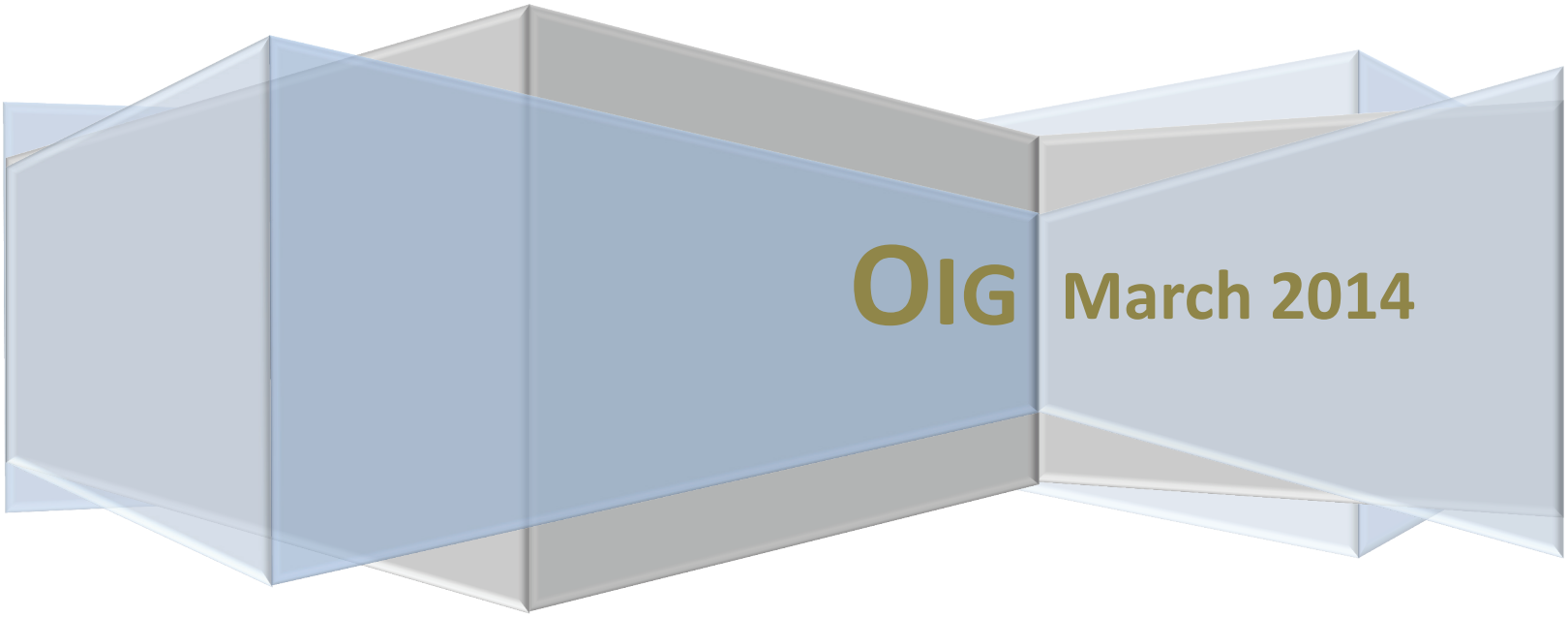
U.S. Department of Health and Human Services

Office of Inspector General

Compendium of Priority Recommendations



OIG Compendium of Priority Recommendations

About the March 2014 edition

This document, entitled the *Compendium of Priority Recommendations (Compendium)*, renames the *Compendium of Unimplemented Recommendations*, a core publication of the Department of Health and Human Services (HHS) Office of Inspector General (OIG). With this edition, we focus on 25 priority issues for which we have open recommendations.

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 2014 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.[1]

The recommendations represent opportunities to achieve cost savings, improve program management, and ensure quality of care and safety of beneficiaries in fiscal year (FY) 2014 and beyond.[2] The 25 broad "Priority Recommendations" we identified for this edition derive from more specific recommendations that OIG has made to HHS in audit and evaluation reports. Those more specific recommendations, or action steps, are included in the summary of each broad recommendation, and the underlying reports are referenced. The 25 priority recommendations are generally grouped by the underlying HHS program or operation; thus, they are not internally ranked and so do not reflect relative priority among the 25.

Implementation of OIG's recommendations

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.

[1] 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, Department of Health and Human Services, Office of Inspector General, p. 63.

[2] 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.

OIG relies on policymakers, such as HHS and its operating divisions (OPDIVs) and staff divisions (STAFFDIVs), 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. In some instances, HHS disagrees with OIG's recommendations. Congress sometimes steps in to incorporate OIG's recommendations into legislative actions, resulting in substantial savings or public funds' being put to better use and/or in improvements in quality of care, program integrity, or better information systems and processes.

Many of the recommendations in this *Compendium* have seen some progress. However, as of March 2014, the date of publication, OIG had reason to believe that more should be achieved.

Emerging issues and the OIG *Work Plan*

The 25 priority 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 currently underway in OIG on many emerging issues, including analyzing the implementation of programs established by the Patient Protection and Affordable Care Act of 2010 that recently took effect.

Brief descriptions of our FY 2014 work in progress and planned "new starts" are presented in the OIG *Work Plan* for FY 2014, which is available on our Web site. When the reviews are completed and final reports are issued, we publish them on a flow basis on our home page under "What's New." Subsequently, the reports that are particularly significant are consolidated into and summarized in our *Semiannual Reports to Congress.*

HHS agencies, programs, and functions

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 about 80 percent of HHS's budget. The programs provide medical coverage for adults and children in certain statutorily defined categories.

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 on 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.

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 *Medicaid Integrity Program Report.* 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 https://forms.oig.hhs.gov/hotlineoperations.

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Selected Acronyms and Abbreviations

ACF	Administration for Children and Families
ACL	Administration for Community Living
AMP	average manufacturer price
AWP	average wholesale price
CAH	critical access hospital
CBO	Congressional Budget Office
CCDF	Childcare and Development Fund
CERT	comprehensive error rate testing
CHIP	Children's Health Insurance Program
CMHC	community mental health center
CMS	Centers for Medicare & Medicaid Services
CMS-ARTS	CMS Analysis, Reporting, and Tracking System
DEA	Drug Enforcement Administration
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
HRSA	Health Resources and Services Administration
IPIA	Improper Payments Information Act
MA	Medicare Advantage
MAC	Medicare administrative contractor
MCE	managed care entity
MCO	managed care organization
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
PBM	pharmacy benefit manager
PCS	personal care services
PIHP	prepaid inpatient health plan
PSC	program safeguard contractor
P&T	pharmacy and therapeutics (committee)
RAC	recovery audit contractor
RUG	resource utilization group
SNF	skilled nursing facility
SOSI	statement of social insurance
T-MSIS	Transformed MSIS
UPL	upper payment limit
WAC	wholesale acquisition cost
ZPIC	zone program integrity contractor

Medicare Policies and Payments

01 Address wasteful Medicare policies and payment rates for clinical laboratories, hospitals, and hospices.

Clinical laboratories.

Medicare pays significantly more than other insurers, including Medicaid, for clinical laboratory tests. In 2011, Medicare could have saved $910 million on 20 high-volume/high-expenditure lab tests if it had paid providers at the lowest established rate we identified for each geographical area. Medicare savings could also be achieved by reinstating beneficiary copayments and deductibles. One such proposal by the Congressional Budget Office (CBO) was estimated to save $23.8 billion over 10 years.[1]

Key OIG Reports	Specific Recommendations
Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings. OEI-07-11-00010. 2013 JUN.	■ Seek legislation that would allow CMS to establish lower payment rates for lab tests and ■ seek legislation to institute copayments and deductibles for lab tests.
Variation in the Clinical Laboratory Fee Schedule. OEI-05-08-00400. 2009 JUL.	■ Seek legislation allowing CMS to set accurate and reasonable payment rates for laboratory tests.

See also:

- *1996 JAN—Follow-up to Report. Changes Are Needed in the Way Medicare Pays for Clinical Laboratory Tests. A-09-93-00056.*

Critical access hospitals.

If the Centers for Medicare & Medicaid Services (CMS) had decertified critical access hospitals (CAHs) that were 15 or fewer miles from their nearest hospitals in 2011 and had paid them at the applicable non-CAH rates, Medicare and its beneficiaries would have saved $449 million. Medicare and its beneficiaries pay more for care in CAH-certified hospitals, but most CAHs would not meet the location requirements if required to re-enroll in Medicare.

One Office of Inspector General (OIG) report revealed that nearly two-thirds of CAHs would not meet the location requirements if required to re-enroll and the vast majority would not meet the distance requirement.

[1] (CBO: *Budget Options, Volume 1: Health Care*. Option 86. "Impose a Deductible and Coinsurance for Clinical Laboratory Services Covered by Medicare," p. 159.)

Key OIG Report	Specific Recommendations
Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare. *OEI-05-12-00080. 2013 AUG.*	▪ Seek legislative authority to remove Necessary Provider CAHs' permanent exemption from the distance requirement, thus allowing CMS to reassess these CAHs; ▪ seek legislative authority to revise the CAH Conditions of Participation to include alternative location-related requirements; ▪ periodically reassess CAHs' compliance with all location-related Conditions of Participation; and ▪ apply the uniform definition of "mountainous terrain" to all CAHs.

See also:

- *2013 DEC—Services Provided at Critical Access Hospitals in 2011. OEI-05-12-00081.*

Inpatient hospital payment policies.

We highlight two priority issue areas: payments for outpatient services related to inpatient admissions and payments associated with early transfers to hospice care. A February 2014 report concluded that expanding the window of time covered by Medicare's lump sum payments for inpatient care would result in cost savings. We reviewed outpatient services that the admitting hospitals provided during the 11 days prior to the existing window and found that In 2011, Medicare and its beneficiaries paid an estimated $263 million for such services. OIG has previously recommended expanding the window but CMS has not sought authority to do so. Regarding hospital transfer policy, a May 2013 report revealed that If Medicare Part A had implemented a hospital transfer payment policy for early discharges from hospitals to hospice care in 2009 and 2010, it could have saved over $600 million. Generally, instead of making full payments, Medicare pays the discharging hospitals a reduced rate for early discharges to other care settings. There is no similar policy for transfers to hospice care. We found that about 30 percent of all hospital discharges to hospice care were early discharges that, under a transfer payment policy, could have resulted in reduced payments.

Key OIG Report	Specific Recommendation
Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded. *OEI-05-12-00480. 2014 FEB.*	▪ CMS should seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission and ▪ CMS seek legislative authority to expand the DRG window to include other hospital ownership arrangements, such as affiliated hospital groups.
Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for	▪ Change regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to

Key OIG Report	Specific Recommendation
Early Discharges to Hospice Care. A-01-12-00507. 2013 MAY.	hospice care.

See Also:

- *2003 AUG—Expansion of the Diagnosis Related Group Payment Window, A-01-02-00503.*

Hospice care in nursing homes.

Medicare's hospice payment methodology may lead some hospices to inappropriately seek out beneficiaries in nursing facilities. Medicare spending on hospice care for nursing facility residents increased nearly 70 percent from $2.55 billion in 2005 to $4.31 billion in 2009, an increase not explained by the demographics of the Medicare population. Medicare pays hospices an all-inclusive daily rate under Part A. The rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services furnished. We identified hundreds of hospices that had more than two-thirds of their beneficiaries residing in nursing facilities in 2009.

Key OIG Report	Specific Recommendations
Medicare Hospices That Focus on Nursing Facility Residents. OEI-02-10-00070. 2011 JUL.	▪ Monitor hospices that depend heavily on nursing facility residents and ▪ modify the payment system for hospice care in nursing facilities, seeking statutory authority, if necessary.

See also:

- *2011 JUL—OIG Spotlight: Hospice Care Claim Problems.*

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02 Improve controls to address improper Medicare billings by community mental health centers, home health agencies, and skilled nursing facilities.

Community mental health center services.

We estimated that during 2010, about half of community mental health centers (CMHCs) that we reviewed met or exceeded thresholds that indicated unusually high Medicare billing for at least one of nine questionable billing characteristics. About 90 percent of CMHCs with questionable billing were in States that do not require CMHCs to be licensed or certified. We found problems with CMS's oversight

of its contractors' activities to detect and deter CMHC fraud and found that Medicare continued to pay CMHCs that did not comply with its requirements.

Key OIG Reports	Specific Recommendations
Vulnerabilities in CMS's and Contractors' Activities To Detect and Deter Fraud in Community Mental Health Centers. OEI-04-11-00101. *2013 JAN.*	■ Develop a system to track billing-privilege revocation recommendations and improve CMS's revocation communication with Medicare contractors and ■ coordinate activities to deter CMHC fraud in Florida.
Questionable Billing by Community Mental Health Centers. OEI-04-11-00100. *2012 AUG.*	■ Increase monitoring of Medicare billing and fraud prevention controls, and ■ review and take appropriate actions against CMHCs with questionable billing.

See also:

- *2013 DEC—OIG Spotlight: Fighting Fraud at Community Mental Health Centers.*

Home health services.

One OIG review found that about one in every four home health agencies (HHAs) exceeded a threshold that indicated unusually high billing for at least one of our six measures of questionable billing. A separate review found that as of February 29, 2012, over 2,000 HHAs owed CMS about $408 million for $590 million in known overpayments that were incurred between 2007 and 2011. We estimated that CMS could have recovered at least $39 million of that amount if it had required each HHA to obtain a $50,000 surety bond.

Key OIG Reports	Specific Recommendations
Inappropriate and Questionable Billing by Medicare Home Health Agencies. OEI-04-11-00240. *2012 AUG.*	■ Implement claims processing edits or improve existing edits to prevent inappropriate payments, ■ increase monitoring of billing for home health services, ■ enforce and consider lowering the 10-percent cap on the total outlier payments an HHA may receive annually, and ■ take appropriate action regarding inappropriate payments and HHAs with questionable billing.
Surety Bonds Remain an Unused Tool To Protect	■ CMS should implement the HHA surety bond requirement.

Medicare From Home Health Overpayments.
OEI-03-12-00070. 2012 SEP.

Skilled nursing facilities.

OIG has identified a number of problems with billing by skilled nursing facilities (SNF), including the submission of inaccurate, medically unnecessary, and fraudulent claims. SNFs billed one-quarter of all claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments. Payments to SNFs for ultra-high therapy rose from $5.7 billion in 2006 to $10.7 billion in 2008, an increase of nearly 90 percent.

Key OIG Reports	Specific Recommendations
Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than $1 Billion in 2009. *OEI-02-09-00200. 2012 NOV.*	■ Increase and expand reviews of SNF claims, ■ monitor compliance with the new therapy assessments, ■ change the current method for determining how much therapy is needed to ensure appropriate payments, ■ improve the accuracy of data items submitted by SNFs, and ■ follow up on SNFs that billed in error.
Questionable Billing by Skilled Nursing Facilities. *OEI-02-09-00202. 2010 DEC.*	■ Monitor overall Medicare payments to SNFs and adjust rates as necessary, ■ strengthen monitoring of SNFs that disproportionately bill for higher paying resource utilization groups (RUGs), and ■ follow up on the SNFs identified as having questionable billing practices.

03 Detect and recover improper Medicare payments for services to incarcerated, unlawfully present, or deceased individuals.

Incarcerated beneficiaries.

We identified nearly $33.6 million in uncollected improper payments on behalf of incarcerated beneficiaries in Part A and Part B during calendar years (CYs) 2009 through 2011. With certain exceptions, prisons (instead of Medicare) pay for the health care of incarcerated people who are

otherwise eligible for Medicare (incarcerated beneficiaries). CMS does not always receive timely updates regarding incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries. Similarly, we estimated that more than $11.6 million in gross drug costs were associated with incarcerated beneficiaries in Part D for CYs 2006 through 2010.

Key OIG Reports	Specific Recommendations
Incarcerated beneficiaries in Part B. Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011. A-07-12-01113. 2013 JAN.	■ Implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to incarcerated beneficiaries, ■ ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements, ■ work with other entities, including the Social Security Administration (SSA), to identify ways to improve the timeliness with which CMS receives incarceration information, ■ ensure that Medicare contractors recoup the improper payments we identified, and ■ identify improper payments made on behalf of incarcerated beneficiaries after our audit period and recoup those payments.
Incarcerated beneficiaries in Part D. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Incarcerated Beneficiaries During 2006 Through 2010. A-07-12-06035. 2014 JAN.	■ Develop and implement policies and procedures that provide Part D sponsors on a timely basis with all of the incarceration information that is necessary for them to verify beneficiaries' dates and status of incarceration, ■ reopen and revise final payment determinations for CYs 2006 through 2010 to remove gross drug costs for the sampled incarcerated beneficiaries, and ■ work with the sponsors to identify and resolve improper Part D payments made for prescription drugs provided to incarcerated beneficiaries.

Unlawfully present beneficiaries.

We identified $91.6 million in improper payments to unlawfully present beneficiaries in Part B during CYs 2009 through 2011. When CMS received untimely information indicating that unlawful presence overlapped with the dates of service on previously paid Medicare claims, CMS did not notify Medicare's contractors of this updated information, and the contractors did not detect and recoup improper payments. For the same period, we estimated $29 million in gross drug costs associated with unlawfully present beneficiaries in Part D. CMS used the supporting records to make final payment determinations to Part D sponsors.

Key OIG Reports	Specific Recommendations
Unlawfully present beneficiaries in Part B. Medicare Improperly Paid Providers Millions of Dollars for Unlawfully Present Beneficiaries Who Received Services During 2009 Through 2011. A-07-12-01116. 2013 JAN.	■ Implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to unlawfully present beneficiaries and ■ ensure that Medicare contractors recoup the improper payments we identified.
Unlawfully present beneficiaries in Part D. Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011. A-07-12-06038. 2013 OCT.	■ 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; ■ reopen and revise final payment determinations for CYs 2009 through 2011 to remove prescription drug costs for unlawfully present beneficiaries; and ■ reopen and revise final payment determinations for periods after the period of this review but before implementation of improved policies and procedures.

Deceased beneficiaries.

Health care fraud schemes have involved the submission of fraudulent claims by providers or suppliers to Medicare, including claims for deceased beneficiaries, and prior OIG studies and audit reports have identified Medicare payments made on behalf of deceased beneficiaries. Our October 2013 report revealed that although CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries, it inappropriately paid $23 million in 2011 for dates of service after beneficiaries' deaths. Part C accounted for 86 percent of these improper payments. Additionally, 11 percent of these improper payments resulted from the fact that dates of death were missing or incorrect. Further, we identified 251 providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

Key OIG Reports	Specific Recommendations
Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011. OEI-04-12-00130. 2013 OCT.	■ 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,

Key OIG Reports	Specific Recommendations
	▪ monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths, and ▪ take appropriate action on providers and suppliers that had high numbers of paid and/or unpaid part b claims with service dates after beneficiaries' deaths.

See Also:

- *2011 MAY—Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees. A-05-09-00027.*
- *2010 SEP—Review of Medicare Parts A and B Services Billed With Dates of Service After Beneficiaries' Deaths. A-01-09-00519.*
- *2009 MAR—Review of Medicare Payments to Managed Care Plans on Behalf of Deceased Enrollees. A-07-07-01046.*
- *2000 MAR—Medicare Payments for Services After Date of Death. OEI-03-99-00200.*

04 Maximize recovery of Medicare overpayments.

CMS did not provide adequate guidance for collecting millions of dollars of overpayments and did not have an effective system for monitoring collection efforts. We could not verify the amounts that CMS reported collecting, and we identified inaccuracies in the reported amounts. Though recent improvements were made in Medicare's statute of limitations policy, problems with the reopening period and other deficient policies and practices continue.

Key OIG Reports	Specific Recommendations
Obstacles to Collection of Millions in Medicare Overpayments. A-04-10-03059. 2012 MAY.	▪ Ensure that the Audit Tracking and Reporting System is updated to accurately reflect the status of audit report recommendations, ▪ ensure that collections information is consistently recorded in the Audit Tracking and Reporting System, and ▪ collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under the law.
Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors. OEI-03-08-00030. 2010 MAY.	▪ Require controls in the tracking systems to ensure that all overpayment referrals and data related to collection status can be found.

05 Improve monitoring and reconciliation of Medicare hospital outlier payments.

The routine receipt of outlier payments for certain diagnoses at high-outlier hospitals raises concerns about why charges for similar patient-care cases vary substantially across hospitals. Outliers are supplemental payments that protect hospitals from significant financial losses from patient-care cases that are extraordinarily costly. Nearly all hospitals receive outlier payments, and some receive a much higher proportion of Medicare reimbursements from outlier payments. We found that payments to selected hospitals averaged 12.8 percent of their Medicare inpatient care reimbursements, compared to an average of only 2.2 percent for all other hospitals. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRG), even though their patients had similar lengths of stay as those in all other hospitals. We have also reported problems with Medicare's reconciliation and settlement of outlier payments. Work is continuing in this area and many cost reports that are in our review have not yet been settled.

Key OIG Reports	Specific Recommendations
Medicare Hospital Outlier Payments Warrant Increased Scrutiny. OEI-06-10-00520. 2013 NOV.	■ Instruct Medicare contractors to increase monitoring of outlier payments, ■ include information about the distribution of outlier payments with other publicly reported hospital data, and ■ examine whether diagnosis codes associated with high rates of outlier payments warrant coding changes or other adjustments.
The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance. A-07-10-02764. 2012 JUN.	■ Implement an automated system that will recalculate outlier claims to facilitate reconciliations, ■ 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 cost reports we reviewed in accordance with Federal regulations and guidance, and ■ 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.

06 Medicare Part C—Ensure that Medicare Advantage Organizations are implementing programs to prevent and detect waste, fraud, and abuse.

MA program costs were $115 billion in fiscal year 2010. CMS does not require MA organizations to report, nor does CMS routinely review the results of, MA organizations' fraud and abuse program efforts. Of the Medicare Advantage (MA) organizations we reviewed, 19 percent did not identify any potential fraud and abuse incidents in 2009 in either their Part C health benefits or their Part D prescription drug benefits. Notably, 95 percent of incidents reported were identified by only 3 of 137 organizations reporting. HHS reported a composite payment error rate of 14.1 percent for the MA program for that period. Progress has been made as evidenced by a reduction in the error rate from 11.4 percent for FY 2012 to 9.5 percent for FY 2013 and various initiatives to reduce the errors in risk-adjustment data and resulting improper payments. We continue to monitor CMS's implementation of the actions we specified.

Key OIG Report	Specific Recommendations
Medicare Advantage Organizations' Identification of Potential Fraud and Abuse. OEI-03-10-00310. 2012 FEB.	■ 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; ■ 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; ■ develop specific guidance for MA organizations on defining 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; and ■ require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities.

07 Medicare Part D—Improve controls to address questionable billing and prescribing practices for prescription drugs.

OIG conducted a series of reviews on the basis of PDE records that Part D sponsors submit to CMS to carry out Part D payment provisions. Sponsors complete the PDE records using information provided by the pharmacies responsible for filling the prescriptions.

Pharmacies with questionable billing. From the PDE records, we identified 2,600 pharmacies that had extremely high billing for at least one of the eight measures of questionable billing we developed. Such pharmacies could be billing for drugs that are not medically necessary or that were not provided to beneficiaries.

Questionable and invalid prescribers. We identified over 700 general-care physicians who prescribed extremely high amounts for at least one of the five measures of questionable billing we developed. We also found that Medicare and Part D sponsors failed to detect many drugs, including controlled substances, that were being ordered by individuals without the authority to prescribe, such as massage therapists, athletic trainers, interpreters, counselors, and social workers.

Schedule II drugs billed as refills. We estimated that Medicare Part D paid $25 million for Schedule II drugs billed as refills in 2009. Such drugs may cause severe psychological or physical dependence if abused. Federal law prohibits the refilling of prescriptions for them. Over 25,000 of the Schedule II refills had invalid prescribers. An earlier analysis concluded that sponsors should include a valid Drug Enforcement Administration (DEA) number on records involving Schedule II drugs. The DEA number is the only identifier type that indicates whether prescribers are registered to prescribe Schedule II drugs.

Several specific recommendations associated with our findings are presented below.

Key OIG Reports	Specific Recommendations
Retail Pharmacies With Questionable Part D Billing. *OEI-02-09-00600. 2012 MAY.*	■ Strengthen benefit integrity contractors' monitoring of pharmacies and their ability to identify pharmacies for further review, ■ require sponsors to refer potential fraud and abuse incidents that may warrant further investigation, ■ develop risk scores for pharmacies, and ■ follow up on the pharmacies identified as having questionable billing.
Prescribers With Questionable Patterns in Medicare Part D. *OEI-02-09-00603. 2013 JUN.*	■ Instruct the benefit integrity contractor to expand its analysis of prescribers, ■ provide sponsors with additional guidance on monitoring

Key OIG Reports	Specific Recommendations
	prescribing patterns, ▪ provide education and training for prescribers, and ▪ follow up on prescribers with questionable prescribing patterns.
Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority. OEI-02-09-00608. *2013 JUN.*	▪ Require sponsors to verify that prescribers have the authority to prescribe drugs, ▪ increase the benefit integrity contractor's monitoring of prescribers, ▪ ensure that Medicare does not pay for prescriptions from individuals without prescribing authority, and ▪ follow up on individuals without prescribing authority who ordered prescriptions.
Schedule II Drugs: Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills. OEI-02-09-00605. *2012 SEP.*	▪ Exclude Schedule II refills when calculating payments to sponsors, ▪ monitor sponsors to ensure they validate prescriber numbers for Schedule II drugs, and ▪ follow up on sponsors and pharmacies with high numbers of refills.
Schedule II Drugs: Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs. (A-14-09-00302. *2011 FEB.*	▪ Implement an edit to reject PDE records for Schedule II drugs when the prescriber ID field contains an invalid prescriber ID number and ▪ issue specific guidance requiring sponsors to include a valid DEA number on both standard and nonstandard format PDE records involving Schedule II drugs.

See also:

- *2013 JUN—OIG Spotlight:* Drug Diversion.
- *2013 JUN—Testimony of Gary Cantrell, Deputy Inspector General for Investigations and Stuart Wright, Deputy Inspector General for Evaluation and Inspections, Office of Inspector General before the Senate Committee on Homeland Security and Governmental Affairs. "Curbing Prescription Drug Abuse in Medicare."* (Testimony.)
- *2010 JUL—Testimony of Robert A. Vito, Acting Assistant Inspector General for Centers for Medicare & Medicaid Audits, before the Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. "Recovering Government Payment Errors."* (Testimony.) *See also, Invalid Prescriber Identifiers:* OEI-03-09-00140.

Medicare Quality of Care and Safety Issues

08 Hospitals—Address adverse events in hospital settings.

The term "adverse event" describes harm to a patient as a result of medical care. We estimated that over one-quarter of hospitalized Medicare beneficiaries were harmed during their hospital stays in October 2008. Although we found that State agencies' responses to serious safety allegations were timely and often found problems, the State agencies and CMS missed opportunities to incorporate patient safety principles into their responses. Hospitals investigated most complaints in our sample, but State agencies performed little longer term monitoring to verify that hospitals' corrective actions resulted in sustained improvements.

We note that the Affordable Care Act, § 3008, provides for adjustments to Medicare hospital payments for hospital acquired conditions; the adjustments will take effect in FY 2015. We will monitor the implementation of the provision.

Key OIG Reports	Specific Recommendations
Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events. *OEI-01-08-00590. 2011 OCT.*	▪ Require that all Immediate Jeopardy complaint surveys evaluate compliance with the Conditions of Participation on quality assurance and performance improvement, ▪ ensure that State agencies monitor hospitals' corrective actions for sustained improvements, and ▪ amend guidance on disclosure to explain the nature of complaints to hospitals.
Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. *OEI-06-09-00090. 2010 NOV.*	▪ The Agency for Healthcare Research and Quality (AHRQ) and CMS should broaden patient safety efforts to include all types of adverse events. ▪ AHRQ and CMS should enhance efforts to identify adverse events.
Adverse Events in Hospitals: Methods for Identifying Events. OEI-06-08-00221. 2010 MAR.	▪ CMS should provide interpretive guidelines for State survey agencies to assess hospital compliance to track and monitor adverse events.

See also:

- *2012 JUL—OIG Spotlight: Adverse Events in Hospitals.*

09 Nursing homes—Improve care planning and discharge planning for beneficiaries in nursing home settings.

Medicare paid approximately $5.1 billion for a sample of 2009 stays in which SNFs did not meet quality-of-care requirements. Our February 2013 report raised concerns about what Medicare is paying for (i.e., possible wasteful spending of Medicare dollars for questionable care) and demonstrated that oversight needs to be strengthened to ensure that SNFs perform appropriate care planning and discharge planning. We found that for 37 percent of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Additionally, reviewers found examples of poor quality care related to wound care, medication management, and therapy.

Key OIG Report

Plans for Care and Discharge—Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements. OEI-02-09-00201. *2013 FEB.*

Specific Recommendations

- Strengthen regulations on care planning and discharge planning,
- provide guidance to SNFs to improve care planning and discharge planning,
- increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable,
- link payments to meeting quality of care requirements, and
- follow up on the SNFs that failed to meet care planning and discharge planning requirements and that provided poor quality of care.

10 Nursing homes—Address harm to patients, questionable resident hospitalizations, and inappropriate drug use.

There are many steps that Federal and State agencies can take to prevent harm and ensure appropriate care in nursing homes. A February 2014 report revealed that about 33 percent of Medicare beneficiaries experienced adverse or temporary-harm events during their SNF stays. Fifty-nine percent of the adverse events and temporary-harm events were clearly or likely preventable and resulted, for example, from substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.

A November 2013 report found that nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Rates of Medicare resident hospitalizations varied widely across nursing homes with some States having higher rates of resident hospitalizations than others. A May 2011 report questioned safeguards against unnecessary atypical antipsychotic drugs used for residents of nursing homes. We found that for a 6-month period in 2007, 95 percent of claims for

such drugs were for elderly nursing home residents diagnosed with conditions for which the drugs' use was not approved by FDA or were for residents diagnosed with dementia, the condition specified in a Food and Drug Administration (FDA) warning about such drugs.

Key OIG Reports	Specific Recommendations
Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. *OEI-06-11-00370. 2014 FEB.*	▪ CMS should Include potential events and information about resident harm in its quality guidance to nursing homes and ▪ instruct nursing home surveyors to review facility practices for identifying and reducing adverse events. ▪ AHRQ and CMS should collaborate to create and promote a list of potential nursing home events and ▪ encourage nursing homes to report adverse events to Patient Safety Organizations.
Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring. *OEI-06-11-00040. 2013 NOV.*	▪ CMS should develop a quality measure that describes nursing home rates of resident hospitalization and ▪ instruct State agency surveyors to review nursing home rates of resident hospitalization as part of the survey and certification process.
Drug Utilization—Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents. *OEI-07-08-00150. 2011 MAY.*	▪ CMS should assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes, ▪ explore alternative methods for the survey and certification process to promote compliance with established Federal standards regarding unnecessary drug use in nursing homes, ▪ take appropriate action regarding the claims associated with erroneous payments identified in our sample, and ▪ facilitate access to information necessary to ensure accurate coverage and reimbursement determination.

See also:

- *2013 FEB—OIG Spotlight: Skilled Nursing Facilities.*
- *2011 NOV—Testimony of Daniel R. Levinson, Inspector General, before the U.S. Senate Special Committee on Aging. "Overprescribed: The Human and Taxpayer Costs of Antipsychotics in Nursing Homes." (Testimony.)*
- *2011 MAY—Article by Daniel R. Levinson, Inspector General. "Overmedication of Nursing Home Patients Troubling." (Article.)*

11 Nursing homes—Improve emergency preparedness and response.

Our April 2012 report identified gaps in nursing home preparedness and response. Emergency plans lacked relevant information—including only about half of the tasks on the CMS checklist. Nursing homes faced challenges with unreliable transportation contracts, lack of collaboration with local emergency management, and residents who developed health problems. State long-term-care ombudsmen were often unable to support nursing home residents during disasters; most had no contact with residents until after the disasters.

Key OIG Report

Emergency Preparedness—Gaps Continue To Exist in Nursing Home Preparedness and Response During Disasters. OEI-06-09-00270. 2012 APR.

Specific Recommendations

Recommendations for CMS:

- CMS should revise Federal regulations by identifying and including in its regulations requirements for specific elements of emergency plans and training,
- update the *State Operations Manual* to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training,
- promote use of the emergency preparedness checklists for nursing homes, State long-term-care ombudsman programs and Medicaid State agencies.

Recommendation for the Administration for Community Living (ACL):

- ACL should develop model policies and procedures to protect resident health, safety, welfare, and rights during and after disasters.

See Also:

- *2006 AUG—Nursing Home Emergency Preparedness and Response During Recent Hurricanes. OEI-06-06-00020.*

12 Hospices—Ensure compliance with Medicare Conditions of Participation.

Our August 2013 report confirmed that the frequency of hospice recertification surveys had not improved since 2005. We found that as of February 2013, 17 percent of State-surveyed hospices had not been recertified within the preceding 6 years, with some hospices experiencing longer intervals since their most recent survey. In 12 States, more than 25 percent of hospices had not been recertified within the last 6 years. Such findings raise concerns about whether CMS and contracted State survey agencies can ensure that hospices comply with Medicare Conditions of Participation and quality-of-care

requirements. Therefore, we restated the recommendation from an April 2007 report that CMS set specific timeframes for the frequency of hospice recertification surveys.

Key OIG Reports	Specific Recommendations
Medicare Hospices: Frequency of Medicare Recertification Surveys for Hospices Is Unimproved. OEI-06-13-00130. *2013 AUG.*	▪ Seek legislation or promulgate regulations to set specific timeframes for the frequency of hospice recertification surveys. (This is a followup reiteration of the action recommended in the 2007 report below.)
Medicare Hospices: Certfication and CMS Oversight. OEI-06-05-00260. *2007 APR.*	▪ Seek regulatory or statutory change to establish specific requirements for the frequency of hospice certification.

Medicaid Program Policies and Payments

13 Federal share of Medicaid—Ensure that State claims and practices do not inappropriately inflate Federal reimbursements.

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 permits States to provide enhanced payments that qualify for Federal reimbursement to non-State-owned government providers, such as county or local publicly owned nursing facilities and hospitals. But some States have required such facilities to transfer the funds to the States to be put to other uses, leaving the facilities underfunded. Another example is the misalignment of costs and payments at certain State-operated facilities in New York in which the Medicaid rate grew to the equivalent of $1.5 million per year per Medicaid beneficiary, artificially inflating the Federal share.

Key OIG Report	Specific Recommendations
Payments to Public Providers— Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers. A-03-00-00216.	▪ 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 and ▪ require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments

Key OIG Report	Specific Recommendations
2001 SEP.	and thus be used to offset the Federal share generated by the original payment.

See also:

- *2014 MAR—Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive. A-02-13-01008.*
- *2014 JAN—New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care. A-02-12-01007.*
- *2013 APR—New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers. A-02-11-01006.*
- *2012 SEP—Testimony of John Hagg, Director of Medicaid Audits, before the Subcommittee on Government Organization, Efficiency and Financial Management; and Subcommittee on Health Care, District of Columbia, Census and the National Archives of the House Committee on Oversight and Government Reform. "Medicaid Payment Rates for New York State-Operated Developmental Centers." (Testimony.)*
- *2012 MAY—Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive. A-02-11-01029.*
- *2005 JUN—Office of Inspector General Testimony Before the Senate Committee on Finance. "Financing Mechanisms To Shift the Cost of Medicaid to the Federal Government Contrary to Federal and State Sharing Formulas." (Testimony.)*

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14 Improper payments—Ensure that States prevent, detect, and recover improper payments and return the Federal share of recoveries to the Federal Government.

Medicaid payments for services for which third-parties are liable.

Millions of Medicaid beneficiaries have additional health insurance through third-party sources, such as Medicare, TRICARE, or other payers. If beneficiaries have another source of payment, that source should pay before Medicaid does, up to the extent of its liability. States reported longstanding challenges with third parties when trying to identify insurance coverage and recover payments. In addition, States reported challenges—caused, they say, by laws and regulations—that hinder the recovery of payments.

The Consolidated Appropriations Act, 2014 enacted stronger third-party liability rules for Medicaid, which is likely to have changed the reported estimate of third-party liability overpayments at risk of not being recovered. We will monitor CMS's implementation of the provision.

Key OIG Report	Specific Recommendations
Medicaid Third-Party Liability Savings Increased, But Challenges Remain. *OEI-05-11-00130. 2013 JAN.*	▪ CMS should work with States to address longstanding challenges working with third parties to identify insurance coverage and recover payments. ▪ address States' challenges with 1-year timely filing limits for Medicare and TRICARE, and ▪ strengthen enforcement mechanisms designed to deal with uncooperative third parties.

See also:

- *2001 AUG—Medicaid Recovery of Pharmacy Payments From Liable Third Parties. OEI-03-00-00030*

Personal care services overpayments.

In 2011, Medicaid costs for personal care services (PCS) were about $12.7 billion, a 35-percent increase from 2005. OIG has issued more than 20 reports in recent years about Medicaid PCS payments. We found that improper payments for PCS occurred because the services were not provided in compliance with State requirements, were unsupported by documentation indicating they had been rendered, were provided during periods in which the beneficiaries were in institutional stays reimbursed by Medicare or Medicaid, and/or were provided by PCS attendants who did not meet State qualification requirements.

Key OIG Report	Specific Recommendations
Personal Care Services Portfolio—Trends, Vulnerabilities, and Recommendations for Improvement. OIG 12-12-01. 2012 NOV.	▪ 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, and ▪ 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.

See also:

- *2012 NOV—OIG Spotlight: Personal Care Services Overpayments.*

OIG-identified overpayments.

As of December 2012, CMS had not collected $225.6 million of $1.2 billion in Medicaid overpayments to States that OIG had identified. When CMS concurs with a recommendation to collect overpayments, it may sustain (agree to collect or offset) either the entire amount or a different amount. If the overpaid State agrees in writing with OIG or CMS to refund the overpayment, the State should refund it to the

Federal Government. If the State does not agree, CMS should follow other procedures to resolve the OIG recommendations.

Key OIG Report	Specific Recommendations
Medicaid overpayments—The Centers for Medicare & Medicaid Services Collected the Majority of Medicaid Overpayments but Millions Remain Uncollected. A-05-11-00071. 2013 FEB.	■ Review and address delays in resolving OIG audit recommendations and promptly pursue corrective actions, ■ maintain adequate documentation to support the collection of overpayments in accordance with Office of Management and Budget (OMB) Circular A-50 and CMS Standard Operating Procedures, ■ educate the States about their responsibility to report overpayments on the correct line of the CMS-64 to improve oversight of the reporting process, and ■ collect the remaining $225.6 million we identified as due the Federal Government.

15 Medicaid drug pricing—Assist States to better align drug reimbursements with pharmacy acquisition costs.

OIG has conducted several reviews that explored the relationships between three recognized drug pricing benchmarks—the average wholesale price (AWP), wholesale acquisition costs (WAC), and average manufacturer price (AMP)—and pharmacy invoice prices (acquisition costs) for Medicaid-reimbursed drugs. We concluded that States may be able to better approximate the invoice prices of drugs by developing different reimbursement methodologies for single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs.

Key OIG Reports	Specific Recommendations
Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices. A-06-11-00002. 2011 OCT.	■ 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.
Replacing Average Wholesale Price: Medicaid Drug Payment Policy. OEI-03-11-00060. 2011 JUL.	■ Develop a national benchmark that accurately estimates acquisition costs and encourage States to use it in determining Medicaid reimbursement for prescription drugs.
36Additional Analyses of the Actual Acquisition Cost of	■ Encourage States to adopt a multitiered payment system to bring pharmacy reimbursement more in line with the actual acquisition

Key OIG Reports	Specific Recommendations
Prescription Drug Products. A-06-02-00041. 2002 SEP.	cost of drug products.

16 Ensure that Medicaid Information Systems are fully functional.

Transformed Medicaid Statistical Information System (T-MSIS).

The Medicaid Statistical Information System (MSIS) is Medicaid's only nationwide Medicaid eligibility and claims database. The "transformed MSIS" (T-MSIS) is a continuation of CMS's past attempts to improve the nationally available data. Our September 2013 report raised concerns about States' abilities to submit complete and accurate data to the T-MSIS. Evidence from our review indicates continued problems with completeness, accuracy, and other issues. The early outcomes of volunteer States' efforts to implement T-MSIS may also provide insight into the remaining 39 States' abilities to implement T-MSIS. The data are intended for use in analytical research, program integrity, planning, budgeting, and policy analyses associated with Medicaid. Prior reviews also identified problems with missing or outdated data that made MSIS an inadequate tool for national Medicaid program integrity data analysis strategies.

Key OIG Report	Specific Recommendations
Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System. OEI-05-12-00610. 2013 SEP.	▪ Establish a deadline for when national T-MSIS data will be available, ▪ ensure that States submit required T-MSIS data, and ▪ ensure that T-MSIS data are complete, accurate, and timely upon T-MSIS implementation.

See also:

- *2014 MAR—High-Risk Security Vulnerabilities Identified During Reviews of Information Technology General Controls at State Medicaid Agencies. A-07-14-00433.*
- *2012 JUN— Testimony of Ann Maxwell, Regional Inspector General for Evaluation and Inspections, before the U.S. Senate Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. Saving Taxpayer Dollars by Curbing Waste and Fraud in Medicaid. (Testimony.)*
- *2012 JUN—Testimony of Ann Maxwell, Regional Inspector General for Evaluation and Inspections, before the House Committee on Oversight and Government Reform Subcommittee on Government Organization, Efficiency and Financial Management. (Testimony.)*
- *2012 APR—The Medicare-Medicaid (Medi-Medi) Data Match Program. OEI-09-08-00370.*

- *2012 MAR— Early Assessment of Audit Medicaid Integrity Contractors. OEI-05-10-00210.*
- *2012 FEB—Medicaid. Early Assessment of Review Medicaid Integrity Contractors. OEI-05-10-00200.*
- *2009 AUG—MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse, OEI-04-07-00240.*

Medicaid managed care encounter data.

Encounter data are the primary records of Medicaid services provided to beneficiaries enrolled in capitated Medicaid managed care. At the time of our review, CMS had no graduated sanctions or penalties against States that do not fully comply with MSIS reporting requirements. The absence of encounter data from States with Medicaid managed care limits the usefulness of the MSIS. The implementation of T-MSIS may not address the underlying problems causing the lack of encounter data reported to MSIS.

Section 6402(c) of the Patient Protection and Affordable Care Act (Affordable Care Act) authorizes the Secretary to withhold the Federal matching payment for States that fail to report enrollee encounter data in the MSIS. We are monitoring CMS's efforts in the implementation of its actions and promulgation of Federal regulations regarding section 6402(c).

Key OIG Report	Specific Recommendation
Medicaid Managed Care Encounter Data: Collection and Use. OEI-07-06-00540. 2009 MAY.	▪ Enforce existing Federal requirements that States include encounter data in MSIS submissions.

17 Address Medicaid managed care fraud and abuse concerns.

As of June 2009, 72 percent of all Medicaid beneficiaries were enrolled in managed care. We asked Medicaid managed care entities (MCEs), States, and CMS to identify their major concerns regarding fraud and abuse. The primary concern centered on providers billing for services not rendered. Other concerns included providers rendering services that are not medically necessary and billing for higher levels of services than were provided (upcoding); questionable beneficiary eligibility; and prescription drug abuse by beneficiaries.

In addition to their fee-for-service programs, States may contract with different types of MCEs[2] to provide health care services on a statewide or a community basis. Managed care's capitated payments create incentives for providers to render fewer services to beneficiaries and States must bear financial risk that could threaten the viability of their Medicaid managed care programs.

[2] Two types of MCEs are subject to specific Federal program integrity requirements: Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).

Key OIG Report	Specific Recommendations
Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards. OEI-01-09-00550. 2011 DEC.	■ Require that State contracts with MCEs include methods to verify with beneficiaries whether services billed by providers were received and ■ update guidance to reflect concerns expressed by MCEs and States.

Medicaid Quality of Care and Safety Issues

18 Medicaid home- and community-based care settings—Ensure that service providers comply with quality and safety requirements.

Quality of care assurances associated with waiver programs.

States are now providing more care in homes and other community-based settings. States most often provide this care through home and community-based services (HCBS) waiver programs. (Social Security Act, § 1915(c).) In fiscal year (FY) 2010, Medicaid expenditures for HCBS waiver programs were estimated at $8.9 billion. In June 2012, we reported that 7 of 25 States we reviewed did not have adequate systems to ensure the quality of care provided to beneficiaries. Also, CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care. In December 2012, we reported that assisted living facilities in 7 selected States did not always comply with federally mandated standards and patient plans of care did not always meet requirements. CMS is responsible for determining whether State Medicaid programs comply with the Federal requirements for covering HCBS under section 1915(c) waivers.

Key OIG Reports	Specific Recommendations
Medicaid—Oversight of Quality of Care in Medicaid Home- and Community-Based Services Waiver Programs. OEI-02-08-00170. 2012 JUN.	■ Provide additional guidance to states to help ensure that they meet the assurances, ■ require states that do not meet one or more assurances to develop corrective action plans, ■ require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits, and ■ make information about state compliance with the assurances

Key OIG Reports	Specific Recommendations
	available to the public.
Home and Community-Based Services in Assisted Living Facilities. OEI-09-08-00360. 2012 DEC.	▪ Issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under section 1915(c) waivers.

Personal care services—Attendant qualifications and supervision.

A November 2012 OIG Portfolio summarized our body of work pertaining to PCS. With regard to quality of care and beneficiary safety, our work demonstrated that existing program safeguards intended to ensure medical necessity, patient safety, and quality were often ineffective. We found inconsistent standards for, and monitoring of, the qualifications of PCS attendants and problematic billing practices (e.g., claims that lack details regarding dates of service and/or the identity of the PCS attendants providing services). 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.

Key OIG Report	Specific Recommendations
Medicaid—Personal Care Services Portfolio—Trends, Vulnerabilities, and Recommendations for Improvement. OIG 12-12-01. 2012 NOV.	▪ Establish minimum Federal PCS attendant qualification standards applicable to all PCS reimbursed by Medicaid, ▪ require States to either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier, ▪ require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants, and ▪ issue operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.

19 Prevention—Ensure that States improve utilization of preventive screening services for eligible children.

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. Services are intended to screen, diagnose, and treat children eligible for EPSDT services at early, regular intervals to avoid or minimize childhood illness. Our review focused on medical, vision, and hearing screenings.

We found that very few children received the correct number of complete medical screenings or the correct number of vision and hearing screenings. 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 had the desired effect. The disconnect between States' efforts to improve the EPSDT program and the low number of children receiving required screenings is difficult to account for, but indicates that additional efforts are needed.

Key OIG Report

Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services. *OEI-05-08-00520. 2010 MAY.*

Specific Recommendations

- CMS should require States to report vision and hearing screenings,
- collaborate with States and providers to develop effective strategies to encourage beneficiary participation in screenings,
- collaborate with States and providers to develop education and incentives for providers to encourage complete medical screenings, and
- identify and disseminate promising State practices for increasing children's participation in screenings and providers' delivery of complete medical screenings.

Oversight of Food Safety

20 Improve oversight of dietary supplements

Under Federal law, FDA does not test or approve dietary supplements prior to sale. The first of two October 2012 reports demonstrated the extent to which supplement manufacturers' substantiation of their claims about the structure and function of the supplements fell short of meeting FDA's recommendations for competent and reliable evidence and revealed problems with FDA's notification process. The second report revealed that 28 percent of contacted companies had facilities that failed to register with FDA, as required. Of those that did register, 72 percent failed to provide all the information required, raising questions about FDA's ability to identify and contact manufacturers in an emergency.

Key OIG Report	Specific Recommendations
Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements. *OEI-01-11-00210. 2012 OCT.*	■ FDA should seek statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading, ■ improve the notification system to make it more organized, complete, and accurate, and ■ expand market surveillance of dietary supplements to enforce the use of disclaimers for structure/function claims and detect disease claims.
Dietary Supplements: Companies May Be Difficult To Locate in an Emergency. *OEI-01-11-00211. 2012 OCT.*	■ FDA should improve the accuracy of the information in its Food Facility Registry, ■ seek statutory authority to impose civil monetary penalties on companies that do not comply with registration requirements, and ■ educate the dietary supplement industry about registration and labeling requirements.

21 Improve oversight of food inspections and traceability.

State and FDA inspections of food facilities.

In addition to conducting its own inspections of food facilities, FDA relies on State agencies to conduct inspections on its behalf; however, in recent years, concerns have been raised about the rigor of these State inspections. We found instances in which FDA failed to ensure that the required number of inspections was completed; it paid for many inspections that were incomplete; it did not ensure that all State inspections were properly classified and that all violations were remedied; it failed to complete the required number of audits for one-third of the States; and it did not always follow up on systemic problems identified.

In a review of FDA's own inspections, we found that for 54 percent of violations designated as official action indicated (OAI), FDA either lowered the classification or took no action. FDA did not reinspect 36 percent of OAI facilities within a year. Nor did FDA review evidence of corrective action.

Key OIG Reports	Specific Recommendations
Food Safety—Vulnerabilities In FDA's Oversight of State Food Facility Inspections.	■ FDA should ensure that all contract inspections are completed, properly documented, and appropriately paid for;

Key OIG Reports	Specific Recommendations
OEI-02-09-00430. 2011 DEC.	■ ensure that contract inspections are properly classified in accordance with FDA guidance; ■ ensure that all inspection violations are remedied by routinely tracking all actions taken to correct violations; ■ ensure that the minimum audit rate is met in all States; and ■ address any systemic problems identified by audits.
Food Safety—FDA Inspections of Domestic Food Facilities. OEI-02-08-00080. 2010 APR.	■ FDA should provide additional guidance about when it is appropriate to lower OAI classifications; ■ take appropriate actions against facilities with OAI classifications; ■ ensure that violations are corrected for all facilities that receive OAI classifications, particularly those that have histories of violations; and ■ consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily comply with statutory and regulatory requirements.

See Also:

- *2010 May—Testimony of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations. " FDA's Role in Protecting the Nation's Food Supply." (Testimony)*

Traceability in the food supply chain.

In a food emergency, information about traceability of food products and the ability of food facilities to provide information about their sources, recipients, and transporters allows FDA to identify the source of contamination and help remove unsafe food products from retail shelves. In a March 2009 report, our findings included that 59 percent of the food facilities in our traceability exercise did not meet FDA's requirements to maintain records about their sources, recipients, and transporters. We also found that one-quarter of the food facilities were not aware of FDA's records requirements, whereas others highlighted practices designed to improve traceability.

A December 2009 report examined whether selected facilities registered with FDA as required and whether information in FDA's registry was complete and accurate. We found that while most facilities registered, almost half did not provide accurate information and certain useful information that is optional. Over half the facilities were unaware of FDA's registry requirements.

Key OIG Reports	Specific Recommendations
Food Safety—Traceability in the Food Supply Chain. *OEI-02-06-00210. 2009 MAR.*	▪ FDA should address issues related to mixing raw food products from a large number of farms, ▪ seek statutory authority to conduct activities to ensure that facilities are complying with records requirements, ▪ conduct education and outreach activities to inform the food industry about records requirements, and ▪ work with the food industry to develop additional guidance to strengthen traceability.
Food Safety—FDA's Food Facility Registry. *OEI-02-08-00060. 2009 DEC.*	▪ FDA should consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not comply with the registry requirements and ▪ work with the food industry to increase facilities' awareness of the registry requirements.

See also:

- *2009 MAR—Testimony of Daniel R. Levinson, Inspector General before the House Committee on Appropriations Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies. Traceability of the Food Supply. (Testimony.)*

HHS Grants and Contracts

22 Grants—Improve oversight of grantee compliance, quality assurance, and conflicts of interest.

In FY 2012, the Department of Health and Human Services (HHS) awarded 81,000 grants for a combined $347 billion. Of these, about 80,000, totaling about $90 billion, were for programs other than Medicare and Medicaid. In addition to ongoing grant programs, there are a number of time-limited special purpose grant programs and some, such as the Recovery Act grants, that also supplement ongoing programs. The following are priority reports with open recommendations for corrective action that represent significant immediate opportunities to improve grant management and performance at HHS.

ACF grantee health and safety standards and requirements for participation.

The Administration for Children and Families (ACF) administers the Child Care and Development Fund (CCDF) grant program, which provides financial assistance with child care for approximately 1.6 million children each month. In November 2013, we reported that States' monitoring requirements did not always meet ACF's recommendations for background screenings or the recommended standards for

unannounced inspections. In some States, monitoring of licensed providers was not conducted in accordance with the States' own requirements. Moreover, ACF did little to monitor how States were overseeing CCDF providers. Similarly, in December 2011, we reported that of the 24 Head Start program 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.

Key OIG Reports	Specific Recommendations
Child Care and Development Fund. Monitoring of Licensed Child Care Providers. OEI-07-10-00230. 2013 NOV.	■ ACF should seek authority to develop health and safety standards and to ensure that States' requirements meet them, ■ develop requirements for States to conduct mandatory background screenings, ■ develop requirements for States to conduct periodic unannounced inspections, ■ conduct periodic reviews of States' compliance with their own requirements related to minimum health and safety standards [applicable to licensed child care providers], and ■ ensure that State plans comply with health and safety requirements and take action when States do not comply.
Head Start—Review of 24 Head Start Grantees' Compliance With Health and Safety Requirements. A-01-11-02503. 2011 DEC.	■ ACF should ensure through onsite monitoring that Head Start grantees comply with health and safety regulations; ■ perform an analysis to determine whether HHS should seek a legislative amendment of Federal health and safety requirements that would require periodic background checks for all Head Start employees; and ■ 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.

See Also:

- *2011 DEC—OIG Spotlight: Head Start Health and Safety.*
- *2011 NOV—Review of 83 Early Head Start Applicants Under the American Recovery and Reinvestment Act. A-01-10-02501.*

HRSA grantee quality assurance programs.

Health centers funded by Health Resources and Services Administration (HRSA) grants provide care to patients in medically underserved urban or rural areas or in medically underserved populations. Improving quality assessments and documentation requirements would help ensure the value of the services received. In March 2012, we reported that almost all health centers we reviewed had quality assurance programs, and health services were appropriate for most health center patients. However, insufficient documentation prevented detailed assessments of some medical records. HRSA's oversight and review activities provided only limited information about the extent to which individual health center patients received required primary health services. Although HRSA's requirements specify which services health centers must make available to patients, they do not establish specific quality standards for the services.

Key OIG Report	Specific Recommendations
Health Centers—Quality Assurance and Care Provided at HRSA-Funded Health Centers. OEI-09-06-00420. *2012 MAR.*	▪ HRSA should provide more specific guidance about what health center grantees should address in their quality assurance programs and how they should conduct their periodic assessments, ▪ provide more specific guidance concerning what information is required in patient records at health centers, ▪ provide more specificity about the required primary health services, and ▪ establish procedures to independently assess patients' receipt of primary health services and the adequacy of patients' records.

NIH grantee conflicts of interest.

Grantee institutions consist of universities, medical schools, and other research institutions (e.g., private or nonprofit research organizations) receiving research grants from the National Institutes of Health (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. Currently, no Federal regulations require grantee institutions to identify and report institutional conflicts to NIH. Therefore, NIH lacks information on the number of institutional conflicts that exist among its grantee institutions and the impact these conflicts may have on NIH-sponsored research. Our January 2011 report encourages NIH to ensure that related research is free from any intended or unintended bias.

With regard to researchers' financial interests, a November 2009 report revealed that the most common type of financial conflict of interest among NIH-funded researchers is equity ownership (including stock and stock options) in companies in which the researchers' financial interests could significantly affect the grant research. Other conflicts involved researchers inventing technology, consulting, or holding positions with outside companies. Our recommendations are to NIH.

Key OIG Reports	Specific Recommendations
Institutional Conflicts of Interest at NIH Grantees. OEI-03-09-00480. 2011 JAN.	■ NIH should promulgate regulations that address institutional financial conflicts of interest.
Review of How Grantees Manage Financial Conflicts of Interest in Research Funded by the National Institutes of Health. OEI-03-07-00700. 2009 NOV.	■ NIH should develop and disseminate guidance on methods to verify researchers' financial interests, ■ ensure that grantee institutions are providing adequate oversight of subgrantee compliance with Federal financial conflicts of interest regulations, ■ ensure that grantee institutions are maintaining proper documentation as outlined in the Federal financial conflict of interest regulations, ■ ensure that grantee institutions take appropriate actions against researchers who do not follow grantee institutions' financial conflict-of-interest policies and procedures, and ■ develop regulations that address institutional financial conflicts of interest.

23 Contracts—Improve oversight of Medicare contractor performance and conflicts of interest.

CMS relies on contractors to administer the Medicare program and is responsible for overseeing the contractors' performance. Medicare contractors are responsible for administering more than a half-trillion dollars in benefits each year. MACs process Parts A and B claims; Medicare Advantage (MA) plans provide managed care services under Part C; Part D plans provide prescription drug coverage under Part D; and various benefit integrity contractors serve to protect Medicare from fraud, waste, and abuse.

Medicare contractor performance.

Regardless of the types of Medicare contractors, there are common issues that limit CMS's oversight of their performance. CMS has not leveraged contractor-reported data to improve oversight; has not investigated variation in data across contractors to determine underlying causes, especially when it is not explained by the size or geographical jurisdiction of contractors; has not addressed underperforming contractors timely and required corrective actions for all performance standards that were not met; and has not shared information with beneficiaries and other stakeholders that could assist antifraud efforts.

Key OIG Reports	Specific Recommendations
Part A and Part B. Medicare Administrative Contractors' Performance. *OEI-03-11-00740. 2014 JAN.*	■ CMS should seek a legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements, ■ require action plans for all unmet quality assurance standards, ■ 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, ■ meet timeframes for completing draft and final quality assurance summary reports, ■ meet timeframes for completing award fee determinations, and ■ establish reasonable timeframes for issuing final contractor performance reports.
Part A and Part B. Over Four Million Medicare Summary Notices Mailed to Beneficiaries Were Not Delivered in 2012. *OEI-03-12-00600. 2014 JAN.*	■ CMS should provide guidance to claims processors about handling [for program integrity purposes] Medicare Summary Notices (MSNs) that are returned as undeliverable and ■ ensure that the address information used by claims processors to print addresses on MSNs is complete and properly formatted.
Part A and Part B. Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance. *OEI-04-11-00680. 2013 SEP.*	■ CMS should take action, as appropriate, on vulnerabilities that are pending corrective action and evaluate the effectiveness of implemented corrective actions, ■ ensure that Recovery Audit Contractors (RACs) refer all appropriate cases of potential fraud, ■ review and take appropriate, timely action on RAC referrals of potential fraud, and ■ develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on contract requirements.
Part A and Part B. Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight.	■ CMS should clarify the workload definitions in the CMS Analysis, Reporting, and Tracking System (CMS ARTS) to ensure that ZPICs' workload statistics are accurate and that ZPICs report their data

Key OIG Reports	Specific Recommendations
OEI-03-09-00520. 2011 NOV.	uniformly, ▪ utilize and report Zone Program Integrity Contractors' (ZPICs') workload statistics in ZPIC evaluations, and ▪ ensure that ZPICs have access to all data necessary to effectively carry out their program integrity activities.
Part C. CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited. *OEI-03-11-00720. 2014 MAR.*	▪ CMS should 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, and ▪ establish a timeline for releasing public use files for Part C reporting requirements data.
Part D. Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse. *OEI-03-13-00030. 2014 MAR.*	▪ CMS should 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; and ▪ share sponsors' data on potential fraud and abuse with all sponsors and law enforcement.

See Also:

- *2014 MAR— Testimony of Robert A. Vito, Regional Inspector General for Evaluation and Inspections, before the House Committee on Energy and Commerce Subcommittee on Health. "How Better Managing Medicare Can Protect Seniors." (Testimony.)*
- *2012 JUN—Testimony of Robert A. Vito, Regional Inspector General for Evaluation and Inspections, before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce. "Medicare Contractors' Efforts To Fight Fraud." (Testimony.)*

Medicare contractor conflicts of interest.

With regard to ZPICs, CMS does not have a written policy for reviewing conflict and financial interest information submitted by offerors. We found that the submitted information was not always consistent or complete. Some offerors and subcontractors failed to provide all the requisite information regarding financial interests in other entities. With regard to Part D, conflicts of interest could result in inappropriately higher costs. Sponsors' Pharmacy and Therapeutics (P&T) committees make prescription drug coverage decisions on the basis of scientific evidence and standards of practice. Such decisions affect beneficiaries' access to specific prescription drugs and the cost of drugs to beneficiaries and the Federal Government.

Key OIG Report	Specific Recommendations
Medicare Part A and Part B. Conflicts and Financial Relationships Among Potential Zone Program Integrity Contractors. OEI-03-10-00300. 2012 JUL.	■ CMS should 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; ■ 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; ■ 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; ■ create a standardized format for reporting information in the organizational conflict-of-interest certificate and require its use by offerors and subcontractors; and ■ develop a formal, written policy outlining how organization conflict-of-interest certificates are to be reviewed by CMS.
Medicare Part D. Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions. OEI-05-10-00450. 2013 MAR.	■ CMS should define Pharmacy Benefit Managers (PBM) as entities that could benefit from formulary decisions. ■ establish minimum standards requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the P&T committee, ■ establish minimum standards requiring sponsors to ensure that an objective process is used to determine whether disclosed financial interests are conflicts .

Key OIG Report	Specific Recommendations
	■ establish minimum standards requiring sponsors to ensure that an objective process is used to manage recusals due to conflicts of interest and ■ oversee compliance with P&T committee conflict-of-interest requirements and guidance

HHS Financial Stewardship

24 Reduce improper payments and fraud.

An improper payment is one that should not have been made or that was made in an incorrect amount (either an overpayment or an underpayment). While most improper payments are caused by error, some are caused by fraud or other abusive billing practices. To improve accountability of Federal agencies' administration of funds, the Improper Payments Information Act of 2002 (IPIA) requires agencies to annually report to the President and Congress on the agencies' improper payments. CMS established the Comprehensive Error Rate Testing (CERT) program to produce a national Medicare fee-for-service (FFS) error rate. To reduce Medicare's error rate, CMS requires claims administration contractors to submit error rate reduction plans.

We note that regarding the Children's Health Insurance Program (CHIP) recommendations below, HHS said that HHS received State-specific corrective action plans (CAPs) from all States whose CHIP programs were measured and reported in FY 2012 as a part of calculating the error rate for FY 2013, and all States measured in FY 2013 are in the process of developing their CAPs for submission to HHS.

Key OIG Reports	Specific Recommendations
U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Was Not Fully Compliant. A-17-13-52000. 2013 MAR.	■ Assess the need for additional actions to meet improper payment rate reduction targets, ■ develop and report improper payment rate reduction targets and corrective actions plans for the Children's Health Insurance Program (CHIP), ■ ensure that amounts used in computations for reporting overpayments recaptured are accurate and complete, and ■ ensure that data are retained in accordance with program requirements.
Part A and Part B. Medicare	■ CMS should review the process for overseeing contractors' error

Key OIG Reports	Specific Recommendations
Claims Administrative Contractors' Error Rate Reduction Plans. *OEI-09-12-00090. 2014 JAN.*	rate reduction, ■ ensure that contractors submit clear plans for reducing their error rates, ■ provide additional guidance for contractors and CMS staff who review plans, and ■ provide error rate reduction incentives that are aligned with the contracts' error rates and performance periods.

See also:

- *2012 JUL—U.S. Department of Health and Human Services Did Not Fully Comply With Executive Order 13520 When Reporting Fiscal Year 2010 High-Dollar Improper Payments. A-02-11-01007.*
- *2012 MAR—U.S. Department of Health and Human Services Did Not Fully Comply With Federal Requirements for Reporting Improper Payments A-17-12-52000.*
- *2012 MAR—Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010. A-01-11-00504.*
- *2011 JUL—Testimony of Daniel R. Levinson, Inspector General, before the House of Representatives, Committee on Oversight and Government Reform, Subcommittee on Government Organization Efficiency and Financial Management. "Improper Medicare Payments." (Testimony.)*
- *2011 JUL—Testimony of Lewis Morris, Chief Counsel to the Inspector General, before the United States Senate Committee on Homeland Security & Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. "Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs." (Testimony.)*
- *2011 MAR—Testimony of Daniel R. Levinson, Inspector General (PDF), before the United States House of Representatives Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. "Improper Payments." (Testimony.)*
- *2011 MAR—Testimony of Daniel R. Levinson, Inspector General (PDF), before the United States Senate Committee on Finance. "Preventing Health Care Fraud: New Tools and Approaches to Combat Old Challenges." (Testimony.)*

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25 Correct deficiencies found in financial statement audits

HHS's financial management systems.

The Chief Financial Officers Act of 1990, as amended, (CFO Act) requires OIG or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards. We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to conduct the audit.

The FY 2013 financial statement audit noted that HHS continued to make strides to improve controls within the Information Technology infrastructure that supports the financial application system. HHS continued to address and implement the existing governance, financial process and practices, and system tools needed to enhance controls over application information security and contingency planning. The audit noted a focused effort is still needed to more completely remediate long outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, change management, and access to HHS financial systems. The FY 2013 financial statement audit also noted internal control weaknesses in financial systems and processes, including the lack of integrated financial management systems and insufficient analysis of certain accounts that impaired the abilities of HHS and its operating divisions to adequately support and analyze account balances in a timely fashion. HHS's financial management systems still did not substantially comply with Federal financial management systems requirements.

Key OIG Report	Specific Recommendations
Department Health and Human Services Fiscal Year 2013 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 2013 . (pp. 43, 44, 53, 56, 57, and 63.) *A-17-13-00001. 2013 DEC.*	▪ HHS should continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity and ▪ continue to focus on remediating the remaining financial management system deficiencies.

CMS's financial reporting and related processes and Medicare information systems controls.

Financial reporting. CMS relies on a decentralized organizational structure and complex financial management systems—not only within its central office and regional offices' processes, but also within many of the Medicare contractor organizations—to accumulate data for its financial reporting. Most recommendations were carried forward from past years. During FY 2013, CMS continued to improve its financial management performance in many areas and continues to focus its efforts to address the remaining significant deficiencies.

Systems Controls. CMS's information systems controls were considered a significant deficiency in the FY 2013 financial statement audit because CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights, and mitigating the potential impact on adequate segregation of duties. Also, there was inconsistent implementation planning and execution of CMS's overall directives and guidance over information security controls across the CMS enterprise, including the Medicare claims processing contractors.

Key OIG Report	Specific Recommendations
CMS Financial Report, Fiscal Year 2013. Audit Opinion Section. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2013, pp. 109, 127, 134-135. A-17-13-02013. 2013 DEC. (p. 108)	Improve CMS's financial reporting and related processes. ■ CMS should continuously monitor the State Medicaid draws and improve grant oversight activities to ensure that States deposit the funds back after a deferral is issued 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; and ■ Continue to adhere to established policies and procedures to ensure that the statement of social insurance (SOSI) model methodology, related calculations and estimates are consistently documented. Improve Medicare information systems controls. ■ CMS should 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; and

Key OIG Report	Specific Recommendations
	ensure that appropriate segregation of duties is established for all systems that support CMS's programs, including Medicare fee-for-service claims and related financial processing at claims processing contractors and enterprise data centers to prevent excessive or inappropriate access.