

**OFFICE OF  
INSPECTOR GENERAL**

U.S. Department of Health and Human Services

**COMPENDIUM  
OF UNIMPLEMENTED  
RECOMMENDATIONS**

March 2015

# OIG Compendium of Unimplemented Recommendations

## About the March 2015 edition

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This document, entitled the *Compendium of Unimplemented Recommendations* (Compendium), is a core publication of the Department of Health and Human Services (HHS) Office of Inspector General (OIG). With this edition, we focus on the top 25 unimplemented recommendations that, on the basis of OIG's professional opinion, would most positively impact HHS programs in terms of cost savings and/or quality improvements and should, therefore, be prioritized for implementation. The recommendations come from OIG audits and evaluations, performed pursuant to the Inspector General Act of 1978, as amended. The Appendix of the *Compendium* includes a comprehensive list of OIG's significant unimplemented recommendations, including the top 25 unimplemented recommendations as well as other open recommendations that are not in the top 25 list.

The *Compendium* constitutes OIG's response to a specific requirement of the Inspector General Act of 1978, as amended (section 5(a)(3)). That is, it identifies significant recommendations described in previous *Semiannual Reports to Congress* with respect to problems, abuses, or deficiencies for which corrective actions have not been completed. The 2015 edition also responds to a requirement associated with the Consolidated Appropriations Act of 2014 directing OIG to report its top 25 unimplemented recommendations that, on the basis of the professional opinion of OIG, would best protect the integrity of HHS programs if implemented.<sup>1</sup>

The recommendations represent opportunities to achieve expected impact through improvements in program effectiveness and efficiency and to better ensure quality of care and safety of beneficiaries in fiscal year (FY) 2015 and beyond.<sup>2</sup> The top 25 unimplemented recommendations are generally grouped by the underlying program area or operation; thus, they are not internally ranked and so do not reflect relative priority among the 25. The recommendations in the Appendix are similarly grouped and further organized by HHS operating division and program area.

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<sup>1</sup> Explanatory Statement Submitted by Mr. Rogers of Kentucky, Chairman of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment on H.R. 3547 Consolidated Appropriations Act, 2014; Division H – Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2014; Title II, HHS, OIG, p. 63.

<sup>2</sup> The *Compendium* does not include all unimplemented OIG recommendations. For example, it does not include recommendations that are only to collect improper payments or those that are addressed to specific non-Federal entities. It also does not include recommendations that are significant but involve sensitive security issues.

## Implementation of OIG's recommendations

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Implementing OIG's recommendations generally requires one of three types of actions: legislative, regulatory, or administrative. Some issues involve more than one type of corrective action. The expected impact of OIG's recommendations varies from direct cost savings to improvements in payment efficiency, program operations, and/or quality and safety. These improvements may not result in direct monetary recoveries, but their impact on ensuring the integrity of HHS programs and the health and welfare of program beneficiaries is crucial.

OIG relies on policymakers, such as HHS and its operating divisions and staff divisions, the Administration, Congress, and States, to take the necessary steps to achieve optimal outcomes. Although many OIG recommendations are directly implemented by organizations within HHS, some are acted on by States that collaborate with HHS to administer, operate, and/or oversee designated federally funded programs, such as Medicaid.

Some of the recommendations in the *Compendium* would require additional authority or other legislative change to implement, including instances where HHS disagrees with OIG's recommendations. Congress has previously incorporated OIG's recommendations into legislative actions in order to achieve substantial savings; put public funds to better use; and/or improve quality of care, program integrity, or information systems and processes.

Many of the recommendations in this *Compendium* have seen some progress. However, as of March 2015, the date of publication, OIG had reason to believe that more should be achieved.

## Emerging issues and the OIG *Work Plan*

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The significant unimplemented recommendations described in the body of this report reflect OIG's past and recently issued final reports. As such, the recommendations do not reflect the significant amount of work we have currently underway on many emerging issues.

Brief descriptions of our FY 2015 work in progress and planned work are presented in the OIG *Work Plan* for FY 2015, which is available on our Web site. Once reviews are complete and final reports are issued, we publish them on our Web site—<http://oig.hhs.gov>—under "What's New." Particularly significant reports are summarized in our *Semiannual Reports to Congress*.

# HHS agencies, programs, and functions

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## Centers for Medicare & Medicaid Services Programs

The programs of the Centers for Medicare & Medicaid Services (CMS), which include Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), account for over 80 percent of HHS's budget. The programs provide medical coverage for adults and children in certain statutorily defined categories. CMS is also responsible within HHS for the health insurance Marketplaces and related programs under the Affordable Care Act (ACA).

## Public Health and Human Service Programs and Other HHS-Related Issues

**Public Health**—Public Health-related agencies, which include the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and the National Institutes of Health (NIH), promote biomedical research; prevent and cure diseases; ensure the safety and efficacy of marketed food, drugs, and medical devices; or conduct other activities designed to ensure the general health and safety of Americans.

**Human Services**—The Administration for Community Living (ACL) and the Administration for Children and Families (ACF) provide Federal direction and funding for State-administered efforts designed to promote stability, economic security, responsibility, and self-support for the Nation's families and to establish comprehensive community-based systems to help maintain dignity and quality of life.

**Other HHS-Related Issues**—Departmental functions include policies and procedures for financial accounting, information systems management, oversight of grants and contracts, and selected initiatives involving more than one HHS organizational entity.

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If more information is needed on any report listed in this publication, the report numbers are hyperlinked to the full text of the reports on our Web site. The full reports can also be located by entering the report numbers into any major Internet search engine or into the search field on our Web site. Questions about the *Compendium* or other publications should be directed to OIG's Office of External Affairs at 202-619-1343.

- OIG's Web site, which provides a full range of OIG output, includes the *Compendium* and other key publications, such as the *OIG Work Plan*, *Semiannual Report to Congress*, and *Top Management and Performance Challenges*. The Web site is at <http://oig.hhs.gov>.
- You may report potential instances of waste, fraud, or abuse related to HHS's programs via our Web site at <http://forms.oig.hhs.gov/hotlineoperations>.

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## Selected Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
ACL	Administration for Community Living
ASFR	Assistant Secretary for Financial Resources
CAH	critical access hospital
CMHC	community mental health center
CMS	Centers for Medicare & Medicaid Services
CY	calendar year
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FDA	Food and Drug Administration
FFS	fee for service
FY	fiscal year
HCBS	home- and community-based services
HHA	home health agency
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MAC	Medicare administrative contractor
MCE	managed care entity
MSIS	Medicaid Statistical Information System
NIH	National Institutes of Health
OAI	official action indicated
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
OPPS	outpatient prospective payment system
PCS	personal care services
P&T	pharmacy and therapeutics (committee)
RAC	recovery audit contractor
RUG	resource utilization group
SMRC	Supplemental Medical Review Contractor
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
T-MSIS	Transformed MSIS
UPL	upper payment limit
ZPIC	zone program integrity contractor

## TOP 25 UNIMPLEMENTED RECOMMENDATIONS

# Payment Policies and Practices

## Establish accurate and reasonable Medicare payment rates for hospital inpatient services

### Top Recommendation To Be Implemented

#### 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.

**Recommendation Issued: February 2014**

### Overview

The DRG window policy defines when outpatient services related to inpatient admissions are not paid for separately, but rather are considered to be included in the inpatient lump-sum payment. The lump-sum payment represents all operating costs associated with the inpatient admission, including costs for routine nursing services, radiology services, and laboratory services. Under the current DRG window, Medicare and beneficiaries do not pay separately for related outpatient services delivered within 3 days of an inpatient admission in a setting owned by the admitting hospital. Three days is not a medical standard and the medical community has identified benefits to providing certain preadmission services weeks and sometimes months prior to an inpatient stay. Services that are provided by hospitals that share a common owner (i.e., multiple hospitals owned by the same corporation, hereinafter referred to as affiliated hospitals) are not subject to the DRG window policy.

The DRG window was intended to ensure that Medicare and beneficiaries did not pay the same organization twice for outpatient services related to inpatient admissions. However, the current DRG window does not capture all these services. Medicare and beneficiaries could realize substantial savings if the DRG window was expanded to include additional days prior to the inpatient admission. In 2011, Medicare and beneficiaries paid an estimated \$263 million for 4.3 million related outpatient services provided at settings owned by admitting hospitals in the 11 days prior to the DRG window. Additionally, Medicare and beneficiaries paid an estimated \$45 million for 777,000 related outpatient services provided at hospitals affiliated with, but not owned by, admitting hospitals during the 3 days prior to inpatient admissions.

- Expected Impact:**
- **Estimated savings** - \$308 million<sup>3</sup>
  - **Improved payment efficiency**

<sup>3</sup> The estimated \$308 million in savings is based on OIG's analysis of claims for services provided just prior to the window or provided at affiliated hospitals during the window in 2011.

## Implementation Status

CMS did not concur with the recommendation, stating that it would require a legislative proposal that is not currently included in the President’s budget. We continue to recommend that CMS draft, and submit for review, a legislative proposal that expands the DRG window to include additional days and other hospital ownership arrangements. While we understand that CMS cannot dictate which legislative proposals are included in the President’s budget, CMS does have the authority to develop legislative proposals that pertain to Medicare. We continue to monitor CMS’s progress in implementing our recommendations.

### Key OIG Report

- *Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded.* [OEI-05-12-00480](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve Medicare payment policies and practices in the Appendix.

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## Establish accurate and reasonable Medicare payment rates for hospital transfers

### Top Recommendation To Be Implemented

#### CMS should:

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

**Recommendation Issued: May 2013**

### Overview

Medicare has two “transfer payment policies.” One adjusts payments for discharges from hospitals to other hospitals. The other adjusts payments for discharges from hospitals to postacute-care facilities for continued treatment that are made sooner than a Medicare-established average length of stay<sup>4</sup> (early discharge). Medicare pays hospitals a per diem rate for early discharges when beneficiaries are transferred to these types of settings. These policies aim to curb the financial incentive to discharge early by ensuring that hospitals do not receive full payments for Medicare beneficiaries that are

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<sup>4</sup> Consistent with Medicare’s existing transfer payment policies, OIG defines an “early discharge” as being more than one day earlier than the Medicare-established geometric mean length of stay for an applicable DRG.

discharged early, then admitted in another clinical setting. However, Medicare does not have a transfer payment policy to adjust the payment to the hospital for instances when a beneficiary is discharged early from a hospital to hospice care.

On the basis of OIG’s sample results, Medicare would have saved approximately \$602.5 million during calendar years (CYs) 2009 and 2010 by implementing a hospital transfer policy for early discharges to hospice similar to the transfer payment policy it has for early discharges to other postacute-care facilities. Furthermore, OIG found that this reform would not cause hospitals a significant financial disadvantage or disproportionately affect any hospital.

- Expected Impact:**
- **Estimated savings** - \$602.5 million
  - **Improved payment efficiency**

## Implementation Status

In its April 1, 2013, response to the draft report, CMS indicated it would like to study our recommendation further. It questioned the savings estimates, stating that adopting a policy for transfers to the hospice setting may produce lower than estimated savings by discouraging hospitals from making transfers to more appropriate and cost-effective care settings “until a patient's length of stay would not result in a reduction of payment to hospitals.” CMS also stated that further analysis would be needed to determine the savings, if any. We continue to monitor CMS’s progress in implementing our recommendations.

### Key OIG Report

- *Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care. [A-01-12-00507](#).*

### See Also:

Find [additional significant OIG recommendations](#) to improve Medicare payment policies and practices in the Appendix.

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## Reduce hospital outpatient department payment rates for ambulatory surgical center-approved procedures

### Top Recommendation To Be Implemented

#### CMS should:

- Seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system (OPPS) payment rates from budget neutrality adjustments for ambulatory surgical center (ASC)-approved procedures.

**Recommendation Issued: April 2014**

*Companion recommendations:*

- Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.
- Develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

## Overview

Medicare covers many outpatient surgical procedures commonly performed in both hospital outpatient departments (outpatient departments) and ASCs. ASCs provide surgical services in less intensive and less costly settings to patients who do not require an overnight stay. Medicare ASC payment rates are frequently lower than outpatient department payment rates. Medicare generally saves when outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department. Currently, OPPS rates for ASC-approved procedures are determined in a budget-neutral manner—in which the rates for some procedures would result in higher rates for others—negating the potential savings in reducing OPPS rates.

On the basis of current payment differentials and 2011 utilization data, Medicare saved almost \$7 billion during CYs 2007 through 2011 and could potentially save \$12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. Additionally, beneficiaries would save through reduced cost sharing—saving approximately \$2 billion during CYs 2007 through 2011 and potentially saving an additional \$3 billion for the next 6 years. Furthermore, if legislation passes allowing the OPPS rates for ASC-approved procedures to be determined in a non-budget-neutral manner, Medicare could generate potential savings of as much as \$15 billion for CYs 2012 through 2017.

We recognize that not all procedures can be performed in an ASC because a procedure might pose a significant safety risk to the patient. To account for this, we obtained patient-risk statistics from AHRQ. These statistics showed that 33 percent of hospital patients 65 and older were considered to have no-risk medical profiles and an additional 35 percent were considered to be at low risk for procedures performed at an ASC. In total, 68 percent of patients had either low- or no-risk medical profiles.

**Expected Impact:**

- **Estimated Savings:** \$15 billion<sup>5</sup>
- **Improved payment efficiency**

## Implementation Status

In response to our report, CMS stated that adopting the recommendations would require legislation and that such a proposal is not currently included in the President's Budget. CMS also noted that the recommended changes "...may raise circularity concerns with respect to the rate calculation process" because most ASC payment rates are based on the OPPS payment rates that we are recommending that

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<sup>5</sup> Medicare could have generated savings of as much as \$15 billion for CYs 2012 through 2017 if CMS reduced outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs. In addition, beneficiaries could potentially save as much as \$2 billion to \$4 billion more during the 6 years through CY 2017 if CMS reduced outpatient department payment rates for ASC-approved procedures to ASC payment levels.

CMS reduce and that we did not provide specific clinical criteria to distinguish patients' risk levels. We continue to monitor CMS's progress in implementing our recommendations.

**Key OIG Report**

- *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates.* [A-05-12-00020](#).

**See Also:**

Find [additional significant OIG recommendations](#) to improve Medicare payment policies and practices in the Appendix.

# Billing and Payment

## Prevent inappropriate payments to Medicare home health agencies

### Top Recommendation To Be Implemented

#### CMS should:

- Develop other oversight mechanisms for the home health face-to-face requirement.

**Recommendation Issued: April 2014**

#### *Companion recommendation:*

- Develop a specific strategy to communicate directly with physicians about the face-to-face requirement.

## Overview

OIG work has demonstrated that home health care is an area particularly vulnerable to abuse, including fraud. The Patient Protection and Affordable Care Act (ACA) provided new tools to enhance CMS's efforts to prevent and detect fraud in its programs. One tool requires that physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services document that face-to-face encounters with those beneficiaries occurred. The home health agency (HHA) must obtain documentation that the face-to-face encounter with the patient occurred and that the encounter was related to the primary reason the beneficiary needs home health care. If the certifying physician does not complete the documentation correctly, CMS can deny the HHA payment because the face-to-face requirement is a Medicare condition of payment.

CMS oversight of the face-to-face requirement is minimal. It does not have a specific program to oversee compliance with this requirement; rather, it reviews documentation when conducting medical record reviews as part of general fraud-fighting efforts, but only a fraction include the face-to-face document. However, our analysis found that 32 percent of home health claims that required face-to-face encounters during 2011-2012 did not meet Medicare's documentation requirements, resulting in \$2 billion in payments that should not have been made. Furthermore, physicians inconsistently completed the narrative portion of the face-to-face documentation. Some face-to-face documents provided information that, although not required by Medicare, could be useful in its program integrity efforts, such as a printed name for the physician and a list of the home health services needed.

- Expected Impact:**
- **Estimated savings - \$2 billion**
  - **Improved program integrity**

## Implementation Status

CMS concurred with our recommendation. In its status update, CMS stated that it is implementing a plan for oversight of home health agencies through the Supplemental Medical Review Contractor (SMRC). OIG requests documentation of the plan and will consider this recommendation implemented upon receipt and satisfactory review of the SMRC's plan. We request that in its notification of final

action to OIG, CMS provide documentation of that plan. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Limited Compliance With Medicare's Home Health Face-to-Face Documentation Requirements.*  
**OEI-01-12-00390.**

### See Also:

Find [additional significant OIG recommendations](#) to improve billing and payment policies and procedures in the Appendix.

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## Reduce inappropriate payments to skilled nursing facilities

### Top Recommendation To Be Implemented

#### CMS should:

- Change the current method for determining how much therapy is needed to ensure appropriate payments.

**Recommendation Issued: November 2012**

#### Companion recommendations:

- Monitor compliance with the new therapy assessments.
- Improve accuracy of data items submitted by skilled nursing facilities (SNFs).

### Overview

Medicare paid \$26.9 billion for SNF services in FY 2013. In recent years, OIG has identified a number of issues with billing by SNFs, including the submission of inaccurate and fraudulent claims and claims for services that were medically unnecessary. Additionally, the Medicare Payment Advisory Commission has raised concerns about SNFs' improperly billing for therapy to obtain additional Medicare payments. SNFs use a standardized tool known as the Minimum Data Set (MDS) to assess each beneficiary's clinical condition, functional status, and expected and actual use of services in order to classify beneficiaries into resource utilization groups (RUGs). Each RUG has a different Medicare per diem payment rate. RUGs associated with therapy, such as physical therapy, speech therapy, or occupational therapy, typically have higher rates. SNFs usually document their beneficiary assessments and plans of care retrospectively in the MDS during what is called the "look-back period," which occurs every 7–14 days. This method creates incentives for SNFs to provide and bill for high levels of therapy when these levels may not be needed.

SNFs commonly misreported therapy, which largely determines the amount that Medicare pays the SNF. SNFs billed one-quarter of all claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded to ultrahigh therapy, the highest paying

therapy level. The remaining claims in error were downcoded or did not meet Medicare coverage requirements. In addition, SNFs misreported information on the MDS for 47 percent of claims.

- Expected Impact:**
- **Improved payment efficiency**
  - **Improved program integrity**

## Implementation Status

CMS concurred with our recommendation and completed the first phase of its project, which will identify potential alternative payments methods for SNF therapy services. According to CMS, the second phase of the project is in progress. OIG is conducting ongoing work examining the extent to which changes in SNFs' billing affected Medicare payments in FYs 2012 and 2013 and the extent to which beneficiary characteristics changed during this time period and is comparing Medicare payments and SNFs' costs for therapy for selected years from FY 2002 to FY 2012. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than \$1 Billion in 2009.*  
[OEI-02-09-00200](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve billing and payment policies and procedures in the Appendix.

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## Prevent payments to ineligible Medicare beneficiaries

### Top Recommendation To Be Implemented

#### CMS should:

- Implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to incarcerated beneficiaries.

**Recommendation Issued: January 2013**

### Companion recommendation:

- Ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements and work with other entities, including the Social Security Administration (SSA), to identify ways to improve the timeliness with which CMS receives incarceration information.

## Overview

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare generally does not pay for services rendered to individuals who are incarcerated in correctional facilities (incarcerated beneficiaries). Other beneficiary eligibility restrictions pertain to individuals unlawfully present in the United States, the deceased, or those who no longer meet the requirements for participation in Medicare. Federal requirements, however, allow Medicare payment if State or local law requires incarcerated beneficiaries to repay the cost of medical services. SSA is CMS's primary source of information about incarcerated beneficiaries. CMS's Enrollment Database interfaces with SSA's systems to identify incarcerated individuals. Several applications, including CMS's Common Working File, can then be used by Medicare contractors to access the dates of incarceration for processing and prepayment and postpayment reviews.

CMS will not always receive timely updates regarding incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries. As a result, Medicare payments totaling \$33,587,684 were made to providers for services rendered to 11,619 incarcerated beneficiaries during CYs 2009 through 2011. CMS did not have policies and procedures to review incarceration information on a postpayment basis that would have detected improper payments that the prepayment edit could not prevent. Consequently, CMS did not notify the contractors to recoup any of the \$33.6 million in improper payments. Similar findings were reported throughout OIG's series of beneficiary eligibility work.

- Expected Impact:**
- **Estimated savings** - \$33.6 million
  - **Improved payment efficiency**

## Implementation Status

Though CMS concurred with our recommendation to work with other entities to identify ways to improve timelines, it did not concur with our recommendation to work with Medicare contractors to ensure that all claims with exception codes are processed properly. CMS noted that it was not able to fully understand the issue in order to evaluate this recommendation and requested greater specificity regarding inconsistencies in contractor policies on processing claims with exception codes, which we provided. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services during 2009 Through 2011. [A-07-12-01113](#).*

### See Also:

Find [additional significant OIG recommendations](#) to improve billing and payment policies and procedures in the Appendix.

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## Reconcile Medicare outlier payments in accordance with Federal guidance and regulations

### Top Recommendation To Be Implemented

#### CMS should:

- Implement an automated system that will recalculate outlier claims to facilitate reconciliations.

**Recommendation Issued: June 2012**

#### Companion recommendations:

- Work with the Medicare contractors to develop and maintain a complete and accurate list of the cost reports with outlier payments requiring reconciliation.
- Ensure that Medicare contractors reconcile outlier payments and perform final settlement on the costs reports we reviewed in accordance with Federal regulations and guidance.
- Ensure that Medicare contractors reconcile outlier payments and perform final settlement on all cost reports submitted after our audit period in accordance with Federal regulations and guidance.

### Overview

Under the prospective payment system (PPS), CMS adjusts basic prospective payments to hospitals for unusually high costs. These additional payments, known as outlier payments, are designed to protect hospitals from excessive losses that are due to unusually high-cost cases. CMS and OIG have previously determined that some hospitals dramatically increased charges in an effort to inappropriately maximize outlier reimbursement. Regulations mandate that outlier payments to hospitals that rapidly increase charges are subject to reconciliation of outlier payments. Outlier reconciliation is a required step in the final settlement checklist used by all Medicare contractors. CMS reviews outlier reconciliation as part of the Quality Assurance Surveillance Plan conducted yearly for each Medicare administrative contractor (MAC) in order to ensure compliance.

CMS did not reconcile outlier payments and did not reach final settlement for 292 of the 305 cost reports that were referred during the October 1, 2003, through December 31, 2008, audit period. Because CMS did not conduct reconciliations, the payments hospitals owed to Medicare and the payments Medicare owed to hospitals were unknown and outstanding at the conclusion of our fieldwork. Furthermore, the delayed payments and the associated interest should have been returned to the Medicare Trust Fund. At the same time, the delayed processing of outlier payments due from Medicare to hospitals, along with the associated interest, could have affected those hospitals' financial viability.

**Expected Impact:** ■ Improved payment efficiency

## Implementation Status

CMS concurred with all of our recommendations. In its response to our draft report, CMS referenced Transmittal 21111 (CR 7192), which provided instructions to Fiscal Intermediary Shared System (FISS) and MACs on the reconciliation process, specifically regarding use of the Lump Sum Utility to recalculate outlier claims to facilitate reconciliations. Additionally, in the transmittal, CMS required contractors to identify ("flag") providers for outlier reconciliation and to submit lists of these providers to the Central Office for approval. CMS stated that it maintains lists of the hospitals submitted by the MACs for outlier reconciliation and lists of the hospitals for which outlier reconciliation is approved.

CMS also stated that it will work with the MACs to ensure that all cost reports submitted after the audit period have outlier reconciliations (where required) and that cost reports are finally settled properly in accordance with regulations and CMS manual provisions.

OIG is conducting ongoing work to determine whether reconciliations are being completed in a timely manner, enabling MACs to perform final settlement of the hospitals' associated cost reports. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance.* [A-07-10-02764](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve billing and payment policies and procedures in the Appendix.

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## Ensure that States calculate accurate costs for Medicaid services provided by local public providers

### Top Recommendation To Be Implemented

#### CMS should:

- Provide States with definitive guidance for calculating the Federal upper payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data.

**Recommendation Issued: September 2001**

### Companion recommendation:

- 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.

## Overview

The Federal Government and States share the cost of Medicaid. From time to time, States have developed mechanisms to obtain Federal Medicaid funds without committing the States' shares of required matching funds or, by other means, artificially inflating the Federal share. Such practices limit Congress's ability to assess the public benefits of Medicaid dollars. OIG addressed this issue broadly in an audit in 2001, and since then, we have continued to identify similar problems in selected States.

For example, Medicaid upper payment level (UPL) rules, which establish aggregate caps on payments to different classes of facilities, permit States to provide enhanced payments that qualify for Federal reimbursement to one of those classes. But some States have required such facilities to transfer the funds to the States to be put to other uses, leaving the facilities underfunded.

- Expected Impact:**
- **Estimated savings** - \$3.87 billion over 5 years
  - **Improved payment efficiency**

## Implementation Status

OIG has long recommended that Medicaid payments to public providers be based on the costs of providing services. In 2008, CMS issued a final rule that, among other things, would limit Medicaid payments to public providers to their costs of providing care, but the rule was ultimately vacated by Federal District Court. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers.* [A-03-00-00216](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve billing and payment policies and procedures in the Appendix.

# Contractor Oversight

## Maximize CMS contractor performance and oversight

### Top Recommendation To Be Implemented

#### CMS should:

- Utilize and report Zone Program Integrity Contractors' (ZPICs') workload statistics in ZPIC evaluations.

**Recommendation Issued: November 2011**

#### Companion recommendations:

- 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.
- Ensure that ZPICs have access to all data necessary to effectively carry out their program integrity activities.

## Overview

CMS contracts with ZPICs to perform program integrity work in Medicare Parts A and B in established geographical zones. ZPICs are required to report monthly workload statistics related to their program integrity activities and related task orders, including investigations, case referrals, requests for information, and administrative actions. CMS tracks and analyzes these statistics using an online system called the CMS Analysis, Reporting, and Tracking System (CMS ARTS). OIG has a long history of overseeing Medicare's program integrity contractors, including their ability to detect and deter fraud, waste, and abuse.

OIG work examining ZPIC performance found that CMS's performance evaluations of ZPICs contained few workload statistics and that the workload data used by CMS to oversee the ZPICs were not accurate or uniform; as a result, we could not make a conclusive assessment of ZPICs' program integrity activities. The issues identified present serious obstacles to CMS's ability to effectively oversee ZPIC operations and detect and deter fraud, waste, and abuse in the Medicare program.

**Expected Impact:**   ▪ **Improved contractor management**

## Implementation Status

CMS concurred with the recommendation. CMS stated it will consider including workload statistics for future evaluations, if appropriate. CMS also stated that assessing the quality of a case/investigation is part of a ZPIC performance evaluation. OIG maintains that quantitative measures, while not the sole indicator of ZPIC performance, can provide valuable information on the level of ZPIC activity and the quality of ZPIC performance and should be reported in ZPIC performance evaluations. OIG will consider the recommendation implemented when CMS utilizes workload statistics in ZPIC evaluations and provides OIG documentation indicating that the evaluations include ZPICs' workload statistics. We continue to monitor CMS's progress in implementing our recommendations.

**Key OIG Report**

- *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight.* [OEI-03-09-00520](#).

**See Also:**

Find [additional significant OIG recommendations](#) to improve contractor oversight in the Appendix.

# Grants and Contracts

## Prevent institutional conflicts of interest at National Institute of Health grantees

### Top Recommendation To Be Implemented

#### NIH should:

- Promulgate regulations that address institutional financial conflicts of interest.

**Recommendation Issued: January 2011**

### Overview

NIH is the primary Federal agency responsible for conducting and supporting medical research. Organized into 27 Institutes and Centers, NIH receives billions of dollars annually to support its mission. In FY 2014, NIH's budget totaled over \$30 billion. More than 80 percent of this amount was distributed through almost 50,000 competitive grants to more than 300,000 researchers at over 2,500 institutions across the country and around the world. Grantee institutions consist of universities, medical schools, and other research institutions (e.g., private or nonprofit research organizations) receiving research grants from NIH. An institutional conflict may arise when an institution's own financial interests (e.g., royalties, equity, stockholdings, and gifts) or those of its senior officials pose a risk of undue influence on decisions involving the institution's research.

Each grantee institution receiving NIH funds must have a written policy for identifying researchers' financial conflicts of interest (hereinafter referred to as conflicts) and ensuring that conflicts are managed, reduced, or eliminated. However, there are currently no Federal requirements to define, identify, report, and manage actual or potential institutional conflicts. Therefore, NIH lacks information on the number of institutional conflicts at its grantee institutions and the impact these conflicts may have on NIH-sponsored research.

**Expected Impact:** ▪ **Improved grants management**

### Implementation Status

NIH states that it is considering the issue of institutional conflict of interest with interested stakeholders, including the question of whether it is appropriate to propose specific regulations to address this subject. NIH also stated that institutional conflict of interest is a highly complex topic that reaches beyond research and impacts a wide variety of recipient institutions funded by various agencies across the Federal Government. NIH continues to believe that consistent with the public comments received during the formal rulemaking process, further careful consideration is necessary before regulations could be formulated that would address the subject of institutional conflict of interest in the same comprehensive manner as the revised regulations address investigator financial conflict of interest. OIG suggested that until regulations are promulgated, NIH should encourage grantee institutions to develop

policies and procedures regarding institutional financial conflicts of interest. We continue to monitor NIH's progress in implementing our recommendations.

### Key OIG Report

- *Institutional Conflicts of Interest at NIH Grantees.* [OEI-03-09-00480](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve grants and contacts oversight in the Appendix.

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## Ensure grantee compliance with health and safety requirements

### Top Recommendation To Be Implemented

#### ACF should:

- Amend current policy and regulations to require that any prospective or current employee be disqualified for or terminated from employment with a Head Start grantee if the individual has been convicted of sexual abuse of a child, other forms of child abuse and neglect, or a violent felony.

**Recommendation Issued: November 2011**

### Overview

Pursuant to Federal Head Start regulations (45 CFR § 1304.53(a)(7)), Head Start grantees must provide for the maintenance, repair, safety, and security of all Head Start facilities. These regulations also specify that facilities used by Head Start grantees for regularly scheduled, center-based activities must comply with State and local licensing requirements. If State and local licensing standards are less stringent than the Head Start regulations or if no State licensing standards are applicable, grantees must ensure that their facilities comply with the Head Start Program Performance Standards related to health and safety (45 CFR § 1306.30(c)). The Head Start program is administered by each State's designated oversight entity, and varying sets of requirements nationwide present obstacles to ACF's oversight and grant management.

Of the 24 Head Start grantees we reviewed, none complied fully with Federal Head Start or State requirements to protect children from unsafe materials and equipment, and 21 of 24 grantees did not comply fully with Federal Head Start or State requirements to conduct criminal records checks, conduct recurring background checks, document criminal records checks, conduct checks of childcare exclusion lists, or conduct checks of child abuse and neglect registries. Strengthening Federal regulations and requirements regarding employee background checks and employment qualifications will improve ACF's nationwide oversight of health and safety requirements in Head Start.

**Expected Impact:**   ▪ **Improved grants management**

## Implementation Status

In its response to the draft 2015 *Compendium*, ACF stated:

“The Office of Head Start has revised its monitoring system to improve the process for determining if programs are in compliance with criminal background check requirements. Under the new system, every facility of each grantee (rather than a sample) receives a monitoring visit and is reviewed against an Environmental Health & Safety (EnvHS) Protocol. This instrument is used to gather information to assess grantee compliance with federal, state and local criminal background check requirements for all staff.

ACF has performed a legal analysis and determined that we can address Federal health and safety requirements through regulation. A Notice of Proposed Rulemaking (NPRM) is currently under review at Office of Management and Budget (OMB) and publication is expected this spring. The NPRM will strengthen health and safety requirements. Background checks for staff are considered part of health and safety requirements.”

We continue to monitor ACF’s progress in implementing our recommendations.

### Key OIG Report

- *Review of 24 Head Start Grantees’ Compliances With Health and Safety Requirements.* [A-01-11-02503](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve grants and contacts oversight in the Appendix.

# Program and Financial Management

## Ensure the collection of identified Medicare overpayments

### Top Recommendation To Be Implemented

#### CMS should:

- Ensure that the Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations.

**Recommendation Issued: May 2012**

#### Companion recommendations:

- Ensure that collections information is consistently recorded in ATARS.
- Collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law.

## Overview

CMS is required to aggressively and timely collect all overpayments and audit disallowance determinations.<sup>6</sup> CMS uses ATARS to monitor the status of OIG recommendations and manually enters collections data that it receives from Medicare contractors periodically during the year and at the end of the fiscal year. ATARS provides the status of OIG recommendations—both monetary and nonmonetary—during the reporting period.

As of October 8, 2010, CMS had not collected the majority of overpayment amounts identified in OIG audit reports on Medicare with recommendations to collect overpayments greater than \$1,000 that were issued during FY 2007 and 2008 and the first 6 months of FY 2009 to CMS, CMS contractors, or Medicare providers. Of the 154 OIG audit reports with sustained overpayment amounts totaling \$416.3 million, CMS reported collecting \$84.2 million. Of the \$84.2 million, CMS reported collecting the full sustained amounts totaling \$83.3 million for 113 reports and partial amounts totaling \$896,000 for 8 reports. However, for various reasons, CMS did not collect the remaining \$332.1 million. CMS's collections were limited because of time constraints imposed by the statute of limitations on overpayment collections. In addition, it did not provide its contractors with adequate guidance for collecting overpayments and did not have an effective system for monitoring its contractors' collection efforts.

**Expected Impact:**   ▪ **Improved financial management**

## Implementation Status

In its written comments on the draft report, CMS concurred with our recommendation to ensure that ATARS is updated to accurately reflect the status of audit report recommendations and stated that it had begun a review of its reporting in ATARS. CMS said it would make necessary changes to reflect the

<sup>6</sup> Federal Claims Collection Act (FCCA), P.L. No. 89-508 § 3(a). This provision is codified at 31 U.S.C. § 3711(a)(1).

outcomes of recovery work performed and, going forward, would ensure that corrective action plans and recoveries are clearly described and reported. However, in CMS's corrective action plan to address our recommendation, it did not concur with this recommendation. CMS said that it began a review of reports in ATARS and would make necessary changes to reflect the outcomes of the recovery work performed, but it did not agree that the \$332,119,044 was a cost savings. CMS said that, going forward, it would ensure that corrective action plans and recoveries are clearly described and reported. Although the \$332,119,044 was not in our recommendation, these are funds that could be put to better use had CMS collected OIG overpayments as required.

In its written response to the draft report, CMS concurred with the recommendation to ensure that CMS staff record collections information consistently in ATARS. In its corrective action plan, CMS confirmed its intent to consistently and accurately record collection efforts in ATARS.

CMS partially concurred with our recommendation to collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law. More specifically, CMS said that it would collect only sustained amounts in OIG recommendations that are for claims that can be reopened and that it would make collections when it is cost beneficial to reopen and review the claims. CMS also said that it had limited medical review resources and must focus reviews on the most "error-prone claims." However, CMS will continue to consider issues identified in OIG reports when developing medical review and recovery audit strategies. In a prior meeting, CMS indicated that it cost CMS \$80 to recover a claim and that OIG should not ask for any recoveries for claims that are less than that amount. CMS indicated that it would pursue any overpayments over \$80. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Obstacles to Collection of Millions in Medicare Overpayments.* [A-04-10-03059](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve program and financial management practices in the Appendix.

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## Improve oversight and management Medicaid personal care services

### Top Recommendation To Be Implemented

#### CMS should:

- Promulgate regulations to reduce significant variation in States' personal care services (PCS) laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.

**Recommendation Issued: November 2012**

*Companion recommendations:*

- Promulgate regulations to reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.
- Promulgate regulations to improve CMS's and States' ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with the State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identities of the rendering PCS attendants.
- Issue guidance to States regarding adequate prepayment controls.
- Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.
- Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

## Overview

Medicaid PCS consist of nonmedical services supporting activities of daily living, including bathing, dressing, light housework, money management, meal preparation, and transportation. Typically, attendants provide PCS. In many States, PCS attendants work for personal care agencies, which are enrolled in the Medicaid program and bill for services on the attendants' behalf. Several Federal court decisions and HHS policy initiatives aimed at providing more home- and community-based options to Medicaid beneficiaries contribute to the increase in PCS use. OIG's body of work examining Medicaid PCS has found significant and persistent compliance, payment, and fraud vulnerabilities that demonstrate the need for CMS to take a more active role with States to address these issues. As more and more State Medicaid programs explore home care options like PCS, it is critical that adequate safeguards exist to prevent fraud, waste, and abuse in PCS and other important home care benefits.

### Expected Impact

- **Estimated savings - \$1.3 billion<sup>7</sup>**
- **Improved program management**

## Implementation Status

CMS concurred with the recommendation. In June 2014, CMS indicated that it promulgated final rules for the new Community First Choice benefit, under section 1915(k) and for home- and community-based services (HCBS) provided under sections 1915(c) and 1915(i) of the Social Security Act. OIG believes CMS's actions do not fully implement the recommendation. We recommended that CMS promulgate regulations to reduce variation in State rules regarding PCS by creating Federal requirements for claims documentation, beneficiary assessments, plans of care, and supervision of attendants. The final rules

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<sup>7</sup> As of August 2012, OIG completed eight audits with a total amount of \$582 million in questioned costs. The improper payments lack compliance with documentation, plan-of-care, medical supervision, and qualifications requirements. Separately, a 2010 evaluation examined PCS in 10 States over a 1-year period and found that claims totaling \$724 million were inappropriate because the required qualifications for PCS attendants were undocumented.

address beneficiary assessments and plan-of-care provisions. However, they do not address provisions related to consistent claims documentation and supervision of attendants. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement. OIG-12-12-01.*

### See Also:

Find [additional significant OIG recommendations](#) to improve program and financial management practices in the Appendix.

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## Improve the Medicare appeals process at the administrative law judge level

### Top Recommendation To Be Implemented

The Office of Medicare Hearings and Appeals (OMHA) and CMS should:

- Standardize case files and make them electronic.

**Recommendation Issued: November 2012**

### Companion recommendations:

- OMHA and CMS should identify and clarify Medicare policies that are unclear and are interpreted differently.
- OMHA should revise regulations to provide more guidance to administrative law judges (ALJs) regarding the acceptance of new evidence.
- OMHA and CMS should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.
- OMHA should implement a quality assurance process to review ALJ decisions.
- OMHA should develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly.

## Overview

In 2005, HHS established OMHA, which created a group of ALJs dedicated to deciding Medicare appeals. ALJs within OMHA decide appeals at the third of four levels of the Medicare appeals system. In 2005, ALJs were required to follow new regulations addressing how to apply Medicare policy, when to accept new evidence, and how CMS participates in appeals.

Providers (as opposed to beneficiaries or other entities) filed the vast majority of appeals to ALJs in FY 2010; a small number of providers accounted for nearly one-third of all appeals. For 56 percent of

appeals, ALJs reversed qualified independent contractor (QIC) (the second level of the Medicare appeals system) decisions and decided in favor of the appellants; this rate varied substantially across Medicare program areas. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. In addition, the favorable rate varied widely by ALJ. CMS participated in only 10 percent of appeals, but when CMS did participate, ALJ decisions were less likely to be favorable to the appellants. CMS and ALJ staff raised concerns about the acceptance of new evidence, the organization of case files, and ALJ's inconsistent handling of fraud suspicions.

Since the publication of this report, a backlog of appeals developed at the ALJ level. Specifically, the number of appeals grew nearly ninefold, from 44,000 to 384,000, from FY 2010 to FY 2013. This development reiterates the need for OMHA and CMS to implement OIG's recommendations to improve the efficiency and effectiveness of the appeals process.

**Expected Impact:**    ■ **Improved program management**

## Implementation Status

CMS and OMHA concurred with the recommendation. Both agencies are working to finalize a Memorandum of Understanding that would standardize case files. In addition, OMHA is developing an Electronic Case Adjudicating Processing Environment (ECAPE) to standardize case files and make them electronic. CMS plans to develop an interface between its electronic system and ECAPE. Both agencies must ensure that they are coordinating their efforts to ensure a uniform electronic system that improves the efficiency of the entire appeals process. We continue to monitor CMS's and OMHA's progress in implementing our recommendations.

### Key OIG Report

- *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals.* [OEI-02-10-00340](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve program and financial management practices in the Appendix.

# Quality of Care and Safety

## Enhance efforts to identify adverse events to ensure quality of care and safety

### Top Recommendation To Be Implemented

#### CMS should:

- Broaden patient safety efforts to include all types of adverse events.

**Recommendation Issued: November 2010**

#### *Companion recommendation:*

- Enhance efforts to identify adverse events.

### Overview

The need to improve patient safety has received much attention from Federal and State Government, advocacy groups, and the health care industry. Hospitals are required to develop and maintain Quality Assessment and Performance Improvement (QAPI) Programs. As part of their QAPI programs, hospitals must “track medical errors and adverse patient events, analyze their causes, and implement preventive actions.”<sup>8</sup> Federal regulations do not require specific program characteristics. The term “adverse event” describes harm to a patient as a result of medical care. An adverse event can either be preventable or nonpreventable and includes never events (an event that should never occur in a health care setting); hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death.

Many adverse events that were identified through OIG work were preventable. This finding confirms the need and opportunity for hospitals to significantly reduce the incidence of events, and AHRQ and CMS share the responsibility for addressing this issue. Using a random sample of Medicare beneficiaries discharged from hospitals during a 1-month period, we found that 13.5 percent experienced adverse events and that, for 1.5 percent of beneficiaries, these adverse events contributed to their deaths. An additional 13.5 percent of beneficiaries in the sample experienced temporary harm as a result of their medical care, bringing the total percentage of beneficiaries experiencing instances of care-related harm to 27 percent. Physician reviewers determined that 44 percent of adverse and temporary harm events were preventable.

**Expected Impact:**   ▪ **Improved quality and safety**

### Implementation Status

OIG originally directed this recommendation to both CMS and AHRQ. CMS and AHRQ concurred with the recommendation and have collaborated in its implementation. AHRQ and CMS issued guidance to State survey agencies for assessing hospital reporting of a broad range of adverse events using AHRQ’s

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<sup>8</sup> 42 CFR § 482.21(c)(2).

Common Formats and within the CMS Conditions of Participation (CoP) for QAPI. This effort has formalized event definitions and reporting and emphasized identification and reduction of a broader range of adverse events. AHRQ also made numerous modifications to its Common Formats event reporting methodology to accommodate a broader range of events, funded a new methodology to identify events based on harm from all causes, and disseminated toolkits to hospitals focused on certain high-risk adverse events. In February 2015, CMS also reinstated its Partnership for Patients program, a collaboration with hospitals and other stakeholders that provides information-sharing about reducing adverse events and sets national 1-year goals for reduction of certain events.

Regarding the recommendation to broaden patient safety efforts to include all types of adverse events, OIG considers the recommendation to AHRQ fully implemented. OIG considers the recommendation to CMS not fully implemented. CMS has made considerable strides to address the recommendation, and OIG will consider the recommendation to CMS fully implemented following further progress toward use of the QAPI guidance and implementation of the Partnership for Patients initiative. We continue to monitor CMS's progress in implementing our recommendations.

**Key OIG Report**

- *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries.* [OEI-06-09-00090](#).

**See Also:**

Find [additional significant OIG recommendations](#) to improve quality of care and safety in the Appendix.

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## Ensure that Medicaid children receive all required preventive screening services

**Top Recommendation To Be Implemented**

**CMS should:**

- Require States to report to CMS on vision and hearing screening data for eligible children.

**Recommendation Issued: May 2010**

*Companion recommendations:*

- Collaborate with States and providers to develop effective strategies to encourage beneficiary participation in screenings.
- Collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings.
- Identify and disseminate promising State practices for increasing children's participation in screenings and providers' delivery of complete medical screenings.

## Overview

Medicaid provides a comprehensive and preventive child health benefit for children under the age of 21, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. In 2013, 32 million children were eligible for EPSDT. Services are intended to screen, diagnose, and treat children eligible for EPSDT services at early, regular intervals to avoid or minimize childhood illness. Research has confirmed a relationship between low-income and chronic health issues, such as depression and obesity,<sup>9</sup> iron deficiency,<sup>10</sup> and poor cognitive development.<sup>11</sup> Identifying and addressing these issues through preventive screening in childhood may have greater effects on adult health than addressing them later in life.<sup>12</sup>

Our review focused on medical, vision, and hearing screenings. We found that very few children received the correct number of vision, hearing, and/or complete medical screenings. Further, we found that children's participation in EPSDT medical screenings remained lower than established goals. While all States reported strategies to improve both the number of screenings and the completeness of medical screenings, these strategies do not appear to have achieved the desired effect.

**Expected Impact:**    ■ **Improved quality and safety**

## Implementation Status

CMS concurred with the recommendation. In August 2014, CMS indicated that it identified efforts designed to raise awareness about the importance of vision and hearing screenings. In its June 2014 guide, *EPSDT-A Guide for States: Coverage in the Medicaid Program for Children and Adolescents*, CMS reiterated the importance of these screenings. In addition, CMS stated that it is working on a vision screening quality measure. Lastly, CMS also stated that, in 2013, it completed actions related to assessing the feasibility of collecting data for vision and hearing screenings.

OIG recognizes the efforts CMS has made to explore such a requirement and assess its feasibility. Additionally, OIG appreciates CMS's efforts to create a vision screening quality measure. Yet, depending upon how such a measure is implemented, it may not satisfy OIG's recommendation. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

*Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services.* [OEI-05-08-00520](#).<sup>13</sup>

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<sup>9</sup> Elizabeth Goodman, "The Role of Socioeconomic Status Gradients in Explaining Differences in US Adolescents' Health," *American Journal of Public Health*, Vol. 89, No. 10, October 1999. Accessed at <http://www.ajph.org> on September 11, 2009.

<sup>10</sup> Katherine Alaimo, et al., "Food Insufficiency, Family Income, and Health in US Preschool and School-Aged Children," *American Journal of Public Health*, Vol. 91, No. 5, May 2001. Accessed at <http://www.ajph.org> on September 11, 2009.

<sup>11</sup> Sanders Korenman, et al., "Long-Term Poverty and Child Development in the United States: Results from the NLSY," *Children and Youth Services Review*, Vol. 17, No. 1/2, 1995. Accessed at <http://www.sciencedirect.com> on September 11, 2009.

<sup>12</sup> Jack P. Shonkoff, W. Thomas Boyce, and Bruce S. McEwen, "Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities," *JAMA*, 2009, p. 1. Accessed at <http://jama.ama-assn.org> on September 3, 2009.

<sup>13</sup> Earlier report entitled *CMS Needs To Do More To Improve Medicaid Children's Utilization of Preventive Screening Services*. OEI-05-13-00690. 2014 NOV.

**See Also:**

Find [additional significant OIG recommendations](#) to improve quality of care and safety in the Appendix.

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## Strengthen Oversight of State access standards for Medicaid Managed Care

### Top Recommendation To Be Implemented

**CMS should:**

- Strengthen its oversight of State access standards and ensure that States develop standards for key providers.

**Recommendation Issued: September 2014**

*Companion recommendations:*

- Strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards.
- Improve States' efforts to identify and address violations of access standards.
- Provide technical assistance and share effective practices.

### Overview

Most States provide some of their Medicaid services—if not all of them—through managed care. Under the ACA, many States have seen increases in Medicaid enrollment and, thus, in managed care programs. Therefore, ensuring that Medicaid managed care organizations maintain a sufficient network of providers to provide adequate access to care for enrollees takes on heightened importance.

We found that State standards for access to care vary widely and that CMS provides limited oversight of these standards. Additionally, standards are often not specific to certain types of providers or to areas of the State. States have different strategies to assess compliance with access standards, but they do not commonly use what are called “direct tests,” such as making calls to providers. Further, most States did not identify any violations of their access standards over a 5-year period. The States that found the most violations were those that conducted direct tests of compliance.

In a companion report assessing the availability of Medicaid managed care providers, we found that slightly more than half of providers could not offer appointments to enrollees. Notably, 35 percent could not be found at the locations listed by the plans, and another 8 percent were at the locations but were not participating in the plans. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month. Finally, primary care providers were less likely to offer appointments than specialists; however, specialists tended to have longer wait times.

**Expected Impact:**   ▪ **Improved quality and safety**

## Implementation Status

CMS concurred with the recommendation. In its comments on the report, CMS stated that it is considering options to set forth expectations for network access standards through additional guidance to States. CMS did not address whether it intends to issue guidance about requiring States to develop standards for core provider types and to conduct direct tests of their access standards. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *State Standards for Access to Care in Medicaid Managed Care.* [OEI-02-11-00320](#).

### See Also:

Find [additional significant OIG recommendations](#) to strengthen Medicaid managed care access in the Appendix.

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## Expand regulatory authority and oversight of dietary supplements

### Top Recommendation To Be Implemented

#### FDA should:

- Seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading.

**Recommendation Issued: October 2012**

### Companion recommendations:

- Improve the notification system to make it more organized, complete, and accurate.
- Expand market surveillance of dietary supplements to enforce the use of disclaimers for structure/function claims and detect disease claims.

## Overview

Dietary supplements are a \$20 billion-per-year industry and are used by 80 percent of adults for a wide range of purposes. Manufacturers promote the health benefits of their products by making claims about the effect their products have on the structure or function of the human body. The Government Accountability Office and public interest groups have raised concerns, and stakeholders have urged FDA to strengthen oversight of these claims because they are potentially misleading and may lack scientific support. Manufacturers are not required to submit dietary supplements to FDA for safety testing or approval prior to sale, but must have competent and reliable scientific evidence to show that claims are truthful and not misleading. Manufacturers must notify FDA when they use structure/function claims, but they do not have to submit the substantiation to FDA. Finally, a product label must include a disclaimer stating that FDA has not reviewed the claim and that the product is not intended to diagnose, treat, cure, or prevent any disease.

OIG work raises the questions about the extent to which structure/function claims are truthful and not misleading and whether consumers are protected from fraudulent health claims. Overall, substantiation documents for the sampled supplements were inconsistent with FDA guidance on competent and reliable scientific evidence, and FDA could not readily determine whether manufacturers had submitted the required notification for their claims. Seven percent of the supplements lacked the required disclaimer, and 20 percent included prohibited disease claims on their labels.

**Expected Impact:**   ▪ **Improved quality and safety**

## Implementation Status

FDA is considering whether to seek explicit statutory authority to review substantiation for structure/function claims beyond its preexisting authorities. Additionally, FDA can, and does, request that manufacturers voluntarily submit substantiation for structure/function claims, but these requests are not always granted. We continue to monitor FDA's progress in implementing our recommendations.

### Key OIG Report

- *Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements.* [OEI-01-11-00210](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve quality of care and safety in the Appendix.

# Emergency Preparedness and Response

## Establish effective emergency preparedness and response policies in hospital settings

### Top Recommendation To Be Implemented

CMS should:

- Examine existing policies and provide guidance regarding flexibility for reimbursement under disaster conditions.

**Recommendation Issued: September 2014**

### Companion recommendation:

- The Assistant Secretary for Preparedness and Response (ASPR) should continue to promote Federal, State, and community collaboration in major disasters.

## Overview

Federal regulations require that hospitals meet a set of minimum quality and safety standards, including requirements such as developing and implementing a comprehensive emergency plan and maintaining a physical environment that ensures the safety and well-being of patients during emergencies.<sup>14</sup> Prior studies by OIG found substantial challenges in health care facility emergency preparedness and response. Hospital and national preparedness and response protocols and experiences during Superstorm Sandy (hereinafter referred to as Sandy) were evaluated.

The challenges created by Sandy revealed gaps in planning and execution that might be applicable to hospitals nationwide. Improvements are needed in hospital planning and infrastructure, community-wide collaboration, and access to resources. CMS should examine existing policies for Medicare and Medicaid reimbursement regarding allowing hospitals greater flexibility to provide medical care to individuals who under normal circumstances do not meet the criteria for hospital admission and provide guidance to hospitals when receiving patients from other States. These improvements will require targeted adjustments in Federal coordination and oversight.

Most hospitals in declared disaster areas sheltered in place during Sandy, and 7 percent evacuated. Eighty-nine percent of hospitals in these areas reported experiencing substantial challenges in responding to the storm. These challenges represented a range of interrelated problems from infrastructure breakdowns, such as electrical and communication failures, to community collaboration issues over resources, such as fuel, transportation, hospital beds, and public shelters. Hospitals reported that prior emergency planning was valuable during the storm and that they subsequently revised their plans as a result of lessons learned.

<sup>14</sup> 42 CFR § 482.41; CMS *State Operations Manual*, Appendix A – “Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.”

**Expected Impact:**    ■ **Improved quality and safety**

## Implementation Status

CMS concurred with the recommendation. CMS noted that with regard to payment for services provided to Medicare beneficiaries, Medicare has no statutory authority to make the requested policy exceptions at this time, since very few program rules can be waived or modified under current law, even in a disaster or emergency. CMS stated that it issued an update in February 2014 regarding information that CMS believes will be helpful to all types of health care facilities in preparing for emergencies. The measures suggested in the guidance are largely optional. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Hospital Emergency Preparedness and Response During Superstorm Sandy.* [OEI-06-13-00260](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve emergency preparedness and response in the Appendix.

# Health Information Technology

## Improve the Transformed Medicaid Statistical Information System

### Top Recommendation To Be Implemented

#### CMS should:

- Ensure that the national Transformed Medicaid Statistical Information System (T-MSIS) is complete, accurate, and timely.

**Recommendation Issued: September 2013**

#### Companion recommendations:

- Ensure that States submit required T-MSIS data.
- Establish a deadline for when national T-MSIS data will be available.

## Overview

T-MSIS is designed to be a detailed national database of Medicaid and CHIP information to cover a broad range of user needs, including program integrity. It is an improved version of the Medicaid Statistical Information System (MSIS). CMS requires States to report MSIS data quarterly.<sup>15</sup> CMS may withhold Federal matching payments for the use, maintenance, or modification of automated data systems from States that fail to report required data.<sup>16</sup> T-MSIS is a continuation of CMS's past attempts to improve the current nationally available Medicaid data after OIG and others found that the current data were not complete, accurate, or timely. A fully functioning Medicaid data system is essential to help protect the integrity of Medicaid.

As of January 2013, CMS and the 12 volunteer States piloting the implementation of T-MSIS had made some progress in implementing T-MSIS. However, most other States had not started implementing T-MSIS, and they reported varied timeframes for when they planned to begin. Furthermore, early T-MSIS implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation. None of the 12 volunteer States can make all T-MSIS data elements available. Both CMS and the 12 States expressed concerns about the accuracy of the data they could provide upon implementation.

**Expected Impact:** ■ Improved program management

## Implementation Status

CMS concurred with the recommendation. In March 2014, CMS indicated that it is working to create a set of rules to govern the submission of T-MSIS data. CMS also indicated that it reviewed States' source-to-target mapping documents and distributed State technical requirements. In addition, CMS plans to define State file processing procedures, delineate a data quality oversight strategy, and provide

<sup>15</sup> CMS, *State Medicaid Manual*, Pub. No. 45, § 2700.2.

<sup>16</sup> Social Security Act, § 1903(r)(1)(F).

stakeholders with information on data quality issues. OIG has ongoing work that will assess the completeness of States' submission of T-MSIS data. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System.* [OEI-05-12-00610](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve health information technology systems and practices in the Appendix.

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## Address fraud vulnerabilities in electronic health records

### Top Recommendation to Be Implemented

#### CMS and the Office of the National Coordinator (ONC) should:

- Strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in electronic health records (EHRs).

**Recommendation Issued: December 2013**

### Companion recommendations:

- Audit logs should be operational whenever EHR technology is available for updates or viewing.
- CMS should develop guidance on the use of the copy-paste feature in EHR technology.

## Overview

EHRs replace traditional paper medical records with computerized recordkeeping to document and store patient health information. As of September 2014, 95 percent of eligible hospitals and critical access hospitals (CAHs) had registered to participate in the EHR Incentive Programs, accelerating the adoption and use of EHRs. Experts in health information technology caution that EHR technology can make it easier to commit fraud. ONC, which coordinates the adoption, implementation, and exchange of EHRs, contracted with RTI International (RTI) to develop recommendations to enhance data protection; increase data validity, accuracy, and integrity; and strengthen fraud protection in EHR technology. Fraudulent altering of EHRs not only harms the defrauded programs, it also puts patients at risk.

HHS must do more to ensure that all hospitals' EHRs contain safeguards and that hospitals use them to protect against electronically enabled health care fraud. We found that nearly all hospitals with EHR technology had RTI-recommended audit functions in place, but they may not be using them to their full extent. In addition, all hospitals employed a variety of RTI-recommended user authorization and access controls. Nearly all hospitals were using RTI-recommended data transfer safeguards. Almost half of

hospitals had begun implementing RTI-recommended tools to include patient involvement in anti-fraud efforts. Finally, only about one quarter of hospitals had policies regarding the use of the copy-paste feature in EHR technology, which, if used improperly, could pose a fraud vulnerability.

**Expected Impact:**   ▪ **Improved program integrity**

## Implementation Status

CMS and ONC concurred with the recommendation. In July 2014, CMS stated that it is planning to work with ONC to develop a comprehensive plan to detect and reduce fraud in EHRs. CMS cited a May 2013 meeting that it and ONC hosted on EHRs, coding, and billing. CMS also described numerous steps it is taking to ensure the integrity of EHR incentive payments. In June 2014, ONC stated that it is committed to providing technical assistance to Federal agencies that have health care fraud enforcement authority. Although CMS's and ONC's May 2013 meeting was an encouraging step toward addressing fraud in EHRs related to payments for health care services, we do not believe it is sufficient to address this recommendation. We would consider this recommendation implemented upon receipt and satisfactory review of a plan from CMS and ONC to detect and reduce fraud in EHRs with respect to payments for health care services. We continue to monitor CMS and ONC's progress in implementing our recommendations.

### Key OIG Report

- *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology.*  
[OEI-01-11-00570](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve program integrity efforts in health information technology in the Appendix.

# Program Integrity

## Increase reviews of clinicians associated with high cumulative payments

### Top Recommendation To Be Implemented

#### CMS should:

- Establish a cumulative payment threshold, taking into consideration costs and potential program integrity benefits above which a clinician's claims would be selected for review.

**Recommendation Issued: December 2013**

#### Companion recommendation:

- Implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

## Overview

Medicare paid more than \$65 billion for Part B services in Cys 2008 through 2011. In each of these 4 years, approximately 2 percent of clinicians were responsible for almost 25 percent of all Part B payments; annual payments totaled more than \$500,000 per clinician. These clinicians were responsible for average annual payments of approximately \$1 million.

The results of these reviews demonstrate that identifying clinicians who are responsible for high cumulative payments could be a useful means of identifying possible improper payments. Of the 303 clinicians who each furnished more than \$3 million of Part B services during 2009, MACs and ZPICs identified 104 (34 percent) for improper payment reviews. As of December 31, 2011, the MACs and ZPICs had completed reviews of 80 of the 104 clinicians and identified \$34 million in overpayments. In addition, three of the clinicians had their medical licenses suspended and two were indicted. Although existing procedures may identify some of these clinicians for review, the procedures were not designed specifically to identify all clinicians whose payments exceed an established threshold. In addition, existing procedures may not always identify clinicians responsible for high cumulative payments in a timely manner.

**Expected Impact:** ■ Improved program integrity

## Implementation Status

In its response to our recommendation that CMS implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold, CMS stated that it partially concurs. CMS stated that to address this recommendation, it will review the results of the contractor's reviews based on the OIG-identified clinicians who each furnished Part B services that were reimbursed more than \$3 million in CY 2009. CMS will take into account the results from its research as well as these

reviews when developing a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.

Regarding our recommendation that CMS establish a cumulative payment threshold, taking into consideration costs and potential program integrity benefits above which a clinician's claims would be selected for review, CMS stated that it partially concurs. Specifically, CMS stated that it will work with its contractors to research and develop an appropriate, cumulative payment threshold that considers costs as well as potential benefits in determining which claims and providers should be selected for review. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Report

- *Reviews of Clinicians Associated With High Cumulative Payments Could Improve Medicare Program Integrity Efforts.* [A-01-11-00511](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve program integrity efforts in the Appendix.

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## Expand oversight and monitoring of Medicare beneficiary drug utilization

### Top Recommendation To Be Implemented

CMS should:

- Restrict certain beneficiaries to a limited number of pharmacies or prescribers.

**Recommendation Issued: August 2014**

### Companion recommendations:

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

## Overview

Medicare Part D prescription drug coverage is vulnerable to fraud, waste, and abuse and limited safeguards exist. OIG work has focused on questionable practices by pharmacies and prescribers and beneficiary utilization patterns. CMS has placed limited restrictions on specific beneficiaries. Most of these restrictions have focused on opioids, but other Part D drugs, such as those that treat human immunodeficiency virus (HIV), are vulnerable because of their expense and psychoactive effects. CMS

contracts with the National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC) to perform program integrity activities and relies on Part D sponsors to monitor drug utilization.

Restricting certain beneficiaries to a limited number of pharmacies or prescribers could reduce inappropriate utilization. This practice, known as “lock-in,” is currently used by some State Medicaid programs. OIG found that almost 1,600 Part D beneficiaries who received HIV drugs had questionable utilization patterns in 2012. While some of this utilization may be legitimate, all of these patterns warrant further scrutiny. These patterns indicate that beneficiaries may be receiving inappropriate or unnecessary drugs. Other possibilities include that the pharmacy submitted claims for drugs never dispensed or that the beneficiary’s identification was stolen. Almost 900 of the 1,600 beneficiaries had no indication of HIV in their Medicare histories. Others received an excessive dose or excessive supply of HIV drugs, obtained HIV drugs from a high number of pharmacies, had a high number of prescribers, or received contraindicated HIV drugs.

**Expected Impact:**   ▪ **Improved program integrity<sup>17</sup>**

## Implementation Status

CMS concurred with this recommendation. In its comments on our draft report, CMS stated that it would need legislative authority for “lock-in” in Part D. CMS also indicated that it would be receptive to such legislative authority. We continue to monitor CMS’s progress in implementing our recommendations.

### Key OIG Report

- *Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs.* [OEI-02-11-00170](#).

### See Also:

Find [additional significant OIG recommendations](#) to improve program integrity efforts in the Appendix.

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<sup>17</sup> We found \$32 million in questionable billing for HIV/AIDS drugs in 2012; however, this recommendation would also combat fraud, waste, and abuse for additional types of drugs.

# Affordable Care Act

## Improve internal controls related to determining applicants' eligibility for enrollment in qualified health plans

### Top Recommendation To Be Implemented

#### CMS should:

- Improve internal controls related to determining applicants' eligibility for enrollment in qualified health plans (QHPs) and eligibility for insurance affordability programs.

**Recommendation Issued: June 2014**

### Companion recommendations:

- Improve internal controls related to verifying identity of applicants and entering applicant information.
- Improve internal controls related to maintaining and updating eligibility and enrollment data.
- Develop and make public a plan on how and by what date the Federal marketplace will resolve inconsistencies.
- Conduct additional oversight of State marketplaces to ensure that they are resolving inconsistencies related to applicant and eligibility information according to Federal requirements.
- Redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

## Overview

The ACA established health insurance marketplaces in all 50 States and the District of Columbia to allow individuals and small businesses to shop for and enroll in health insurance plans, known as QHPs. Congress requested that OIG review the effectiveness of the procedures and safeguards provided under the ACA for preventing submission of inaccurate or fraudulent information by applicants for enrollment in QHPs offered through the individual marketplace. OIG reviewed the internal controls that the Federal, California, and Connecticut marketplaces implemented to comply with the procedures and safeguards required by the ACA for determining the eligibility of applicants for enrollment in QHPs and for insurance affordability programs. We reviewed the first 3 months of the open enrollment period (October through December 2013). A companion study focused on the procedures used by marketplaces nationwide for resolving inconsistencies between self-attested applicant information and data sources used for verification (A-09-14-01000).

We found that not all internal controls implemented by the Federal, California, and Connecticut marketplaces were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. Further, we found that the marketplaces nationwide were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income. Specifically, the Federal marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies.

**Expected Impact:**    ■ **Improved program integrity**

## Implementation Status

CMS concurred with all of our recommendations and stated that it had already begun and will continue working to resolve these issues. Specifically, CMS stated that it had already implemented system functionality to allow enrollees to report life changes. CMS also stated that it is working expeditiously to resolve inconsistencies between eligibility information provided on applications and those obtained through other data sources. This includes the creation of an interim manual process, which should be replaced by an automated system, that CMS indicated allows it to reconcile inconsistencies in eligibility data. Additionally, CMS stated that it will continue to monitor State-based marketplaces through technical assistance and financial assessments to ensure that they are resolving inconsistencies according to Federal requirements. OIG is conducting followup work to assess CMS's progress in resolving inconsistencies since our initial review. We continue to monitor CMS's progress in implementing our recommendations.

### Key OIG Reports

- *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements.* [A-09-14-01000](#).
- *Marketplaces Faced Early Challenges Resolving Inconsistencies with Applicant Data.* [OEI-01-14-00180](#).

### See Also:

Find [additional significant OIG recommendations](#) on ACA implementation oversight in the Appendix.

# Financial Stewardship

## Comply with yearly Improper Payments Information Act of 2002 requirements

### Top Recommendation To Be Implemented

#### HHS should:

- Report an improper payment estimate for Temporary Assistance for Needy Families (TANF) and reduce error rates below 10 percent.

**Recommendation Issued: April 2014**

### Overview

For the third year in a row, OIG determined that the TANF program was in noncompliance with the Improper Payments Information Act of 2002, as amended, for not reporting an error rate in FY 2013. Under the Improper Payments Elimination and Recovery Act of 2010 (IPERA, which amended the Improper Payments Information Act of 2002) and OMB's implementing guidance, after a program has been noncompliant for 3 consecutive years, the agency is responsible for submitting to Congress, within 30 days of OIG's determination of noncompliance, legislative proposals to bring the program into compliance.

**Expected Impact:**   ▪ **Improved financial management**

### Implementation Status

For the TANF program to come into compliance by developing and reporting an improper payment estimate, ACF would need new statutory authority to collect State improper payment reporting data. In compliance with IPERA and OMB's implementing guidance, information on a series of proposals and current actions for the TANF program was provided to Congress as part of HHS's *Improper Payments Information Act Compliance Report*, dated May 15, 2014. One of the proposed actions, HHS revisions to the TANF financial reporting form, has been completed and is in effect for FY 2015. These revisions will increase understanding and analysis of how States utilize their TANF block grant and State Maintenance-of-Effort funds. HHS is currently providing technical assistance to States in order to facilitate the transition to this new TANF financial reporting form. In addition, HHS continues to work with States on reducing improper payments in the TANF program.

In FY 2014, HHS reported improper payment estimates for seven high-risk programs, each of which reported improper payment rates below 10 percent, with the exception of the Medicare Fee-for-Service (FFS) program. HHS has taken, and continues to take, a number of actions outlined in the FY 2014 [Agency Financial Report](#) to reduce error rates in all of its programs, including Medicare FFS. HHS believes that these actions will enable HHS to reduce error rates in the future. We continue to monitor HHS's progress in implementing our recommendation.

**Key OIG Report**

- *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2013. [A-17-14-52000](#).*

**See Also:**

Find [additional significant OIG recommendations](#) to improve financial stewardship in the Appendix.

## APPENDIX

# List of Significant Unimplemented Recommendations

## Payment Policies and Practices

Hospitals		CMS	Expected Impact:	
<ul style="list-style-type: none"> <li>Seek legislative authority to remove Necessary Provider CAHs' permanent exemption from the distance requirement, thus allowing CMS to reassess these CAHs.</li> <li>Seek legislative authority to review the CAH COPs to include alternative location-related requirements.</li> <li>Periodically reassess CAHs' compliance with all location-related COPs.</li> <li>Apply the uniform definition of "mountainous terrain" to all CAHs.</li> </ul>			<p>Estimated savings: \$449 million<sup>18</sup></p>	<p><i>Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-Enroll in Medicare. <a href="#">OEI-05-12-00080</a>. 2013 AUG.</i></p>
<ul style="list-style-type: none"> <li>Seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission.</li> <li>Seek legislative authority to expand the DRG window to include other hospital ownership arrangements, such as affiliated hospital groups.</li> </ul>			<p>Estimated savings: \$308 million<sup>19</sup></p>	<p><i>Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded. <a href="#">OEI-05-12-00480</a>. 2014 FEB.</i></p>
<ul style="list-style-type: none"> <li>Change regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.</li> </ul>			<p>Estimated savings: \$602.5 million</p>	<p><i>Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care. <a href="#">A-01-12-00507</a>. 2013 MAY.</i></p>

<sup>18</sup> Medicare and beneficiaries would have saved \$449 million if CMS had decertified CAHs that were 15 or fewer miles from their nearest hospitals in 2011.

<sup>19</sup> The estimated \$308 million in savings is based on OIG's analysis of claims for services provided just prior to the window or provided at affiliated hospitals during the window in 2011.

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| <ul style="list-style-type: none"><li>■ Seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.</li><li>■ Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.</li><li>■ Develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.</li></ul>  | CMS | <b>Expected Impact:</b><br>Estimated savings:<br>\$15 billion | <i>Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates.</i><br><b>A-05-12-00020. 2014 APR.</b> |
| <ul style="list-style-type: none"><li>■ Review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays.</li><li>■ Conduct additional analysis to determine the extent to which financial incentives influence long-term care hospital (LTCH) readmission decisions.</li><li>■ Take appropriate action regarding LTCHs with a high number of readmissions immediately after the fixed-day period and LTCHs with a high number of readmissions following multiple short stays at intervening facilities.</li><li>■ Take appropriate action on inappropriate payments for interruptions and overpayments to co-located LTCHs that exceeded the 5-percent readmission threshold.</li></ul> | CMS | <b>Expected Impact:</b><br>Improved payment efficiency        | <i>Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals.</i><br><b>OEI-04-12-00490. 2014 JUN.</b>  |

**Physician Services**

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| <ul style="list-style-type: none"> <li>■ Adjust the estimated number of evaluation and management (E&amp;M) services within global surgery fees to reflect the number of E&amp;M services actually being provided to beneficiaries, or use the financial results of the audit, in conjunction with other information, during the annual updates of the physician fee schedule.</li> </ul> | CMS | <p><b>Expected Impact:</b><br/>           Estimated savings: \$97.6 million per year.<sup>20</sup></p> | <p><i>Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005. <b>A-05-07-00077. 2009 APR.</b></i></p> |
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| <ul style="list-style-type: none"> <li>■ Adjust the estimated number of E&amp;M services within musculoskeletal global surgery fees to reflect the actual number of E&amp;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.</li> </ul> | CMS | <p><b>Expected Impact:</b><br/>           Estimated savings: \$49 million</p> | <p><i>Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. <b>A-05-09-00053. 2012 MAY.</b></i></p> |
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| <ul style="list-style-type: none"> <li>■ Adjust the estimated number of E&amp;M services within cardiovascular global surgery fees to reflect the actual number of E&amp;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.</li> </ul> | CMS | <p><b>Expected Impact:</b><br/>           Estimated savings: \$14.6 million</p> | <p><i>Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. <b>A-05-09-00054. 2012 MAY.</b></i></p> |
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| <ul style="list-style-type: none"> <li>■ Consider the results of our reviews when developing and evaluating coverage and reimbursement policies related to test strips and lancets.</li> </ul> | CMS | <p><b>Expected Impact:</b><br/>           Estimated savings: \$209 million</p> | <p><i>Medicare Contractors Lacked Controls To Prevent Millions in Improper Payments for High Utilization Claims for Home Blood-Glucose Test Strips and Lancets. <b>A-09-11-02027. 2012 JUN.</b></i></p> |
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<sup>20</sup> Estimate based on CY 2005 data.

<b>Clinical Laboratories</b>	<ul style="list-style-type: none"> <li>Reinstate beneficiary deductibles and coinsurance (and notifications of amounts paid on their behalf) as a means of controlling utilization.</li> <li>Periodically evaluate the national fee schedule to ensure that reimbursement is aligned with the prices that physicians pay for clinical laboratory tests.</li> </ul>	CMS	<b>Expected Impact:</b> Estimated savings: \$23.8 billion <sup>21</sup>	<i>Followup Report to “Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.”</i> <a href="#">A-09-93-00056</a> . <b>1996 JAN.</b> <i>Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests.</i> <a href="#">A-09-89-00031</a> . <b>1990 JAN.</b>
<b>Hospice</b>	<ul style="list-style-type: none"> <li>Monitor hospices that depend heavily on nursing facility residents.</li> <li>Modify the payment system for hospice care in nursing facilities, seeking statutory authority, if necessary.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Hospices That Focus on Nursing Facility Residents.</i> <a href="#">OEI-02-10-00070</a> . <b>2011 JUL.</b>
<b>Surety Bonds</b>	<ul style="list-style-type: none"> <li>Implement the HHA surety bond requirement.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Surety Bonds Remain an Unused Tool To Protect Medicare From Home Health Overpayments.</i> <a href="#">OEI-03-12-00070</a> . <b>2012 SEP.</b>
<b>Medicare Coverage</b>	<ul style="list-style-type: none"> <li>Establish a plan to evaluate new Local coverage determinations (LCDs) for national coverage consistent with requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.</li> <li>Continue efforts to increase consistency among existing LCDs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Local Coverage Determinations Create Inconsistency in Medicare Coverage.</i> <a href="#">OEI-01-11-00500</a> . <b>2014 JAN.</b>

<sup>21</sup> 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.

<b>Part B Drugs</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs.</i> <a href="#">A-06-12-00038</a> . 2014 SEP.
	<ul style="list-style-type: none"> <li>Expand the price substitution policy to include Health Care Common Procedure Coding System (HCPCS) codes with complete average manufacturer price (AMP) data that exceed the threshold in a single quarter.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Comparing Average Sales Prices and Average Manufacturer Prices For Medicare Part B Drugs: An Overview of 2012.</i> <a href="#">OEI-03-13-00570</a> . 2014 MAR.
	<ul style="list-style-type: none"> <li>Expand the price substitution policy to include HCPCS codes with partial AMP data.</li> </ul>			
	<ul style="list-style-type: none"> <li>Rebase the end stage renal disease (ESRD) base rate to reflect current trends in drug acquisition costs, as required by law.</li> <li>Distinguish payments in the ESRD base rate between independent and hospital-based dialysis facilities.</li> <li>Consider updating the ESRD payment bundle using a factor that takes into account drug acquisition costs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Update: Medicare Payments for End Stage Renal Disease Drugs.</i> <a href="#">OEI-03-12-00550</a> . 2014 MAR.
<b>Part D</b>	<ul style="list-style-type: none"> <li>Change its practice of paying for drugs that have a date of service within 32 days after the beneficiary's date of death.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Paid for HIV Drugs for Deceased Beneficiaries.</i> <a href="#">OEI-02-11-00172</a> . 2014 OCT.
<b>Medicaid Drugs</b>	<ul style="list-style-type: none"> <li>Seek legislative authority to extend the additional rebate provisions for brand-name drugs to generic drugs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency <sup>22</sup>	<i>Review of Generic Drug Price Increases.</i> <a href="#">A-06-07-00042</a> . 2007 OCT

<sup>22</sup> Savings probable but not estimated. An August 2011 OIG report estimated that rebates reduced Medicaid's expenditures for selected generic drugs by only 3 percent in 2009 compared to 45 percent for selected brand-name drugs.

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| <ul style="list-style-type: none"> <li>■ Provide the results of this review to States for their use when they consider changes to their pharmacy reimbursement methodologies, including those for single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs.</li> </ul> | CMS | <b>Expected Impact:</b><br>Improved payment efficiency | <i>Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices. <a href="#">A-06-11-00002</a>. 2011 OCT.</i>                   |
| <ul style="list-style-type: none"> <li>■ Encourage States to adopt a multitiered payment system to bring pharmacy reimbursement more in line with the actual acquisition cost of drug products.</li> </ul>   | CMS | <b>Expected Impact:</b><br>Improved payment efficiency | <i>Medicaid Pharmacy - Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products. <a href="#">A-06-02-00041</a>. 2002 SEP.</i> |

## Billing and Payment

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| <p><b>Medicare Home Health</b></p> <ul style="list-style-type: none"> <li>■ Implement claims processing edits or improve existing edits to prevent inappropriate payments.</li> <li>■ Increase monitoring of billing for home health services.</li> </ul>   | CMS | <b>Expected Impact:</b><br>Improved payment efficiency       | <i>Inappropriate and Questionable Billing by Medicare Home Health Agencies. <a href="#">OEI-04-11-00240</a>. 2012 AUG.</i>   |
| <ul style="list-style-type: none"> <li>■ Complete a process that would allow the claims processing system to interface with State survey agency systems to identify, on a prepayment basis, HHA claims without accepted Outcome and Assessment Information Set (OASIS) data submissions.</li> <li>■ Encourage its contractors to conduct periodic postpayment reviews of HHA claims, to include ensuring that OASIS data support claims, until sufficient prepayment controls are established.</li> <li>■ Adjust the overpayments identified, reopen nonsampled claims, and recover any additional overpayments found.</li> </ul> | CMS | <b>Expected Impact:</b><br>Estimated savings: \$25.1 million | <i>Medicare Often Made Overpayments to New England Home Health Agencies for Claims Without Required Outcome and Assessment Information Set Data for Calendar Year 2010. <a href="#">A-01-12-00508</a>. 2014 MAR.</i> |

<p><b>Inpatient Rehabilitation Facilities</b></p>	<ul style="list-style-type: none"> <li>Develop a specific strategy to communicate directly with physicians about the face-to-face requirement.</li> <li>Develop other oversight mechanisms for the face-to-face requirement.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>        Estimated savings: \$2 billion</p>	<p><i>Limited Compliance With Medicare's Home Health Face-to-Face Documentation Requirements.</i> <b>OEI-01-12-00390. 2014 APR.</b></p>
<p><b>Nursing Homes</b></p>	<ul style="list-style-type: none"> <li>Continue to provide specific education to inpatient rehabilitation facilities (IRFs) on the importance of reporting the correct patient assessment instruments (PAIs) transmission dates on their claims.</li> <li>Complete the process that would allow FISS to interface with the National Assessment Collection Database to identify, on a prepayment basis, IRF claims with incorrect PAI transmission dates.</li> <li>Support the MACs' and RACs' (recovery audit contractors') efforts to conduct periodic postpayment reviews of IRF claims.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>        Improved payment efficiency</p>	<p><i>Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims With Late Patient Assessment Instruments for Calendar Years 2009 and 2010.</i> <b>A-01-11-00534. 2012 SEP.</b></p>
<p><b>Sleep Study Services</b></p>	<ul style="list-style-type: none"> <li>Monitor compliance with the new therapy assessments.</li> <li>Change the current method for determining how much therapy is needed to ensure appropriate payments.</li> <li>Improve the accuracy of data items submitted by SNFs.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>        Improved payment efficiency</p>	<p><i>Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars in 2009.</i> <b>OEI-02-09-00200. 2012 NOV.</b></p>
<p><b>Sleep Study Services</b></p>	<ul style="list-style-type: none"> <li>Implement claims processing edits or improve existing edits to prevent inappropriate payments.</li> <li>Recover payments for claims that did not meet Medicare requirements.</li> <li>Consider using measures of questionable billing from this study to identify providers for further investigation.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>        Improved payment efficiency</p>	<p><i>Questionable Billing for Polysomnography Services.</i> <b>OEI-05-12-00340. 2013 OCT.</b></p>

<b>Sleep Study Services</b>	<ul style="list-style-type: none"> <li>Take appropriate action regarding providers that exhibited patterns of questionable billing.</li> <li>Implement claims processing edits or improve existing edits to prevent inappropriate payments.</li> <li>Recover payments for claims that did not meet Medicare requirements.</li> <li>Consider using measures of questionable billing from this study to identify providers for further investigation.</li> <li>Take appropriate action regarding providers that exhibited patterns of questionable billing.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Questionable Billing for Polysomnography Services.</i> <b>OEI-05-12-00340. 2013 OCT.</b>
<b>Electro-diagnostic Tests</b>	<ul style="list-style-type: none"> <li>Increase monitoring of billing for electrodiagnostic tests.</li> <li>Provide additional guidance and education to physicians regarding electrodiagnostic tests.</li> <li>Take appropriate action regarding physicians whom we identified as having inappropriate or questionable billing.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Questionable Billing for Medicare Electrodiagnostic Tests.</i> <b>OEI-04-12-00420. 2014 APR.</b>
<b>Physician Services</b>	<ul style="list-style-type: none"> <li>Educate physicians on coding and documentation requirements for E&amp;M services.</li> <li>Follow up on claims for E&amp;M services that were paid for in error.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010.</i> <b>OEI-04-10-00181. 2014 MAY.</b>
<b>Durable Medical Equipment</b>	<ul style="list-style-type: none"> <li>Develop an alternative mechanism, such as having contractors perform additional prepay and postpay reviews, to ensure that suppliers maintain the required documentation for the specific medical equipment and supply items that currently use the KX modifier.</li> </ul>	CMS	<b>Expected Impact:</b> Estimated savings: \$316.4 million	<i>Claim Modifier Did Not Prevent Medicare From Paying Millions in Unallowable Claims for Selected Durable Medical Equipment.</i> <b>A-04-10-04004. 2012 APR.</b> <sup>23</sup>

<sup>23</sup> This rollup audit report summarizes the cost savings in four reports issued to durable medical equipment MACs (A-01-09-00528, A-04-09-04039, A-05-09-00094, and A-09-09-00111).

<b>Beneficiary Eligibility</b>	<ul style="list-style-type: none"> <li>Implement policies and procedures to detect and recoup \$33.6 million in improper payments made for Medicare services rendered to incarcerated beneficiaries.</li> <li>Ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements work with other entities, including SSA, to identify ways to improve the timeliness with which CMS receives incarceration information.</li> </ul>	CMS	<b>Expected Impact:</b> Estimated savings: \$33.6 million	<i>Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011. <a href="#">A-07-12-01113</a>. 2013 JAN.</i>
	<ul style="list-style-type: none"> <li>Implement policies and procedures to detect and recoup \$91.6 million in improper payments made for Medicare services rendered to unlawfully present beneficiaries.</li> <li>Ensure that Medicare contractors recoup the improper payments we identified.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Improperly Paid Providers Millions of Dollars for Unlawfully Present Beneficiaries Who Received Services During 2009 Through 2011. <a href="#">A-07-12-01116</a>. 2013 JAN.</i>
	<ul style="list-style-type: none"> <li>Ensure that Medicare contractors recoup the almost \$18.4 million in improper payments.</li> <li>Implement policies and procedures to detect and recoup improper payments when entitlement termination information is received on previously paid Medicare claims.</li> <li>Identify these types of improper payments after our audit period but before implementation of policies and procedures and ensure that Medicare contractors recoup the improper payments.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012. <a href="#">A-07-13-01127</a>. 2014 APR.</i>
	<ul style="list-style-type: none"> <li>Implement policies and procedures to notify Medicare Advantage (MA) organizations of unlawful-presence information and thereby prevent enrollment in MA organizations, disenroll beneficiaries already enrolled, and recoup any improper payments.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012. <a href="#">A-07-13-01125</a>. 2014 APR.</i>

- 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.

- Prevent enrollment of unlawfully present beneficiaries, disenroll any currently enrolled unlawful beneficiaries, and automatically reject prescription drug event (PDE) records submitted by sponsors for prescription drugs provided to this population.
- Resolve \$28.9 million in improper Part D payments made for prescription drugs by reopening and revising final payment determinations for CYs 2009 – 2011 to remove prescription drug costs for unlawfully present beneficiaries.
- Reopen and revise final payment determinations for periods after the period of this review but before implementation of improved policies and procedures.

- Improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths.
- Take appropriate action on improper Medicare payments made on behalf of deceased beneficiaries and correct inaccurate dates of death.
- Monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths.
- Take appropriate action regarding providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

**CMS**    **Expected Impact:**    *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011. [A-07-12-06038](#). 2013 OCT.*

**CMS**    **Expected Impact:**    *Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011. [OEI-04-12-00130](#). 2013 OCT.*

	<ul style="list-style-type: none"> <li>■ Improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths.</li> <li>■ Take appropriate action on improper Medicare payments made on behalf of deceased beneficiaries and correct inaccurate dates of death.</li> <li>■ Monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths.</li> <li>■ Take appropriate action regarding providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.</li> </ul>	<p>CMS <b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011. <b>OEI-04-12-00130. 2013 OCT.</b></i></p>
<p><b>Outlier Payments</b></p>	<ul style="list-style-type: none"> <li>■ Implement an automated system that will recalculate outlier claims to facilitate reconciliations.</li> <li>■ Work with the Medicare contractors to develop and maintain a complete and accurate list of the cost reports with outlier payments requiring reconciliation.</li> <li>■ Ensure that Medicare contractors reconcile outlier payments and perform final settlement on the cost reports we reviewed in accordance with Federal regulations and guidance.</li> <li>■ Ensure that Medicare contractors reconcile outlier payments and perform final settlement on all cost reports submitted after our audit period in accordance with Federal regulations and guidance.</li> </ul>	<p>CMS <b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>The Centers for Medicare &amp; Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance. <b>A-07-10-02764. 2012 JUN.</b></i></p>
	<ul style="list-style-type: none"> <li>■ Instruct Medicare contractors to increase monitoring of outlier payments.</li> <li>■ Include information about the distribution of outlier payments with other publicly reported hospital data.</li> </ul>	<p>CMS <b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>Medicare Hospital Outlier Payments Warrant Increased Scrutiny. <b>OEI-06-10-00520. 2013 NOV.</b></i></p>

<b>Part D</b>	<ul style="list-style-type: none"> <li>Examine whether diagnosis codes associated with high rates of outlier payments warrant coding changes or other adjustments.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority.</i> <b>OEI-02-09-00608. 2013 JUN.</b>
	<ul style="list-style-type: none"> <li>Exclude Schedule II refills when calculating payments to sponsors.</li> <li>Monitor sponsors to ensure that they validate prescriber numbers for Schedule II drugs.</li> <li>Follow up on sponsors and pharmacies with high numbers of refills.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills.</i> <b>OEI-02-09-00605. 2012 SEP.</b>
<b>Medicaid</b>	<ul style="list-style-type: none"> <li>Provide States with definitive guidance for calculating the Federal UPL, which should include using facility-specific UPLs that are based on actual cost report data.</li> <li>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.</li> </ul>	CMS	<b>Expected Impact:</b> Estimated savings: \$3.87 billion over 5 years.	<i>Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers.</i> <b>A-03-00-00216. 2001 SEP.</b>
	<ul style="list-style-type: none"> <li>Work with States to address longstanding challenges working with third parties to identify insurance coverage and recover payments.</li> <li>Address States' challenges with 1-year timely filing limits for Medicare and TRICARE.</li> </ul>	CMS	<b>Expected Impact:</b> Improved payment efficiency	<i>Medicaid Third-Party Liability Savings Increased, But Challenges Remain.</i> <b>OEI-05-11-00130. 2013 JAN.</b>

<p><b>Medicaid HCBS</b></p>	<ul style="list-style-type: none"> <li>■ Review and address delays in resolving OIG audit recommendations and promptly pursue corrective actions.</li> <li>■ Maintain adequate documentation to support the collection of overpayments in accordance with OMB Circular A-50 and CMS Standard Operating Procedures.</li> <li>■ Educate the States about their responsibility to report overpayments on the correct line of the CMS-64 to improve oversight of the reporting process.</li> <li>■ Collect the remaining \$225.6 million we identified as due the Federal Government.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>The Centers for Medicare &amp; Medicaid Services Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected, <a href="#">A-05-11-00071</a>. 2013 FEB.</i></p>
	<ul style="list-style-type: none"> <li>■ Work with State Medicaid agencies to determine whether the use of manufacturer rebates and lower provider reimbursement rates could achieve net savings for the purchase of test strips.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>State Medicaid Agencies Can Significantly Reduce Medicaid Costs for Diabetic Test Strips. <a href="#">A-05-13-00033</a>. 2014 MAR.</i></p>
	<ul style="list-style-type: none"> <li>■ Issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under section 1915(c) waivers.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved payment efficiency</p>	<p><i>Home and Community-Based Services in Assisted Living Facilities. <a href="#">OEI-09-08-00360</a>. 2012 DEC.</i></p>

**Contractor Oversight**

<p><b>ZPICs</b></p>	<ul style="list-style-type: none"> <li>■ Clarify the workload definitions in the CMS ARTS to ensure that ZPICs' workload statistics are accurate and that ZPICs report their data uniformly.</li> <li>■ Utilize and report ZPICs' workload statistics in ZPIC evaluations.</li> <li>■ Ensure that ZPICs have access to all data necessary to effectively carry out their program integrity activities.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved contractor management</p>	<p><i>Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight. <a href="#">OEI-03-09-00520</a>. 2011 NOV.</i></p>
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<ul style="list-style-type: none"> <li>■ Provide clearer guidance in the requests for proposal to offerors and subcontractors regarding which business and contractual relationships should be identified as actual conflicts and which should be identified as possible conflicts.</li> <li>■ Require offerors and subcontractors to distinguish those business and contractual relationships that they deem to be actual conflicts from those that are possible conflicts (i.e., apparent or potential conflicts) in their organizational conflict of interest certificates.</li> <li>■ State whether offerors and subcontractors need to report income amounts, periods of performance, and types of work performed for their contracts with CMS and income amounts generated from key personnel’s other employment.</li> <li>■ Create a standardized format for reporting information in the organizational conflict-of-interest certificate and require its use by offerors and subcontractors.</li> <li>■ Develop a formal, written policy outlining how organization conflict of interest certificates are to be reviewed by CMS.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Improved contractor management</p>	<p><i>Conflicts and Financial Relationships Among Potential Zone Program Integrity Contractors.</i>  <b>OEI-03-10-00300. 2012 JUL.</b></p>
<p><b>MACs</b></p> <ul style="list-style-type: none"> <li>■ Review the process for overseeing contractors’ error rate reduction.</li> <li>■ Ensure that contractors submit clear plans for reducing their error rates.</li> <li>■ Provide additional guidance for contractors and CMS staff who review plans.</li> <li>■ Provide error rate reduction incentives that are aligned with the contracts’ error rates and performance periods.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Improved contractor management</p>	<p><i>Medicare Claims Administrative Contractors’ Error Rate Reduction Plans.</i> <b>OEI-09-12-00090. 2014 JAN.</b></p>

	<ul style="list-style-type: none"> <li>■ Require action plans for all unmet quality assurance standards.</li> <li>■ Use quality assurance review results to help select award fee metrics for review and to establish award fee metrics for the “Medicare secondary payer” area.</li> <li>■ Meet timeframes for completing draft and final quality assurance summary reports.</li> <li>■ Meet timeframes for completing award fee determinations.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Improved contractor management</p>	<p><i>Medicare Administrative Contractors’ Performance.</i> <b>OEI-03-11-00740. 2014 JAN.</b></p>
	<ul style="list-style-type: none"> <li>■ Require controls in the tracking systems to ensure that all overpayment referrals and data related to collection status can be found.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Improved contractor management</p>	<p><i>Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors.</i> <b>OEI-03-08-00030. 2010 MAY.</b></p>
<p><b>RACs</b></p>	<ul style="list-style-type: none"> <li>■ Take action, as appropriate, on vulnerabilities that are pending corrective action and evaluate the effectiveness of implemented corrective actions.</li> <li>■ Ensure that RACs refer all appropriate cases of potential fraud.</li> <li>■ Review and take appropriate, timely action on RAC referrals of potential fraud.</li> <li>■ Develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on contract requirements.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Estimated savings: \$1.3 billion</p>	<p><i>Medicare Recovery Audit Contractors and CMS’s Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance.</i> <b>OEI-04-11-00680. 2013 AUG.</b></p>
<p><b>MEDICs</b></p>	<ul style="list-style-type: none"> <li>■ Provide the MEDIC with centralized Part C data to enable it to more comprehensively and proactively identify and investigate Part C fraud and abuse.</li> <li>■ Clarify its policy and instruct the MEDIC under what circumstances it may share specific information with other entities, including ZPICs and State agencies.</li> </ul>	<p>CMS</p> <p><b>Expected Impact:</b> Improved program integrity</p>	<p><i>MEDIC Benefit Integrity Activities in Medicare Parts C and D.</i> <b>OEI-03-11-00310. 2013 JAN.</b></p>

- Explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action.
- Amend regulations to require Part C and Part D sponsors to refer potential fraud and abuse incidents to the MEDIC.
- Enhance monthly workload reporting requirements to improve CMS oversight of the MEDIC's benefit integrity activities.

## Grants and Contract Management

### Conflicts of Interests

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| <ul style="list-style-type: none"> <li>■ Promulgate regulations that address institutional financial conflicts of interest.</li> </ul>   | NIH | <p><b>Expected Impact:</b><br/>Improved grant management</p> | <p><i>Institutional Conflicts of Interest at NIH Grantees.</i><br/><b>OEI-03-09-00480. 2011 JAN.</b></p>   |
| <ul style="list-style-type: none"> <li>■ Develop and disseminate guidance on methods to verify researchers' financial interests.</li> <li>■ Ensure that grantee institutions are providing adequate oversight of subgrantee compliance with Federal financial conflict of interest regulations.</li> <li>■ Ensure that grantee institutions are maintaining proper documentation as outlined in the Federal financial conflict of interest regulations.</li> <li>■ Ensure that grantee institutions take appropriate actions against researchers who do not follow grantee institutions' financial conflict of interest policies and procedures.</li> <li>■ Develop regulations that address institutional financial conflicts of interest.</li> </ul> | NIH | <p><b>Expected Impact:</b><br/>Improved grant management</p> | <p><i>How Grantees Manage Financial Conflicts of Interest in Research Funded by the National Institutes of Health.</i><br/><b>OEI-03-07-00700. 2009 NOV.</b></p> |

<p><b>Small Business Innovation Research Program</b></p>	<ul style="list-style-type: none"> <li>■ Collect information to track and assess Small Business Innovation Research (SBIR)-funded projects' commercialization.</li> <li>■ Improve procedures to check for duplicative awards.</li> <li>■ Create a central office to oversee the SBIR program.</li> <li>■ Ensure compliance with SBIR eligibility requirements.</li> </ul>	<p>ASFR</p>	<p><b>Expected Impact:</b> Improved grant management</p>	<p><i>Vulnerabilities in the HHS Small Business Innovation Research Program.</i> <b>OEI-04-11-00530. 2014 APR.</b></p>
<p><b>Head Start</b></p>	<ul style="list-style-type: none"> <li>■ Amend current policy and regulations to require that any prospective or current employee be disqualified for or terminated from employment with a Head Start grantee if the individual has been convicted of sexual abuse of a child, other forms of child abuse and neglect, or a violent felony.</li> </ul>	<p>ACF</p>	<p><b>Expected Impact:</b> Improved grant management</p>	<p><i>Review of 24 Head Start Grantees' Compliance With Health and Safety Requirements.</i> <b>A-01-11-02503. 2011 DEC.</b></p>
<p><b>Child Care and Development Fund</b></p>	<ul style="list-style-type: none"> <li>■ Conduct periodic reviews of States' compliance with their own requirements related to minimum health and safety standards [applicable to licensed child care providers].</li> <li>■ Ensure that State plans comply with health and safety requirements and take action when States do not comply.</li> </ul>	<p>ACF</p>	<p><b>Expected Impact:</b> Improved grant management</p>	<p><i>Child Care and Development Fund: Monitoring of Licensed Child Care Providers.</i> <b>OEI-07-10-00230. 2013 NOV.</b></p>
<p><b>Lobbying</b></p>	<ul style="list-style-type: none"> <li>■ Facilitate Departmentwide information sharing about methods to identify uses of grant funds for prohibited lobbying activities.</li> <li>■ Centralize on its Web site the guidance pertaining to the prohibitions on the use of grant funds for lobbying.</li> </ul>	<p>ASFR</p>	<p><b>Expected Impact:</b> Improved grant management</p>	<p><i>Laws Prohibit the Use of HHS Grant Funds for Lobbying, but Limited Methods Exist To Identify Noncompliance.</i> <b>OEI-07-12-00620. 2014 JULY.</b></p>

## Program and Financial Management

<b>Overpayments Collection</b>	<ul style="list-style-type: none"> <li>Ensure that ATARS is updated to accurately reflect the status of audit report recommendations.</li> <li>Ensure that collections information is consistently recorded in ATARS.</li> <li>Collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law.</li> </ul>	CMS	<b>Expected Impact:</b> Improved financial management	<i>Obstacles to Collection of Millions in Medicare Overpayments. <a href="#">A-04-10-03059</a>. 2012 MAY</i>
<b>Medicare Summary Notices</b>	<ul style="list-style-type: none"> <li>Provide guidance to claims processors about handling [for program integrity purposes] Medicare Summary Notices (MSNs) that are returned as undeliverable.</li> <li>Ensure that the address information used by claims processors to print addresses on MSNs is complete and properly formatted.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Over Four Million Medicare Summary Notices Mailed to Beneficiaries Were Not Delivered in 2012. <a href="#">OEI-03-12-00600</a>. 2014 JAN.</i>
<b>Part B Drugs</b>	<ul style="list-style-type: none"> <li>Establish a method to identify Part B claims for compounded drugs.</li> <li>Explore the possibility of requiring providers to identify on the Part B claims the pharmacies that produced the compounded drugs.</li> <li>Explore the possibility of conducting descriptive analyses of Part B claims for compounded drugs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Compounded Drugs Under Medicare Part B: Payment and Oversight. <a href="#">OEI-03-13-00270</a>. 2014 APR.</i>
<b>Part D</b>	<ul style="list-style-type: none"> <li>Cooperate with industry stakeholder efforts to identify a solution to prevent coupons from being used to purchase drugs paid for by Part D.</li> <li>Define Pharmacy Benefit Managers as entities that could benefit from formulary decisions.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs. <a href="#">OEI-05-12-00540</a>. 2014 SEPT.</i>
		CMS	<b>Expected Impact:</b> Improved program management	<i>Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions. <a href="#">OEI-05-10-00450</a>. 2013 MAR.</i>

- Establish minimum standards requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the Pharmacy and Therapeutics (P&T) committee.
  - Establish minimum standards requiring sponsors to ensure that an objective process is used to determine whether disclosed financial interests are conflicts.
  - Establish minimum standards requiring sponsors to ensure that an objective process is used to manage recusals due to conflicts of interest.
  - Oversee compliance with P&T committee conflict-of-interest requirements and guidance.
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| <ul style="list-style-type: none"><li>■ Define Pharmacy Benefit Managers as entities that could benefit from formulary decisions.</li><li>■ Establish minimum standards requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the Pharmacy and Therapeutics (P&amp;T) committee.</li><li>■ Establish minimum standards requiring sponsors to ensure that an objective process is used to determine whether disclosed financial interests are conflicts.</li><li>■ Establish minimum standards requiring sponsors to ensure that an objective process is used to manage recusals due to conflicts of interest.</li><li>■ Oversee compliance with P&amp;T committee conflict-of-interest requirements and guidance.</li></ul> | CMS | <b>Expected Impact:</b><br>Improved program management | <i>Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions.</i> <b>OEI-05-10-00450. 2013 MAR.</b> |
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<p><b>Medicare Appeals</b></p>	<ul style="list-style-type: none"> <li>■ OMHA and CMS should identify and clarify Medicare policies that are unclear and are interpreted differently.</li> <li>■ OMHA and CMS should standardize case files and make them electronic.</li> <li>■ OMHA should revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence.</li> <li>■ OMHA and CMS should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.</li> <li>■ OMHA should implement a quality assurance process to review ALJ decisions.</li> <li>■ OMHA should develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly.</li> </ul>	<p>CMS, OMHA</p>	<p><b>Expected Impact:</b>                  Improved program management</p>	<p><i>Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals.</i> <b>OEI-02-10-00340. 2012 NOV.</b></p>
	<ul style="list-style-type: none"> <li>■ Monitor the quality of redeterminations data in Medicare Appeals System (MAS).</li> <li>■ Use MAS to monitor contractor performance.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>                  Improved program management</p>	<p><i>The First Level of the Medicare Appeals Process, 2008–2012: Volume, Outcomes, and Timeliness.</i> <b>OEI-01-12-00150. 2013 OCT.</b></p>
<p><b>Beneficiary Grievance Process</b></p>	<ul style="list-style-type: none"> <li>■ Define “grievance” for facilities.</li> <li>■ Provide guidance to facilities on what constitutes a robust process for anonymous grievances.</li> <li>■ Work with AHRQ to add a question to the Consumer Assessment of Healthcare Providers and Systems to assess beneficiaries’ fear of reprisal.</li> <li>■ Provide networks with better technical support for the Contact Utility database.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b>                  Improved program management</p>	<p><i>The ESRD Beneficiary Grievance Process.</i> <b>OEI-01-11-00550. 2013 DEC.</b></p>

<b>Beneficiary Eligibility</b>	<ul style="list-style-type: none"> <li>■ Require each State Medicaid agency to report all terminated providers.</li> <li>■ Ensure that the shared information contains only records that meet CMS’s criteria for inclusion.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>CMS’s Process for Sharing Information About Terminated Providers Needs Improvement. <a href="#">OEI-06-12-00031</a>. 2014 MAR.</i>
<b>Medicaid Drugs</b>	<ul style="list-style-type: none"> <li>■ Work with States to improve the quality of claims data submitted by providers and pharmacies.</li> <li>■ Help States obtain better data on ineligible drugs.</li> <li>■ Facilitate States’ submission of standardized claims data.</li> <li>■ Establish a stronger role in dispute resolution.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Medicaid Drug Rebate Dispute Resolution Could Be Improved. <a href="#">OEI-05-11-00580</a>. 2014 AUG.</i>
	<ul style="list-style-type: none"> <li>■ Ensure that all States appropriately report offset rebate amounts.</li> <li>■ Consider further whether to encourage all States to establish supplemental rebate programs.</li> <li>■ Encourage States to explore alternate methods for calculating supplemental rebates.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>States’ Collection of Offset and Supplemental Medicaid Rebates. <a href="#">OEI-03-12-00520</a>. 2014 DEC.</i>
<b>Personal Care Services</b>	<ul style="list-style-type: none"> <li>■ Promulgate regulations to reduce significant variation in States’ PCS laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.</li> <li>■ Promulgate regulations to reduce significant variation in State PCS attendant qualification standards and the potential for beneficiary exposure to unqualified PCS attendants by establishing minimum Federal qualification standards applicable to all PCS reimbursed by Medicaid.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management and integrity	<i>Personal Care Services: Trends, Vulnerabilities and Recommendations for Improvement. <a href="#">OIG-12-12-01</a>. 2012 NOV.</i>

- Promulgate regulations to improve CMS’s and States’ ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with the State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants.
- Issue guidance to States regarding adequate prepayment controls.
- Consider whether additional controls are needed to ensure that PCS are allowed under program rules and are provided.
- Take action to provide States with data suitable for identifying overpayments for PCS claims during periods when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.

**Medicaid  
 Managed Care**

- Issue guidance to States on monitoring Managed Care Entities’ (MCEs’) compliance with the Federal provider nondiscrimination contract provision.

CMS **Expected Impact:** *State and CMS Improved program management*  
*State and CMS Oversight of the Medicaid Managed Care Credentialing Process.*  
**OEI-09-10-00270. 2013 NOV.**

## Quality of Care and Safety

**Hospitals**

- Broaden patient safety efforts to include all types of adverse events.
- Enhance efforts to identify adverse events.

CMS **Expected Impact:** *Improved quality*  
*Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries.*  
**OEI-06-09-00090. 2010 NOV.**

	<ul style="list-style-type: none"> <li>Require that all Immediate Jeopardy complaint surveys evaluate compliance with the COPs on quality assurance and performance improvement.</li> <li>Ensure that State agencies monitor hospitals' corrective actions for sustained improvements.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality	<i>Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events.</i> <b>OEI-01-08-00590. 2011 OCT.</b>
	<ul style="list-style-type: none"> <li>Provide interpretive guidelines for State survey agencies to assess hospital compliance with requirements to track and monitor adverse events.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality	<i>Adverse Events in Hospitals: Methods for Identifying Events.</i> <b>OEI-06-08-00221. 2010 MAR.</b>
<b>Nursing Homes</b>	<ul style="list-style-type: none"> <li>Develop a quality measure that describes nursing home rates of resident hospitalization.</li> <li>Instruct State agency surveyors to review nursing home rates of resident hospitalization as part of the survey and certification process.</li> </ul>	CMS	<b>Expected Impact:</b> Improve quality	<i>Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring.</i> <b>OEI-06-11-00040. 2013 NOV.</b>
	<ul style="list-style-type: none"> <li>Assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes.</li> <li>Explore alternative methods for the survey and certification process to promote compliance with established Federal standards regarding unnecessary drug use in nursing homes.</li> <li>Take appropriate action regarding the claims associated with erroneous payments identified in our sample.</li> <li>Facilitate access to information necessary to ensure accurate coverage and reimbursement determinations.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality	<i>Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents.</i> <b>OEI-07-08-00150. 2011 MAY.</b>

<ul style="list-style-type: none"> <li>■ Include potential events and information about resident harm in quality guidance to nursing homes.</li> <li>■ Instruct nursing home surveyors to review facility practices for identifying and reducing adverse events.</li> <li>■ Collaborate to create and promote a list of potential nursing home events.</li> <li>■ Encourage nursing homes to report adverse events to Patient Safety Organizations.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved quality</p>	<p><i>Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries.</i> <b>OEI-06-11-00370. 2014 FEB.</b></p>
<ul style="list-style-type: none"> <li>■ Strengthen regulations on care planning and discharge planning.</li> <li>■ Provide guidance to SNFs to improve care planning and discharge planning.</li> <li>■ Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable.</li> <li>■ Link payments to meeting quality of care requirements.</li> <li>■ Follow up on the SNFs that failed to meet care planning and discharge planning requirements and that provided poor quality of care.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved quality</p>	<p><i>Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements.</i> <b>OEI-02-09-00201. 2013 FEB.</b></p>
<ul style="list-style-type: none"> <li>■ Ensure that nursing facilities maintain policies related to reporting allegations of abuse or neglect.</li> <li>■ Ensure that nursing facilities comply with their responsibilities under section 1150B of the Social Security Act.</li> <li>■ Ensure that nursing facilities report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals, as required.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved quality</p>	<p><i>Nursing Facilities' Compliance With Federal Requirements for Reporting Allegations of Abuse or Neglect.</i> <b>OEI-07-13-00010. 2014 AUG.</b></p>

<b>Medicaid</b>	<ul style="list-style-type: none"> <li>■ Require States to report vision and hearing screenings.</li> <li>■ Collaborate with States and providers to develop effective strategies to encourage beneficiary participation in screenings.</li> <li>■ Collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings.</li> <li>■ Identify and disseminate promising State practices for increasing children’s participation in screenings and providers’ delivery of complete medical screenings.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality	<i>Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services. <a href="#">OEI-05-08-00520</a>. 2010 MAY.</i>
<b>Medicaid HCBS</b>	<ul style="list-style-type: none"> <li>■ Require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits.</li> <li>■ Make information about State compliance with the assurances available to the public.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality	<i>Oversight of Quality of Care in Medicaid Home- and Community-Based Services Waiver Programs. <a href="#">OEI-02-08-00170</a>. 2012 JUN.</i>
<b>Medicaid Managed Care</b>	<ul style="list-style-type: none"> <li>■ Work with States to assess the number of providers offering appointments and improve the accuracy of plan information.</li> <li>■ Work with States to ensure that plans’ networks are adequate and meet the needs of their Medicaid managed care enrollees.</li> <li>■ Work with States to ensure that plans are complying with existing State standards and assess whether additional standards are needed.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality and access	<i>Access to Care: Provider Availability in Medicaid Managed Care. <a href="#">OEI-02-13-00670</a>. 2014 DEC.</i>
	<ul style="list-style-type: none"> <li>■ Strengthen its oversight of State standards and ensure that States develop standards for key providers.</li> <li>■ Strengthen its oversight of States’ methods to assess plan compliance and ensure that States conduct direct tests of access standards.</li> </ul>	CMS	<b>Expected Impact:</b> Improved quality and access	<i>State Standards for Access to Care in Medicaid Managed Care. <a href="#">OEI-02-11-00320</a>. 2014 SEP.</i>

<p><b>Health Centers</b></p>	<ul style="list-style-type: none"> <li>■ Improve States' efforts to identify and address violations of access standards.</li> <li>■ Provide technical assistance and share effective practices.</li> <li>■ Provide more specific guidance about what health center grantees should address in their quality assurance programs and how they should conduct their periodic assessments.</li> <li>■ Provide more specific guidance concerning what information is required in patient records at health centers.</li> <li>■ Establish procedures to independently assess patients' receipt of primary health services and the adequacy of patients' records.</li> </ul>	<p>HRSA</p>	<p><b>Expected Impact:</b> Improved quality</p>	<p><i>Quality Assurance and Care Provided at HRSA-Funded Health Centers.</i>  <b>OEI-09-06-00420. 2012 MAR.</b></p>
<p><b>Product Safety</b></p>	<ul style="list-style-type: none"> <li>■ Seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading.</li> <li>■ Improve the notification system to make it more organized, complete, and accurate.</li> <li>■ Expand market surveillance of dietary supplements to enforce the use of disclaimers for structure/function claims and detect disease claims.</li> </ul>	<p>FDA</p>	<p><b>Expected Impact:</b> Improved safety</p>	<p><i>Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements.</i>  <b>OEI-01-11-00210. 2012 OCT.</b></p>
	<ul style="list-style-type: none"> <li>■ Improve the accuracy of the information in its Food Facility Registry.</li> <li>■ Seek statutory authority to impose civil monetary penalties on companies that do not comply with registration requirements.</li> </ul>	<p>FDA</p>	<p><b>Expected Impact:</b> Improved safety</p>	<p><i>Dietary Supplements: Companies May Be Difficult To Locate in an Emergency.</i> <b>OEI-01-11-00211. 2012 OCT</b></p>

	<ul style="list-style-type: none"><li>▪ Educate the dietary supplement industry about registration and labeling requirements.</li></ul>			
<b>Food Safety</b>	<ul style="list-style-type: none"><li>▪ Take appropriate actions against facilities with official action indicated (OAI) classifications, particularly those that have histories of violations.</li><li>▪ Ensure that violations are corrected for all facilities that receive OAI classifications.</li><li>▪ Consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.</li></ul>	FDA	<b>Expected Impact:</b> Improved safety	<i>FDA Inspections of Domestic Food Facilities.</i> <b>OEI-02-08-00080. 2010 APR.</b>
<b>Drug Safety</b>	<ul style="list-style-type: none"><li>▪ Develop and implement a plan to identify, develop, validate, and assess Risk Evaluation and Mitigation Strategies (REMS) components.</li><li>▪ Identify REMS that are not meeting their goals and take appropriate actions to protect the public health.</li><li>▪ Identify incomplete sponsor assessments and work with sponsors to obtain missing information.</li><li>▪ Clarify expectations for sponsors' assessments in FDA assessment plans.</li><li>▪ Seek legislative authority to enforce FDA assessment plans.</li><li>▪ Ensure that assessment reviews are timely.</li></ul>	FDA	<b>Expected Impact:</b> Improved safety	<i>FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety.</i> <b>OEI-04-11-00510. 2013 FEB.</b>

## Health Information Technology

<p><b>Medicaid</b></p>	<ul style="list-style-type: none"> <li>Establish a deadline for when national T-MSIS data will be available.</li> <li>Ensure that States submit required T-MSIS data.</li> <li>Ensure that T-MSIS data are complete, accurate, and timely upon T-MSIS implementation.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved program management</p>	<p><i>Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System. <a href="#">OEI-05-12-00610</a>. 2013 SEP.</i></p>
<p><b>Electronic Health Records</b></p>	<ul style="list-style-type: none"> <li>Audit logs should be operational whenever EHR technology is available for updates or viewing.</li> <li>ONC and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.</li> <li>CMS should develop guidance on the use of the copy-paste feature in EHR technology.</li> </ul>	<p>CMS, ONC</p>	<p><b>Expected Impact:</b> Improved program integrity</p>	<p><i>Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology. <a href="#">OEI-01-11-00570</a>. 2013 DEC.</i></p>
	<ul style="list-style-type: none"> <li>CMS should provide guidance to its contractors on detecting fraud associated with EHRs.</li> <li>CMS should direct its contractors to use providers' audit logs.</li> </ul>	<p>CMS</p>	<p><b>Expected Impact:</b> Improved program integrity</p>	<p><i>CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs. <a href="#">OEI-01-11-00571</a>. 2014 JAN.</i></p>

## Emergency Preparedness and Response

<p><b>Hospitals</b></p>	<ul style="list-style-type: none"> <li>The Assistant Secretary for Preparedness and Response (ASPR) should continue to promote Federal, State, and community collaboration in major disasters.</li> <li>CMS should examine existing policies and provide guidance regarding flexibility for reimbursement under disaster conditions.</li> </ul>	<p>ASPR, CMS</p>	<p><b>Expected Impact:</b> Improved safety</p>	<p><i>Hospital Emergency Preparedness and Response During Superstorm Sandy. <a href="#">OEI-06-13-00260</a>. 2014 SEP.</i></p>
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<b>Nursing Homes</b>	<ul style="list-style-type: none"> <li>■ CMS should revise Federal regulations by identifying and including in its regulations requirements for specific elements of emergency plans and training.</li> <li>■ CMS should update the <i>State Operations Manual</i> to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training.</li> <li>■ ACL should develop model policies and procedures to protect resident health, safety, welfare, and rights during and after disasters.</li> </ul>	CMS, ACL	<b>Expected Impact:</b> Improved safety	<i>Gaps Continue To Exist in Nursing Home Preparedness and Response During Disasters.</i> <b>OEI-06-09-00270. 2012 APR.</b>
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## Program Integrity

<b>Physician Services</b>	<ul style="list-style-type: none"> <li>■ Establish a cumulative payment threshold-taking into consideration costs and potential program integrity benefits above which a clinician's claims would be selected for review.</li> <li>■ Implement a procedure for timely identification and review of clinicians' claims that exceed the cumulative payment threshold.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Reviews of Clinicians Associated With High Cumulative Payments Could Improve Medicare Program Integrity Efforts.</i> <b>A-01-11-00511. 2013 DEC.</b>
<b>Nursing Homes</b>	<ul style="list-style-type: none"> <li>■ Follow up on the SNFs identified as having questionable billing practices.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Questionable Billing by Skilled Nursing Facilities.</i> <b>OEI-02-09-00202. 2010 DEC.</b>
<b>Community Mental Health Centers</b>	<ul style="list-style-type: none"> <li>■ Develop a system to track billing-privilege revocation recommendations and improve revocation communication with Medicare contractors.</li> <li>■ Coordinate activities to deter community mental health center (CMHC) fraud in Florida.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Vulnerabilities in CMS's and Contractors' Activities To Detect and Deter Fraud in Community Mental Health Centers.</i> <b>OEI-04-11-00101. 2013 JAN.</b>

<b>Clinical Laboratories</b>	<ul style="list-style-type: none"> <li>Finalize and implement the proposed COPs for CMHCs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Questionable Billing by Community Mental Health Centers.</i> <b>OEI-04-11-00100. 2012 AUG.</b>
	<ul style="list-style-type: none"> <li>Review the labs identified as having questionable billing and take appropriate action.</li> <li>Review existing program integrity strategies to determine whether they are effectively identifying program vulnerabilities associated with lab services.</li> <li>Ensure that existing edits prevent claims with invalid and ineligible ordering-physician numbers from being paid.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Questionable Billing for Medicare Part B Clinical Laboratory Services.</i> <b>OEI-03-11-00730. 2014 AUG.</b>
<b>Part D</b>	<ul style="list-style-type: none"> <li>Instruct the benefit integrity contractor to expand its analysis of prescribers.</li> <li>Provide sponsors with additional guidance on monitoring prescribing patterns.</li> <li>Provide education and training for prescribers.</li> <li>Follow up on prescribers with questionable prescribing patterns.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Prescribers With Questionable Patterns in Medicare Part D.</i> <b>OEI-02-09-00603. 2013 JUN</b>
	<ul style="list-style-type: none"> <li>Implement an edit to reject prescription drug event (PDE) records for Schedule II drugs when the prescriber ID field contains an invalid prescriber ID number.</li> <li>Issue specific guidance requiring sponsors to include a valid Drug Enforcement Administration number on both standard and nonstandard format PDE records involving Schedule II drugs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs.</i> <b>A-14-09-00302. 2011 FEB.</b>
	<ul style="list-style-type: none"> <li>Expand sponsors' drug utilization review programs.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program integrity	<i>Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs.</i> <b>OEI-02-11-00170. 2014 AUG.</b>

- Expand the Overutilization Monitoring System to include additional drugs susceptible to fraud, waste, and abuse.
- Expand sponsors' use of beneficiary-specific controls.
- Restrict certain beneficiaries to a limited number of pharmacies or prescribers.
- Limit the ability of certain beneficiaries to switch plans.
- Increase monitoring of beneficiaries' utilization patterns.

- Require sponsors to refer potential fraud and abuse incidents that may warrant further investigation.

CMS **Expected Impact:** Improved program integrity  
*Retail Pharmacies With Questionable Part D Billing. OEI-02-09-00600. 2012 MAY.*

- Amend regulations to require sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse.
- Provide sponsors with specific guidelines on how to define and count incidents, related inquiries, and corrective actions.
- Review data to determine why certain sponsors reported especially high or low numbers of incidents, related inquiries, and corrective actions.
- Share sponsors' data on potential fraud and abuse with all sponsors and law enforcement.

CMS **Expected Impact:** Improved payment integrity  
*Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse. OEI-03-13-00030. 2014 MAR.*

### Part C

- Ensure that MA organizations are implementing programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans, so that all potential Part C and Part D fraud and abuse incidents may be identified.

CMS **Expected Impact:** Improved program integrity  
*Medicare Advantage Organizations' Identification of Potential Fraud and Abuse. OEI-03-10-00310. 2012 FEB.*

- Review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries.
- Require MA organizations to report to CMS aggregate data related to their Part C and Part D antifraud, waste, and abuse activities.
- Ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents.
- Require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities.

- Determine whether outlier data values submitted by MA organizations reflect inaccurate reporting or atypical performance.
- Use appropriate Part C reporting requirements data as part of its reviews of MA organizations' performance.
- Establish a timeline for releasing public use files for Part C reporting requirements data.

CMS

**Expected Impact:**  
Improved  
program integrity

*CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited.*  
**OEI-03-11-00720. 2014 MAR.**

**Medicaid  
 Managed  
 Care**

- Require that State contracts with MCEs include methods to verify with beneficiaries whether services billed by providers were received.
- Update guidance to reflect concerns expressed by MCEs and States.

CMS

**Expected Impact:**  
Improved  
program integrity

*Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards.* **OEI-01-09-00550. 2011 DEC.**

## Affordable Care Act

<b>Marketplaces</b>	<ul style="list-style-type: none"> <li>Develop and make public a plan on how and by what date the Federal marketplace will resolve inconsistencies.</li> <li>Conduct additional oversight of State marketplaces to ensure that they are resolving inconsistencies according to Federal requirements.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data. <a href="#">OEI-01-14-00180</a>. 2014 JUN.</i>
	<ul style="list-style-type: none"> <li>Improve internal controls related to determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs.</li> <li>Improve internal controls related to verifying identity of applicants and entering applicant information.</li> <li>Improve internal controls related to maintaining and updating eligibility and enrollment data.</li> </ul>	CMS	<b>Expected Impact:</b> Improved program management	<i>Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements. <a href="#">A-09-14-01000</a>. 2014 JUN.</i>

## Financial Stewardship

<b>Improper Payments</b>	<ul style="list-style-type: none"> <li>Report an improper payment estimate for TANF and reduce error rates below 10 percent.</li> </ul>	HHS	<b>Expected Impact:</b> Improved financial management	<i>HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2013. <a href="#">A-17-14-52000</a>. 2014 APR.</i>
	<ul style="list-style-type: none"> <li>Assess the need for additional actions to meet improper payment rate reduction targets.</li> </ul>	HHS	<b>Expected Impact:</b> Improved financial management	<i>U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Was Not Fully Compliant. <a href="#">A-17-13-52000</a>. 2013 MAR.</i>

**Financial  
 Statement  
 Audit**

- Continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity, and continue to focus on remediating the remaining financial management system deficiencies.

HHS **Expected Impact:**  
 Improved financial management

*Department Health and Human Services Fiscal Year 2014 Agency Financial Report. Section II. Daniel R. Levinson, Inspector General, OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2014. (pp. 51, 52, 53, 60, 64, 65, 71, and 72.)* [A-17-14-00001](#). **2014 NOV.**

**Improve CMS’s financial reporting and related processes**

- Continuously monitor the State Medicaid draws and improve grant oversight activities and report timely, accurately, and consistently on the funds drawn.
- Establish a process to perform a claims-level detailed lookback analysis of Medicaid entitlement benefits due and payable to determine the reasonableness of the methodology used to estimate the accrual.
- Continue to improve the efficiency of the various error rate processes to allow more time to analyze the findings and the development of remediation plans.
- Continue to implement an integrated financial management system to promote consistency and reliability in accounting and financial reporting.
- Continue to enhance its process related to the development, documentation, and validation of critical accounting matters and to delegate the responsibility of the centers or offices to provide robust analyses on a routine and recurring basis.

CMS **Expected Impact:**  
 Improved financial management

*CMS Financial Report, Fiscal Year 2014. Audit Opinion Section. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2014, pp. 117 through 124.* [A-17-14-02014](#). **2014 NOV. (p. 102)**

- Continue to adhere to established policies and procedures to ensure that the statement of social insurance model methodology, related calculations and estimates are consistently documented.

**Improve Medicare Information System Controls**

- Ensure that systems are appropriately and timely certified, related system security plans are complete and prepared by all system owners and Medicare fee-for service contractors, and documentation of all interconnections between Medicare contractors is consistently prepared.
- Ensure that all application changes and interfaces to CMS systems, including Medicare fee-for-service shared systems, are documented and tested timely, adequately, and completely.
- Ensure that appropriate segregation of duties is established and periodically assessed for all systems that support CMS's programs, including Medicare fee-for-service claims and related financial processing at claims processing contractors and virtual data centers to prevent excessive or inappropriate access.