medicare standards. OIG has examined issues related to 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.

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

Top Unimplemented Recommendations

21 IHS should conduct a needs assessment culminating in an agency wide strategic plan with actionable initiatives and target dates.

Key OIG Findings

IHS hospitals have longstanding challenges that may affect their ability to provide quality care and comply with Medicare standards. Challenges included handling increasing numbers of outpatients, limited access to specialists, inability to recruit and retain needed staff, and limited resources for maintaining buildings and equipment.

Progress in Implementing the Recommendation

IHS has developed goals and benchmarks, such as finalizing agency-wide standards for patient wait times and for time spent in a provider's office. It is also developing a needs assessment on improving quality of care using information from recent CMS compliance assessments with CMS certification standards and other internal IHS quality standards.

Relevant Report

OEI-06-14-00011 **(Oct. 2016)**

22 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.

Relevant Report

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

General Departmental

In FY 2017, HHS reported a total of approximately $1.1 trillion in budgetary resources and awarded more than $100 billion in grants (excluding Medicaid) —more grants than any other Federal entity. 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

Protecting HHS Data, Systems, and Beneficiaries from Cybersecurity Threats

Top Unimplemented Recommendations

23 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.

Key OIG Findings

HHS awarding agencies lack a systematic method of sharing information about grantee risks, which has hindered HHS's ability to effectively administer funds to and oversee grantees during the grants cycle.

Progress in Implementing the Recommendation

ASFR is in the process of developing an enterprise-wide Audit Resolution System that will allow awarding agencies to obtain audit report findings from a variety of sources, including OIG and the Government Accountability Office.

Relevant Report

OEI-07-12-00110 **(Sept. 2015)**

24 HHS should address and reduce improper payments in the TANF and Medicaid programs.

Key OIG Findings

HHS did not fully comply with all improper payment reporting required under the Improper Payments Information Act of 2002. Specifically, in FY 2017, HHS did not report an improper payment estimate for the TANF program and its improper payment rate for the Medicaid program exceeded the 10 percent threshold established by law.

Progress in Implementing the Recommendation

HHS uses a multi-faceted approach to support States in improving TANF program integrity and to prevent improper payments. To address improper payments in the Medicaid program, CMS uses data from the Comprehensive Error Rate Test program and other sources of information to address improper payments through various corrective actions and has worked with the States to develop State-specific corrective action Medicaid plans.

Relevant Reports
A-17-18-52000 **(May 2018);** A-17-17-52000 **(May 2017);** A-17-16-52000 **(May 2016);** A-17-15-52000 **(May 2015)**

25 ONC and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.

Key OIG Findings
OIG's review of hospitals' implementation of fraud and abuse safeguards for EHR technology found that while nearly all hospitals with EHR technology had audit functions in place, they may not be using the audit functions to their full extent.

Progress in Implementing the Recommendation
CMS and ONC have undertaken efforts to educate providers about EHR fraud vulnerabilities, including conducting sessions with stakeholders on EHR coding and billing and releasing a booklet with tools and techniques to help providers recognize, report, and prevent EHR fraud. ONC does not plan to take any further action.

Relevant Report
OEI-01-11-00570 **(Dec. 2013)**

Unimplemented Legislative Recommendations

This list 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 [designated with a number below]. The recommendations are grouped by HHS OPDIV. Some recommendations include estimated cost savings that we believe would be generated if the specific recommendation(s) were implemented.

CMS

Recommendation	Estimated Savings	Relevant Report(s)
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.	**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 CAH swing-bed reimbursement rates to the lower SNF rates.	**$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)**
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.	**$449 million in 2011**[3]	*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 (DRG) window to include additional days prior to the inpatient admission and other hospital ownership arrangements, such as affiliated hospital groups.	**$318 million**[4]	*Medicare and Beneficiaries Could Realize Substantial Savings if the DRG Window Were Expanded* OEI-05-12-00480 **(Feb. 2014)**
CMS should take steps to tie payment for hospice care to beneficiary care needs and quality of care to ensure that services rendered adequately serve		*Medicare Hospices that Focus on Nursing Facility Residents* OEI-02-10-00070 **(July 2011)**

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

[4]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	Estimated Savings	Relevant Report(s)
beneficiaries' needs, seeking statutory authority if necessary.		
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 change Medicare's method for paying for therapy in SNFs. **OIG Top Unimplemented Recommendation # 1**		*The Medicare Payment System for SNFs Needs to Be Reevaluated* OEI-02-13-00610 **(Sept. 2015)**
CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs. **OIG Top Unimplemented Recommendation # 5**		*Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals* OEI-05-12-00085 **(Oct. 2014)**
CMS should pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid drug rebate program, including a potential legislative change. **OIG Top Unimplemented Recommendation # 11**		*Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates* OEI-03-17-00100 **(Dec. 2017)**
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 authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.		*Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B* OEI-12-12-00210 **(Nov. 2012)**

Recommendation	Estimated Savings	Relevant Report(s)
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 health care 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 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)**
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)**

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 seek statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.	*FDA Inspections of Domestic Food Facilities* OEI-02-08-00080 **(Apr. 2010)**

Appendix: Significant Unimplemented Recommendations

This appendix includes a list of significant unimplemented recommendations compiled from audit and evaluation reports of the Department of Health and Human Services' (HHS or the Department) Office of Inspector General (OIG). The recommendations represent opportunities to achieve expected impact through costs savings, improvements in program effectiveness and efficiency, and increased quality of care and safety of beneficiaries.

This appendix identifies 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. The recommendations are generally grouped by HHS operating division. Recommendations designated with a number are associated with the top 25 unimplemented recommendations. Note that some wording of the top 25 unimplemented recommendations is paraphrased whereas the recommendations in this appendix include the exact wording from the associated audits or evaluations. Some recommendations include estimated cost savings that we believe would be generated if the specific recommendation 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	Estimated Savings	Relevant Report(s)
CMS should: • reinstate beneficiary deductibles and coinsurance (and notifications of amounts paid on their behalf) as a means of controlling utilization; and • periodically evaluate the national fee schedule to ensure that reimbursement is aligned with the prices that physicians pay for clinical laboratory tests.	**$23.8 billion over 10 years**[5]	*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 prospective payment system (PPS) payment rates from budget neutrality adjustments for ambulatory surgical center (ASC) approved procedures.	**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-*

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

Recommendation	Estimated Savings	Relevant Report(s)
		Approved Procedures to ASC 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 skilled nursing facilities (SNF) PPS rates paid for similar services at alternative facilities.	**$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)**
As CMS implements the Medicare Access and Children's Health Insurance Program Reauthorization Act, any modifications to the electronic health records (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. **OIG Top Unimplemented Recommendation # 8**	**$729 million**	*Medicare Paid Hundreds of Millions in EHR Incentive Payments that Did Not Comply with Federal Requirements* A-05-14-00047 **(June 2017)**
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.	**$449 million in 2011**[6]	*Most CAHs 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 diagnostic related group window to include additional days prior to the inpatient admission and other hospital ownership arrangements, such as affiliated hospital groups.	**$318 million**[7]	*Medicare and Beneficiaries Could Realize Substantial Savings if the Diagnostic Related Group Window Were Expanded* OEI-05-12-00480 **(Feb. 2014)**
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	**$97.6 million per year**[8]	*Nationwide Review of E&M Services Included in Eye and Ocular Adnexa Global Surgery Fees for CY 2005* A-05-07-00077 **(Apr. 2009)**

[6] 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.
[7] 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.
[8] Estimate based on calendar year (CY) 2005 data.

Recommendation	Estimated Savings	Relevant Report(s)
fee schedule.		
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.	**$49 million**[9]	*Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* A-05-09-00053 **(May 2012)**
CMS should expand the price-substitution policy.	**$17 million**[10]	*Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2015 Average Sales Prices (ASP)* OEI-03-17-00360 **(Sept. 2017)**
CMS should adjust the estimated number of E&M services within cardiovascular global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $14.6 million, or use the results of this audit during the annual update of the physician fee schedule.	**$14.6 million**[11]	*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.	**$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 CYs 2011 through 2014, Medicare could have saved at least an additional $10,245,539.	**$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)**

[9] Estimate based on CY 2007 data.

[10] If CMS had expanded its price-substitution criteria to include certain other Part B drugs in 2015, Medicare and its beneficiaries could have saved up to an additional $17 million over 1 year.

[11] Estimate based on CY 2007 data.

Recommendation	Estimated Savings	Relevant Report(s)
CMS should: • work with its contractors to educate chiropractors on the training materials that are available to them; • 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 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.		*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)**

Recommendation	Estimated Savings	Relevant Report(s)
CMS should: • share best practices across Zone Program Integrity Contractors (ZPICs) and Unified Program Integrity Contractors (UPICs) and address challenges that hinder their identification of overpayments; • identify strategies to increase Medicare Administrative Contractors' (MACs') collection of ZPIC- and UPIC-referred overpayments; • work with ZPICs, UPICs, and MACs to create a standard report format both for overpayment referral reports and overpayment collection reports; • require ZPICs, UPICs, and MACs to use a unique identifier for each overpayment; 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.		*Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPIC and Program Safeguard Contractors* OEI-03-13-00630 **(Sept. 2017)**
OIG Top Unimplemented Recommendation # 2 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.		*Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely-Failed Devices* A-01-15-00504 **(Sept. 2017)** *Hospitals Did Not Comply with Medicare Requirements for Reporting Certain Cardiac Device Credits* A-05-16-00059 **(Mar. 2018)**

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 6		
CMS should take immediate action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. These immediate actions include: • 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)** (Note: The audit is still in progress. OIG plans to make formal recommendations when the audit is complete.)
CMS should make better use of data analytics to ensure the integrity of hospital-reported quality data and the resulting payment adjustments. 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.		*CMS Validated Hospital Inpatient Quality Reporting Program Data, But Should Use Additional Tools to Identify Gaming* OEI-01-15-00320 **(Apr. 2017)** *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy* OEI-02-15-00020 **(Dec. 2016)**

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 3 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)**
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 continue coordinating with the Agency for Healthcare Research and Quality (AHRQ) to raise awareness of adverse events in rehabilitation hospitals and work to reduce harm to patients. **OIG Top Unimplemented Recommendation # 7**		*Adverse Events in Inpatient Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* OEI-06-14-00110 **(July 2016)**
CMS should: • take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements; • require hospitals to submit attestations for all their provider-based facilities; and • implement systems and methods to monitor billing by all provider-based facilities.		*CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain* OEI-04-12-00380 **(June 2016)**
CMS should examine the variation in workload statistics among benefit integrity contractors and—as appropriate—identify performance issues that need to be addressed, best practices that can be shared, and workload definitions that need to be clarified to ensure that contractors report data uniformly and in the way CMS intends.		*Medicare Benefit Integrity Contractors' Activities in 2012 and 2013: A Data Compendium* OEI-03-13-00620 **(May 2016)**

Recommendation	Estimated Savings	Relevant Report(s)
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; • require the National Site Visit Contractor to improve quality assurance oversight and training of site visit inspectors; and • ensure that the Provider Enrollment, Chain, and Ownership System data contain the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements. **OIG Top Unimplemented Recommendation # 14**		*Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results* OEI-03-13-00050 **(Apr. 2016)**
CMS should: • increase its oversight of hospice general inpatient (GIP) 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 GIP; • conduct prepayment reviews for lengthy GIP stays; and • follow up on inappropriate GIP 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: • improve required reporting to ensure that CMS can conduct effective oversight of the program; and • fully implement their background check programs.		*National Background Check Program for Long Term Care Employees: Interim Report* OEI-07-10-00420 **(Jan. 2016)**
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**)

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 1		
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 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)**
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 • make hospice data publicly available for beneficiaries.		*Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities* OEI-02-14-00070 **(Jan. 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. **OIG Top Unimplemented Recommendation # 5**		*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)**
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)**

Recommendation	Estimated Savings	Relevant Report(s)
CMS should: • explore the possibility of requiring providers to identify on the Part B claims the pharmacies 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 instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.		*Adverse Events in SNFs: National Incidence Among Medicare Beneficiaries* OEI-06-11-00370 **(Feb. 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)**

Recommendation	Estimated Savings	Relevant Report(s)
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)**
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 average manufacturer prices (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)**
The Office of Medicare Hearings and Appeals and 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 consider seeking legislative authority to implement least costly alternative policies for Part B drugs under appropriate circumstances.		*Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B* OEI-12-12-00210 **(Nov. 2012)**
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)**

Recommendation	Estimated Savings	Relevant Report(s)
CMS should implement the home health agency surety bond requirement. **OIG Top Unimplemented Recommendation # 2**		*Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* OEI-03-12-00070 **(Sept. 2012)**
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)**
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 modify the payment system for hospice care in nursing facilities. **OIG Top Unimplemented Recommendation # 4**		*Medicare Hospices That Focus on Nursing Facility Residents* OEI-02-10-00070 **(July 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 health care in rural underserved areas.		*Status of the Rural Health Clinic Program* OEI-05-03-00170 **(Aug. 2005)**

CMS—Medicare Parts C & D

Recommendation	Relevant Report(s)
CMS should: • require Medicare Advantage (MA) organizations to submit ordering and referring provider identifiers for applicable records; and • ensure that MA organizations submit rendering provider identifiers for applicable records. **OIG Top Unimplemented Recommendation # 10**	*MA Encounter Data Show Promise for Program Oversight, But Improvements Are Needed* OEI-03-15-00060 **(Jan. 2018)**
CMS should: • evaluate the cost-effectiveness of edits and medical reviews that are designed to ensure appropriate payments for covered uses on Part B drug claims; and • assign a single entity to assist MACs in making coverage determinations.	*MACs Continue to Use Different Methods to Determine Drug Coverage* OEI-03-13-00450 **(Aug. 2016)**
CMS should: • add additional data to its contract management system, and improve reports to allow for easier access to contract data that would assist in contract closeout and funds management; and • improve coordination and collaboration with the National Institutes of Health (NIH).	*CMS Has Not Performed Required Closeouts of Contracts Worth Billions* OEI-03-12-00680 **(Dec. 2015)**
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)**
CMS should: • implement policies and procedures to notify MA organizations of unlawful-presence information and thereby prevent their enrollment in MA organizations, 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 MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented; • recoup $26 million in improper payments in accordance with legal requirements; and • reopen and revise final payment determinations for CYs 2009 through 2011 to remove prescription drug costs for unlawfully present beneficiaries.	*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 Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2009 Through 2011* A-07-12-06038 **(Oct. 2013)**

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. **OIG Top Unimplemented 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: • determine whether outlier data values submitted by MA organizations reflect inaccurate reporting or atypical performance; and • use appropriate Part C reporting requirements data as part of its reviews of MA organizations' performance.	*CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited* OEI-03-11-00720 **(Mar. 2014)**
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 pharmacy and therapeutics committee.	*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; • 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 Medicare Drug Integrity Contractor's (MEDIC) benefit integrity activities.	*MEDIC Benefit Integrity Activities in Medicare Parts C and D* OEI-03-11-00310 **(Jan. 2013)**
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)**

Recommendation	Relevant Report(s)
CMS should: • review MA organizations to determine why certain organizations reported high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries; and • ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents.	*MA Organizations' Identification of Potential Fraud and Abuse* OEI-03-10-00310 **(Feb. 2012)**
CMS should: • determine why certain Plan D sponsors have identified especially high or low volumes of potential fraud and abuse incidents; • determine whether the Part D sponsors that identified fraud and abuse initiated inquiries and corrective actions as required by CMS and made referrals for further investigation as recommended by CMS; and • use this required information to help determine the effectiveness of sponsors' fraud and abuse programs. **OIG Top Unimplemented Recommendation # 9**	*Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse* OEI-03-07-00380 **(Oct. 2008)**

CMS—Medicaid

Recommendation	Estimated Savings	Relevant Report(s)
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; and • require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the Federal share generated by the original payment.	**$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)**

Recommendation	Estimated Savings	Relevant Report(s)
CMS should: • follow up with manufacturers associated with potentially misclassified drugs identified in this report to determine whether current classifications are correct; • improve its Drug Data Reporting for Medicaid System to minimize inconsistent data submissions and track potential classification errors for followup; and • pursue a means to compel manufacturers to correct inaccurate classification data reported to the Medicaid rebate program.		*Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates* OEI-03-17-00100 **(Dec. 2017)**
OIG Top Unimplemented Recommendation # 11		
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 require the use of claim level methods to identify 340B claims. The Health Resources and Services Administration should clarify its guidance on preventing duplicate discounts for managed care organization drugs.		*State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates* OEI-05-14-00430 **(June 2016)**
CMS should: • increase coordination with State Medicaid programs on collecting and verifying provider ownership information in Medicare and Medicaid; and • require State Medicaid programs to verify the completeness and accuracy of provider ownership information.		*Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* OEI-04-11-00590 **(May 2016)**

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 14		
CMS should: • assist States in implementing fingerprint-based criminal background checks for all high-risk providers; • assist States in overcoming 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.		*Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented* OEI-05-13-00520 **(May 2016)**
OIG Top Unimplemented Recommendation # 14		
CMS should: • issue guidance to States on how to estimate Medicaid National Correct Coding Initiative (NCCI) cost savings and take steps to ensure that States report as required; and • take appropriate action to ensure that States fully implement NCCI 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 • require States to reconcile total Federal Medicaid		*Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds* A-06-14-00068 **(Mar. 2016)**

Recommendation	Estimated Savings	Relevant Report(s)
funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines		
CMS should: • ensure that States pay for services in accordance with their periodicity schedules; • work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid; • develop benchmarks for dental services and require States to create mandatory action plans to meet them; • work with States to analyze the effects of Medicaid payments on access to dental providers; and • work with States to track children's utilization of required dental services		*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 monitor encounter data to ensure States report data for all managed care entities. **OIG Top Unimplemented Recommendation # 12**		*Not All States Reported Medicaid Managed Care Encounter Data as Required* OEI-07-13-00120 **(July 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)**

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 15		
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)**
OIG Top Unimplemented Recommendation # 15		
CMS should help States obtain better data on ineligible drugs.		*Medicaid Drug Rebate Dispute Resolution Could Be Improved* OEI-05-11-00580 **(Aug. 2014)**
CMS should require each State Medicaid agency to report all terminated providers. **OIG Top Unimplemented Recommendation # 16**		*CMS Process for Sharing Information About Terminated Providers Needs Improvement* OEI-06-12-00031 **(Mar. 2014)**
CMS should establish a deadline for when national Transformed Medicaid Statistical Information System data will be available. **OIG Top Unimplemented Recommendation # 12**		*Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System* OEI-05-12-00610 **(Sept. 2013)**
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.		*Medicaid Overpayments—CMS Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected* A-05-11-00071 **(Feb. 2013)**
CMS should take action to improve CMS's and States' ability to monitor billing and care quality by requiring States to either enroll all personal care service (PCS) attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier.		*PCS: Trends, Vulnerabilities, and Recommendations for Improvement* OIG-12-12-01 **(Nov. 2012)**

Recommendation	Estimated Savings	Relevant Report(s)
OIG Top Unimplemented Recommendation # 13		
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)**
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)**

CMS—General

Recommendation	Estimated Savings	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 or updated enrollment data, and (3) the application of these data to allocate costs.	**$28.4 million**[12]	*Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace* A-01-14-02503 **(Mar. 2015)**

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

Recommendation	Estimated Savings	Relevant Report(s)
CMS should: • establish a process to perform a claims-level detailed lookback analysis of Medicaid entitlement benefits due and payable to determine the reasonableness of the methodology used to estimate the accrual; • continue to improve the efficiency of the various error rate processes to allow more time to analyze the findings and the development of remediation plans; • when considering changes to established methodologies, we recommend that CMS work with its various components prior to the implementation of such changes to ensure that all relevant accounting consequences have been considered; • evaluate the sufficiency of current efforts related to Medicaid risk mitigation so that recoverable amounts are pursued in a timely fashion and to a lesser extent that recovery estimates are properly reflected in the financial statements; • ensure that the appropriate policies are established, implemented and adhered to by the various Centers, regional offices and MACs or if the specific policy is not implemented, determine that the required documentation and approval exists to demonstrate how the risk is appropriately mitigated or responded to through other procedures; and • strengthen oversight and support that will serve to prevent an inordinate backlog of uncertified claims. CMS should: • continually assess the governance and oversight across its organizational units charged with responsibility for configuration management and information security of its Medicare fee-for-service (FFS) systems and data, for both the Central Office and the CMS FFS contractors; • segregate access to develop and approve changes to separate members to ensure proper segregation of duties; and • have continued implementation of configuration management activities at the Central Office and the Medicare FFS contractors in accordance with CMS's policies and guidance, related monitoring procedures, mitigation of risk, and timely remediation of identified vulnerabilities.		Summary of recommendations from *Report on the Financial Statement Audit of CMS for Fiscal Year (FY) 2017 (A-17-17-02016)* **CMS Financial Report FY 2017 (Nov. 2017)** (See pp. 84–102)

Recommendation	Estimated Savings	Relevant Report(s)
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)**
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)**
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 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; • ensure that contract actions are supported by required documentation; and • ensure that all contracts that are subject to its Contract Review Board requirements undergo these reviews. HHS should revise its guidance to include specific standards for conducting past performance reviews of companies under consideration during contract procurement.		*Federal Marketplace: Inadequacies in Contract Planning and Procurement* OEI-03-14-00230 **(Jan. 2015)**

Administration for Children and Families (ACF)

Recommendation	Relevant Report(s)
ACF should: • ensure that management decisions are issued to Head Start grantees within the required 6-month timeframe; • consider providing training to Head Start grantees on preparing corrective action plans with sufficient information for ACF to determine whether corrective actions are adequate to resolve audit findings; • 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; • strengthen its policies and procedures to include monitoring of Head Start grantees and conducting site visits, when feasible, to ensure that grantees implement corrective actions to resolve audit findings; and • 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. **OIG Top Unimplemented Recommendation # 18**	Summary of recommendations from 4 reports: *The ACF Region II Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements* A-02-16-02009 **(Feb. 2018)** *ACF Did Not Always Resolve American Indian and Alaska Native Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements* A-06-17-07003 **(Dec. 2017)** *The ACF Region X Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements* A-09-16-01004 **(Dec. 2017)** *The ACF Region VI Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance with Federal Requirements.* A-06-16-00019 **(Sept. 2017)**
ACF should: • prepare guidance about supplemental Superstorm Sandy Block Grants (SSBG) documentation requirements; • conduct a post-grant review to identify lessons learned and best practices; and • take additional steps to ensure, within the scope of the legislation, that States are given appropriate time to expand any future supplemental SSBG awards.	*SSBG: Funds Benefited States' Reconstruction and Social Service Efforts, Though ACF's Guidance Could be Improved* OEI-09-15-00200 **(Sept. 2016)**
ACF should: • proactively monitor Head Start grantee performance results to verify that those grantees designated for automatic, noncompetitive renewal perform better than their peers; and • take additional steps to increase the number of applicants for recompeted grants.	*Head Start Grant Recompetition: Early Implementation Results Suggest Opportunities for Improvement* OEI-12-14-00650 **(Aug. 2016)**

Recommendation	Relevant Report(s)
ACF should request that States examine the effectiveness of their program integrity and fraud-fighting activities in their Child Care and Development Fund programs. **OIG Top Unimplemented Recommendation # 17**	*More Effort is Needed to Protect the Integrity of the CCDF Block Grant Program* OEI-03-16-00150 **(July 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)**

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. **OIG Top Unimplemented Recommendation # 19**	*FDA's Food-Recall Process Did Not Always Ensure the Safety of the Nation's Food Supply* A-01-16-01502 **(Dec. 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 take appropriate action against all facilities with significant inspection violations. **OIG Top Unimplemented Recommendation # 20**	*Challenges Remain in FDA's Inspections of Domestic Food Facilities* OEI-02-14-00420 **(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 **(July 2016)**

Recommendation	Relevant Report(s)
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: • ensure that violations are corrected for all facilities that receive Official Action Indicated classifications; • take appropriate actions against facilities with Official Action Indicated classifications, particularly those that have histories of violations; and • consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.	*FDA Inspections of Domestic Food Facilities* OEI-02-08-00080 **(Apr. 2010)**

Indian Health Service (IHS)

Recommendation	Relevant Report(s)
IHS should: • implement a quality-focused compliance program to support Federal requirements for health care 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/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. 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. **OIG Top Unimplemented Recommendation # 22**	*IHS Hospitals: More Monitoring Needed to Ensure Quality Care* OEI-06-14-00010 **(Oct. 2016)**
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. **OIG Top Unimplemented Recommendation # 21**	*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 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 develop and refine its financial management systems and processes to improve financial management at NIH and CMS; 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 FY 2017 (A-17-17-00001)* **HHS FY 2017 Agency Financial Report (Nov. 2017)** (See pp. 45–67)
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 (July 2017)**
HHS should address and reduce improper payments in the Temporary Assistance for Needy Families and Medicaid programs. **OIG Top Unimplemented Recommendation # 24**	Summary of recommendations from 4 reports: *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2017* **A-17-18-52000 (May 2018)** *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2016* **A-17-17-52000 (May 2017)** *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2015* **A-17-16-52000 (May 2016)** *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2014* **A-17-15-52000 (May 2015)**
The Office of the Assistant Secretary for Financial Resources (ASFR) should establish a department-wide source for adverse information from audits of grantees. **OIG Top Unimplemented Recommendation # 23**	*HHS Oversight of Grantees could be Improved through Better Information-Sharing* **OEI-07-12-00110 (Sept. 2015)**

Recommendation	Relevant Report(s)
ASFR should: • improve procedures to check for duplicative awards; and • ensure compliance with Small Business Innovation Research Program eligibility requirements.	*Vulnerabilities in the HHS Small Business Innovation Research Program* **OEI-04-11-00530 (Apr. 2014)**
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. **OIG Top Unimplemented Recommendation # 25**	*Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology* **OEI-01-11-00570 (Dec. 2013)**

U.S. Department of Health & Human Services

Office of Inspector General