Department of Health and Human Services

FY 2020 Good Accounting Obligation in Government Act Report

May 2021

Executive Summary

The Good Accounting Obligation in Government Act (GAO-IG Act or "the Act"; Public Law 115-414) requires each agency to include, in its annual budget justification, a report that identifies each public recommendation issued by the Government Accountability Office (GAO) and federal Offices of Inspectors General (OIG), which has remained unimplemented for one year or more as of the annual budget justification submission date. In compliance with this law, the Department of Health and Human Services (HHS) developed this report listing the 753 GAO and the HHS OIG public recommendations that have been open for more than one year as of September 30, 2020. Additionally, this report identifies the 214 closed, unimplemented recommendations with which HHS did not concur or did not implement due to legislative or budgetary constraints.

Background

Congress enacted the GAO-IG Act to enhance transparency into open and unimplemented public recommendations issued by the GAO and agencies' OIG. In addition to reporting on over a year-old unimplemented public recommendations, the Act requires a reconciliation between the agency records and the OIG's Semiannual Report to Congress (SAR report). HHS uses September 30, 2020 as the cutoff date for the annual report to determine which recommendations to include and the current status as these are constantly changing. If necessary, we will revisit this date in future reports.

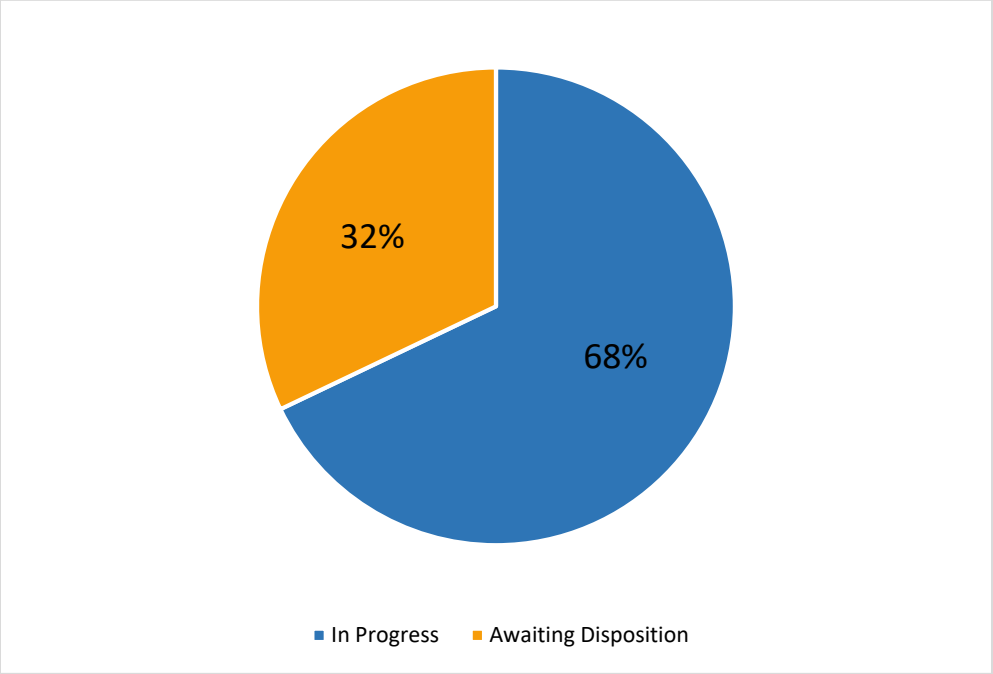
As of September 30, 2020, HHS recognizes a total of 753 public recommendations that have been open for more than one year, i.e., issued on or before September 30, 2019. Consequently, no COVID-19 related recommendations are included. Of the 753 open recommendations,

- GAO issued 299 during the period July 12, 2002 through September 30, 2019.
  The GAO online database shows the same number of open recommendations for this time period.
- HHS OIG issued 454 during the period September 11, 2001 through September 30, 2019.
  The HHS OIG Fall 2020 SAR lists 486 open recommendations for this time period; this variance in recommendation totals (32) is explained by a) combined duplicative recommendations to multiple Operating Division (OpDivs)/Staff Divisions (StaffDivs), and b) recommendations assigned to the Centers for Medicare & Medicaid Services (CMS) and the Administration for Children and Families (ACF) that were actually issued to specific States or grantees and thus are not included in the HHS counts.

For recommendations with which HHS concurred, this report provides timelines for full implementation of the planned corrective actions, as well as updates and constraints as of December 2020 for the recommendations in Appendix 1: *OIG-GAO Open Recommendations.* These recommendations are considered to be "In Progress." For recommendations that HHS believes have been implemented, but the auditor lists as open, this report indicates the status as "Awaiting Disposition," as these recommendations are pending auditor validation and close out. For recommendations with which HHS did not concur or did not implement due to legislative or budgetary constraints, this report identifies the reasons for the "Closed, Unimplemented" status in Appendix 2: *OIG-GAO Closed, Unimplemented Recommendations*.

The Department has made a good faith effort to implement these recommendations. In many cases, HHS determined the required action to be complete and the auditors should close the recommendation. Of the 753 open recommendations, about two thirds are "In Progress." The remaining third are "Awaiting Disposition" by the auditors, and many could be closed and removed from future reports when the auditors complete the review of HHS-provided information and updates.

Implementation Status of All GAO and OIG Public Recommendations



In accordance with OMB Circular A-50, "Audit Follow Up", HHS is committed to preparing prompt, responsive, and constructive corrective actions in response to OIG and GAO audit report findings and recommendations. HHS considers audit recommendation follow-up to be an integral part of sound stewardship and there has been an increased effort dedicated to closing OIG and GAO recommendations at several OpDivs and StaffDivs. As a result, HHS closed a total of 422 recommendations that were over a year old in FY20. The following table presents the changes in recommendation counts since last year's report.

Number of Recommendations by OpDiv/StaffDiv

OpDiv	Open at end-of-FY19	Added in FY20	Closed in FY20	Open at end-of-FY20
CMS	659	125	333*	451
FDA	72	16	26	62
IHS	33	27	4	56
OCIO	15	26	4	37
ACF	20	17	8	29
NIH	23	8	6	25
CDC	47	0	24	23
ASFR	17	6	1	22
All other**	41	24	16	48
HHS Total	927	249	422	753

*Includes recommendations that are actually specific states and grantees responsibility and thus considered closed for HHS.
**Includes all OpDivs/StaffDivs with less than 20 open recommendations at the end of FY20.

GAO and OIG also identify top issues and recommendations (known as Priority Recommendations or Top Unimplemented Recommendations)[1] that they believe could help to significantly improve HHS's program operations. In Appendix 1, provides the 185 GAO Priority Recommendations or OIG Top Unimplemented Recommendations among the open recommendations; of those 185 recommendations, 37 are awaiting disposition and the remaining 148 are in progress.

[1] GAO publishes an annual report highlighting priority open recommendations for HHS. The 2020 Priority Open Recommendations Report can be found here: GAO-20-552PR. The HHS OIG publishes an annual report identifying top unimplemented recommendations. The 2020 report can be found here: OIG's Top Unimplemented Recommendations: Solutions to Reduce Fraud, Waste, and Abuse in HHS Programs.

Appendix 1: OIG-GAO Open Recommendations

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
ACF	OEI-07-13-00460	Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings	2/27/2015	399-915-11-03-04443	Expand the scope of the Child and Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans	TBD	2020	In Progress	As of October 2020, the CFSR team continues to work on revisions for round 4 of the CFSR. We do not anticipate releasing decisions until the 3rd quarter of FY 21.
ACF	GAO-15-368	Regulatory Guidance Processes: Selected Departments Could Strengthen Internal Control and Dissemination Practices	5/18/2015	9	To improve agencies' guidance development, review, evaluation, and dissemination processes for non-significant guidance, we recommend that the Secretaries of USDA, HHS, DOL, and Education should improve the usability of selected component websites to ensure that the public can easily find, access, and comment on online guidance. These improvements could be informed by the web and customer satisfaction metrics that components have collected on their websites. Some examples of changes that could facilitate public access to online guidance	Concur	2020	In Progress	ACF developed "ACF Policy for Clearance of Guidance Documents" . We have shared our updates with OIG/GAO and are waiting for them to close the finding.

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					include (1) improving website usability by clarifying which links contain guidance; (2) highlighting new or important guidance; and (3) ensuring that posted guidance is current.				

ACF	GAO-15-521	Unaccompanied Alien Children: Actions Needed to Ensure that Children Receive Required Care in DHS Custody	7/14/2015	12	To increase the efficiency and improve the accuracy of the interagency UAC referral and placement process, the Secretaries of Homeland Security and Health and Human Services should jointly develop and implement a documented interagency process with clearly defined roles and responsibilities, as well as procedures to disseminate placement decisions, for all agencies involved in the referral and placement of UAC in HHS shelters.	Concur	2019	In Progress	ORR provided written responses to two GAO questions below on 1/16/20: 1. Has ORR coordinated with DHS officials to clarify information sharing details (such as the type of information shared, specific documents, mechanisms to facilitate information sharing, or timing of information sharing, etc.) or more fully implement the expectations laid out in the July 2018 Joint Concept of Operations? If so, please describe any discussions, decisions or agreed upon actions. ORR, ICE, and CBP discussed facilitating the sharing of certain placement documents and information that may indicate a child is a danger to the community in April – June of 2018 as part of discussions to implement the 2018 Information Sharing MOA. Additionally, ORR Representatives had working arrangements with ICE/OPLA offices in order to share information relevant for Flores Bond Hearings in Immigration Court. 2. Are there any planned updates or revisions to the language in the Joint Concept of Operations? If so, please provide the timing of any planned updates and any available supporting documentation. ORR intends to reach out to counterparts at DHS Policy in June 2020 to discuss potential periodic updates to the JCO. Updated October 16, 2020: DHS's

									Customs and Border Patrol (CBP) and Immigration and Customs' Enforcement's (ICE) began sending UAC referrals electronically through the UAC Portal, respectively in May of 2015 and late 2014 . ORR is updating its electronic UAC case management (the UAC Portal), and creating a new system, the UAC Path, which will incorporate the current system's functionality as well as additional enhancements. The new system's launch is scheduled for January 2021. The ORR team responsible for developing the UAC Path is also participating in an interagency effort to develop a Unified Immigration Portal (UIP). The UIP, which Congress has allocated funds to develop, is a technical solution that will connect relevant data from multiple agencies to enable a more complete understanding of an individual's journey through the immigration process. Interagency discussion regarding the UIP that involve DHS components, the U.S. Department of Justice, and HHS are currently in progress. The UIP working group will coordinate all interagency agreements, as necessary, to memorialize data sharing. For instance, by connecting the UAC Path to the UIP, ORR foresees that it will be able to retrieve data regarding a child's separation status in a more

									automated manner. The UIP working group has aligned development work with HHS's work on the UAC Path in an effort to accelerate data-sharing between DHS and HHS, while safeguarding privileged or sensitive information. The initial focus is on automating the UAC placement process so that relevant information can be shared in real-time between agencies. Finally, the UIP is anticipated to include a UAC Coordination Dashboard to help HHS users anticipate resource demands by providing new real-time access to key metric for UAC placement. ORR continues to meet on an ongoing basis with its DHS counterparts at the operational level to troubleshoot and resolve procedural issues related to UAC processing and transfer of custody. ORR intends to collaborate with DHS on whether updates are needed to the Joint Concept of Operations (JCO), as this is an ongoing, living document.
ACF	A-06-14-00036	Teaching & Mentoring Communiti	12/22/2015	024-009-01-1	We recommend that TMC refund to the Federal Government $616,898 for	Concur	2016	In Progress	The grantee, TMC, has taken steps to address this finding by ending its previous practice of applying a multiplier of greater than 1 in

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		es Claimed Unallowable Head Start Costs			health insurance costs that were overcharged				calculating its health insurance cost. ACF also disallowed the $616,898 and the collection was established with the PSC."
ACF	A-06-14-00036	Teaching & Mentoring Communities Claimed Unallowable Head Start Costs	12/22/2015	024-919-10-1	We recommend that TMC develop and implement procedures to review and pay the actual costs of fringe benefits.	Concur	2016	In Progress	"TMC concurs with this finding" and that "TMC wishes to stress that it has taken what it believes to be appropriate steps to ensure against the recurrence of such improper charges to its federal awards. TMC has long-since ceased its previous practice of applying a multiplier of greater than 1 in calculating its health insurance costs. As of the end of the period audited by OIG, the amounts that TMC has paid for health insurance out of Head Start dollars have been no more than the total cost of insurance (less total employee contributions). In addition, TMC has eliminated the separate account for health insurance in its book of accounts and is in the process of closing down all bank accounts except the general and payroll accounts. TMC believes that this will enhance transparency and minimize the potential for confusion over which funds are restricted and which are not." In summary, we believe the corrective actions planned or taken should prevent recurrence of this finding in the future.

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ACF	GAO-16-180	Unaccompanied Children: HHS Can Take Further Actions to Monitor Their Care	2/22/2016	3	The Secretary of the Department of Health and Human Services should direct the Office of Refugee Resettlement to develop a process to ensure all information collected through its existing post-release efforts are reliable and systematically collected so that they can be compiled in summary form and provide useful information to other entities internally and externally.	Concur	2019	In Progress	ORR provided update to GAO below on 7/14/20.In March 2016, ORR added a new section to the ORR Policy Guide requiring that safety and well-being (SWB) follow-up calls be made to children and their sponsors after the child is release from ORR custody. ORR collects and analyzes data from SWB follow-up calls on a monthly and quarterly basis. The data tracked includes, but is not limited to, efforts made to contact both sponsor and child; participation rates; confirmation the child is currently residing with the sponsor; referrals made to the ORR National Call Center (NCC) for additional resources; any concerns regarding the child's safety and well-being; and, whether any reports were made to the ORR Federal Field Specialist, child protective services, local law enforcement, and/or the ORR Sexual Abuse Hotline. In October 2016, the Office of Refugee Resettlement (ORR) drafted updated sections in the ORR Policy Guide that included case reporting, records management, retention, and information sharing requirements for post-release service (PRS) providers. Since then, ORR

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									continues to collect and analyze PRS data on a quarterly and annual basis. The data tracked includes, but is not limited to, reason for referral; level of services provided; services areas accessed by the child and/or sponsor; outcomes; any concerns regarding the child's safety and well-being; and when services were discontinued.In addition, ORR collects and analyzes data from the ORR NCC and the ORR Sexual Abuse Hotline regarding the calls received on a weekly, monthly, quarterly, and annual basis. The data tracked includes, but is not limited to, call volume, wait time, and duration; demographics of UAC served; reasons for incoming and outgoing calls; source of incoming calls; potential threats to the safety of UAC; reporting to local law enforcement and/or child protective services; referrals for post-release services; trend analysis; and after call surveys.The majority of information from post-release efforts is collected manually, outside of ORR's current case management system. As of June 2020, ORR is in the process of developing a new case management system which will include

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									information from post-release efforts. ORR tentatively plans for the first phase of the system to be operational by November 2020 and to deploy a finished product with all planned enhancements in late 2021.Updated October 16, 2020: The launch of the new case management was postponed to the end of January 2021. In preparation, in September, ORR uploaded all active TVPRA/PRS cases to the Portal to ensure swift migration to the new case management system in January 2021.

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ACF	GAO-16-367	Unaccompanied Children: HHS Should Improve Monitoring and Information Sharing Policies to Enhance Child Advocate Program Effectiveness	4/19/2016	1	To help ensure vulnerable unaccompanied children receive child advocate services, the Secretary of the Department of Health and Human Services should direct ORR to develop a monitoring process that includes: (1) regularly reviewing referrals to the program contractor, including identifying which care providers in locations with a child advocate program do not make referrals; and (2) reviewing information on the children the program contractor determines it is unable to serve.	Concur	2020	In Progress	ORR provided update to GAO below on 7/16/20. ORR continues to follow the 2016 joint protocol and its child advocate policy (Section 2.3.4 Child Advocates). ORR also continues to review referrals through monthly reporting and calls with the contractor, which includes review of the number of referrals and locations where the referrals originate. Referrals are only denied when child advocates are unavailable due to the limited number of child advocates. In these cases, child advocates are assigned as they become available based on the greatest need. This information is provided through monthly reporting and reviewed during monthly calls with the contractor. Additionally, ORR is in the process of developing a new electronic case management system which will include a module for child advocate referrals. The new system will enhance ORR's monitoring of child advocate referrals by streamlining information management and consolidating UAC information from disparate storage locations; using automated reporting and data analytics. ORR tentatively plans for the first phase of the system to be

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									operational by November 2020 and to deploy a finished product with all planned enhancements in late 2021. Updated October 16, 2020**:** The new case management system deployment date is now scheduled for the end of January 2021.
ACF	GAO-16-625	Foster Care: Most Tribes Do Not Anticipate Challenges with Case Goal Changes, but HHS Could Further Promote Guardianship Assistance	9/7/2016	1	To help improve tribes' ability to maintain safe, stable, and permanent care for children, the Secretary of Health and Human Services should direct the Children's Bureau to explore the reasons for low tribal participation and identify actions to increase this participation in the title IV-E Guardianship Assistance Program.	Non-Concur	2020	Awaiting Disposition	The Children's Bureau did not concur with GAO's recommendation because its own approach is more proactive and comprehensive. Because the goal of the recommendation has been met we consider this recommendation closed.

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ACF	A-02-15-02009	Economic Opportunity Commission of Nassau County, Inc., Claimed Some Unallowable Hurricane Sandy Disaster Relief Act Funds	4/26/2017	004-009-01-1	We recommend that ACF ensures that EOC refunds $614,278 to the Federal Government for Disaster Relief Act Costs that did not comply with Federal Requirements.	Non-Concur	2018	In Progress	ACF stated that due to an error in the project period noted on award 02SD0008, ACF determined that it was necessary to deobligate $3,386,045 of funds from award 02SD0008 effective August 31, 2015 and immediately reaward them on September 1, 2015 as award 02SD0023 with a corrected project period. The deobligation and reaward of funds was required by ACF and did not change the overall amount awarded or affect the project budget originally submitted by the grantee. ACF does agree, however, that ACF must assure that project management and design service costs are allocable to either award 02SD0008 or 02SD0023 and not duplicated as between the original and replacement awards. ACF upholds the disallowance of $112,296 for Disaster Relief Act costs that did not comply with Federal requirements; specifically, $104,092 for costs claimed based on budgeted rather than actual costs, $6,367 in salaries and fringe benefits which were not supported and $1,837 in Disaster Relief Act funds that had already been reimbursed by other insurance. ACF does not concur with the

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									recommendation to disallow $501,982 (614,278 – 112,296) identified by OIG as not allocable to the grant. The finding is resolved on our part as we have shared our updates with OIG/GAO and are waiting for them to close the finding..
ACF	GAO-18-196	Substance-affected Infants: Additional Guidance Would Help States Better Implement Protections for Children	2/8/2018	1	The Secretary of HHS should direct ACF to provide additional guidance and technical assistance to states to address known challenges and enhance their understanding of CAPTA requirements, including the requirements for health care providers to notify CPS of substance-affected infants and the development of a plan of safe care for these infants.	Non-Concur	2019	Awaiting Disposition	While the Children's Bureau non-concurred with GAO's recommendation, an alternate approach was implemented, thus achieving the goal of the recommendation. The Bureau considers this recommendation closed and implemented.

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ACF	OEI-07-15-00380	Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication	9/13/2018	399-915-11-03-05699	Assist States in strengthening their requirements for oversight of psychotropic medication by incorporating professional practice guidelines for monitoring children at the individual level.	Concur	2020	In Progress	The Children's Bureau committed to: 1) requiring states to report on status of complying with this requirement in the June 2019 Child and Family Services Plan – see Program Instruction 10-02 on the Children's Bureau website; and 2) provide state foster care managers a forum to share best practices through their constituency group. To date, no state has requested technical assistance and the foster care managers have not identified this as an area in need of a best practices discussion. ACF considers this recommendation implemented.
ACF	OEI-07-15-00380	Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication	9/13/2018	399-915-11-03-05698	Develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication.	Concur	2021	In Progress	The CFSR team continues to work on revisions for round 4 of the CFSR. We do not anticipate releasing decisions until the 3rd quarter of FY 21.

ACF	OEI-03-15-00170	States' Payment Rates Under the Child Care and Development Fund Program Could Limit Access to Child Care Providers	8/12/2019	399-915-11-03-05997	ACF should establish a forum for States to share strategies regarding how they set payment rates to ensure equal access for eligible families while balancing competing program priorities.	Concur	2021	In Progress	This remains ongoing. Over the past year, the Office of Child Care with our technical assistance (National Center on Subsidy Innovation and Accountability) and research partners (ACF's Office of Planning, Research and Evaluation) have focused on supporting states efforts in collecting statistically valid and reliable data to improve the market rate survey (MRS) methodology. Resources developed include: • A statistically valid and reliable checklist that was published and distributed to states based on an analysis of each state's methodology that is actively used when states request technical assistance on their planned market rate surveys (https://childcareta.acf.hhs.gov/resource/ensuring-statistically-valid-and-reliable-market-rate-survey). • Links to each states MRS to promote peer learning about each state's MRS practices and methodology (https://childcareta.acf.hhs.gov/resource/links-state-market-rate-survey-reports). • A tool for evaluating MRS questions https://childcareta.acf.hhs.gov/sites/default/files/public/child_care_mrs_tool_evaluation.pdf • Considerations for contracting to conduct a MRS (https://childcareta.acf.hhs.gov/resource/considerations-lead-agencies-

									when-contracting-market-rate-surveys) • Using administrative data to conduct the MRS (https://childcareta.acf.hhs.gov/resource/using-administrative-data-market-rate-surveys) OCC planned to convene a roundtable in Spring 2020 and then schedule a follow-up peer learning opportunity to create a forum for states to share information on the considerations and factors they use when setting payment rates. However, due to COVID-19, the original roundtable was cancelled and because of the impact of the pandemic on the child care market as a whole (providers have closed and parents demand has shifted), we have delayed this peer learning opportunity. To better understand the challenges states are facing as a result of the pandemic, we did hold a peer learning forum/open space discussion on collecting market rate surveys and other data to effectively set subsidy rates in June 2020 and along with a Jumpstarting child care webinar and brainstorming sessions while not directly discussing MRS or setting payment rates did discuss equal access and balancing competing priorities. Based on what we learned from those sessions, we are offering states a waiver opportunity to have another year in which to collect their child care price and cost estimate information, since the

									market has shifted so much over the past 6 months. We are continuing to discuss options, such as a national webinar and peer learning exchanges on using both cost estimates and MRS data to set payment rates, for consideration but recognize that many states are still responding to the pandemic and want to be able to create a meaningful forum for them when they are not in crisis mode.

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ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy Assistance Programs	8/20/2019	513-919-10-1	We recommend that ACF review the FFRs and Carryover Reports to verify that Tribal grantees report unobligated grant funds based on accurate financial information and ensure those amounts are refunded to the Federal Government.	TBD	2021	In Progress	ACF is currently assessing monitoring grants management processes to determine how to best track data more systemically. ACF is also testing a risk prevention strategy that selects a larger sample of tribal grantees from our monitoring prioritization tool that appear to have a disproportionate amount of fiscal deficiencies compared to other tribe and state grantees. Tribes not selected for site visits that year, will receive focused and continuous remote monitoring from ACF. ACF is providing vendor refund process in its T&TA.
ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy	8/20/2019	513-004-10-1	We recommend that ACF review all FFRs, Carryover Reports, and Household Reports to ensure that the reports are complete, are submitted in a timely manner, and are properly supported.	TBD	2021	In Progress	ACF's Office of Grants Management (OGM) is undergoing grants modernization effort designed to improve ACF customer service, financial oversight and financial monitoring. In FY2019, this effort included a new submission portal for the LIHEAP FFRs via PMS. ACF anticipates tribal grantees will begin submitting FFRs via PM in FY2021. ACF's OGM and Office of Community Services, which administers LIHEAP, has begun partnering to develop a

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		Assistance Programs							collaborative fiscal monitoring protocol.
ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy Assistance Programs	8/20/2019	513-913-10-1	We recommend that ACF incorporate the findings from previous monitoring reviews into the monitoring prioritization assessment tool to help evaluate the optimal composition of State, Territory, and Tribal grantees selected for annual on-site reviews.	TBD	2021	In Progress	ACF reviews all grantee LIHEAP plans to ensure proper use of funds. During each year's Plan review process, ACF works extensively with tribal grantees to ensure their benefit matrices meet the statutory requirement of providing maximum possible benefit to households with lowest income in relation to family size. Throughout the year, ACF staff raise the issue of benefit maximization and the use of supplement benefits during one-on-one tribal technical assistance activities, regional grantee quarterly conference calls, webinars and at the LIHEAP Training Conference.

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ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy Assistance Programs	8/20/2019	513-919-10-2	We recommend that ACF educate Tribal grantees on ways to use grant funds to provide the maximum available benefits to eligible households and for other purposes of the program, such as crisis situations, residential weatherization, and energy-related home repairs.	TBD	2021	In Progress	ACF is commencing its public comment process as part of its request of the federal Office of Management and Budget (OMB) to renew ACF's authority to collect data annually from LIHEAP grantees via the LIHEAP Model Plan, i.e., the application for grant funds. The current Model Plan asks questions regarding how grantees' count income during the eligibility determination process, but ACF believes this section could be enhanced to collect further information including requiring certain relevant attachments, such as tribal policy and procedure manuals. Through its T&TA assessment process, ACF is also considering issuing guidance (Information Memorandum) to LIHEAP grantees concerning this topic and the topic noted above in Recommendation 1.

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ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy Assistance Programs	8/20/2019	513-905-10-1	We recommend that ACF revise its policies and procedures to improve the information that it has to oversee the Tribal grantees. Specifically, we recommend that ACF: enhance its policies and procedures to ensure that it can determine whether Tribal grantees: ensure that obligated grant funds are used to provide energy assistance to eligible beneficiaries (rather than being held as credit balances at energy suppliers) and that these funds can be traced to the year of obligation, maintain adequate supporting documentation for LIHEAP obligations and track and verify that prepayments made to energy suppliers are then used to provide services to eligible households, and ensure that energy suppliers return to the Tribes all unused grant funds prior to the end of each FY, thereby enabling the Tribes to re-obligate those funds for allowable LIHEAP purposes within the grant period.	TBD	2021	In Progress	As noted in our response to Recommendation 2, OGM anticipates commencing a new LIHEAP FFR review process via an online portal beginning with FY2020 FRs. LIHEAP grantees must submit a revised,or final LIHEAP Carryover and Reallotment Report by the end of December. ACF waits to issue the next FFY's LIHEAP grant award funding until ACF has reviewed and confirmed that all LIHEAP grantees submitted their prior year's Carryover and Reallotment Report and that it passed our validation check.

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ACF	A-07-17-04105	The Administration for Children and Families Should Improve the Oversight of Tribal Grantees' Low-Income Home Energy Assistance Programs	8/20/2019	513-909-10-1	We recommend that ACF review each Tribal grantee's policies and procedures to ensure that the grantee formalizes its definition of income in ways that conform to Federal requirements and guidance and uses this definition when determining eligibility for LIHEAP assistance.	TBD	2022	In Progress	Our federal LIHEAP monitoring prioritization tool does already include data regarding length of time since the last federal review, grantee characteristics, and more current data regarding federal independent audit findings. We are exploring, however, the feasibility of creating a metric for the prior monitoring findings as suggested by OIG and anticipate testing the revised tool with a selection of grantees for monitoring in FY2021.
ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	9/3/2019	399-915-11-03-06017	ORR should assess whether to establish maximum caseloads for individual mental health clinicians.	Concur	2021	Awaiting Disposition	Implemented. ORR engaged with its internal subject matter experts to assess the viability of the current clinical ratios. ORR's ratio of 1:12 is substantially lower than other mental health programs targeting similar populations with the domestic system. ORR believes its current model provides for sufficient clinical engagement with minors and is suitable for this population.

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ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	9/3/2019	399-915-11-03-06018	ORR should help care provider facilities improve their access to mental health specialists.	Concur	2021	In Progress	Although the partnership with the University of California San Diego was not successful, ORR continues to work with Point Comfort Underwriters to expand ORR's mental health services by vetting additional telemental health providers. The Division of Health for Unaccompanied Children (DHUC) expanded in personnel, allowing for restructuring of DHUC into a team-based structure. The Mental and Behavioral Health Services Team (MBHST), a 4-person team, was formed. Recruiting efforts over the past 6 months have yielded an Advanced Practice Psychiatric Nurse and a Licensed Clinical Social Worker, who are currently collaborating with field staff to provide care provider programs guidance. ORR's child and adolescent psychiatrist remains on leave. Currently, a MBHST Lead (psychiatrist) position is advertised.

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ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	9/3/2019	399-915-11-03-06019	ORR should increase therapeutic placement options for children who require more intensive mental health treatment.	Concur	2021	In Progress	ORR has drafted additional requirements in the Cooperative Agreement Addendums (CAA) for secure, staff secure, residential treatment centers, and therapeutic group homes. The additional requirements in the CAA expands on services and requirements that will enhance therapeutic services for UAC in specialized placements, and is ongoing. ORR has also proposed a pilot to care providers to deliver trauma-informed, evidenced-based behavior management systems throughout the staff secure network. This has been approved to pilot at two staff secure facilities. Additionally, ORR submitted a proposal to implement a pilot for intensive in-care wraparound services throughout the network. This expanded services is designed to preserve a UAC's placement, reduce their time in ORR care, and mitigate existing mental health and behavioral issues.

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ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	9/3/2019	399-915-11-03-06015	ORR should identify and disseminate evidence-based approaches to addressing trauma in short-term therapy.	Concur	2021	In Progress	ORR continues to work with National Child Traumatic Stress Network (NCTSN) grantees who received 2020 supplemental funding. ORR is currently discussing with NCTSN grantees on the use of supplemental funding in providing intensive post-release services to discharged unaccompanied children who are at risk of placement disruption due to challenging behaviors and mental health conditions, providing training and consultation on trauma-focused interventions on challenging UAC cases. ORR also continues to work on identifying evidenced-based approaches in providing short term therapies for children who may be exhibiting functional impairments that can be easily addressed while they are in ORR care and custody. ORR is in the process of developing an ORR Trauma Training Initiative, which is currently in the process of market research.
ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental	9/3/2019	399-915-11-03-06020	ORR should take all reasonable steps to minimize the time that children remain in ORR custody.	Concur	2021	In Progress	ORR continues to take reasonable steps to accelerate discharges to safe, suitable sponsors, as detailed in the Discharge Rate Improvement Plan. While these efforts are still ongoing, the Coronavirus pandemic has caused some delay.

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		Health Needs of Children in HHS Custody							
ACF	OEI-09-18-00431	Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody	9/3/2019	399-915-11-03-06016	ORR should develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians.	Concur	2021	In Progress	ORR has developed a workgroup to discuss strategies on enhancing recruitment of clinicians, encouraging community outreach to professional associations and college/universities, and identifying factors that impede recruitment (i.e., roles/expectations in cooperative agreement vs Flores Settlement Agreement). While these efforts are ongoing, the Coronavirus pandemic has caused some delay.
ACF	GAO-19-519	Head Start: Action Needed to Enhance Program Oversight and Mitigate Significant Fraud and Improper Payment Risks	9/13/2019	1	The Director of OHS should perform a fraud risk assessment for the Head Start program, to include assessing the likelihood and impact of fraud risks it faces.	Concur	2021	In Progress	The Office of Head Start is still committed to working with its colleagues within the Administration for Children and Families (ACF) to improve fraud risk strategies. ACF pushed the pilot phase for implementing its Fraud Risk Assessment template from June 30, 2020 to December 31, 2020. However, ACF is still on track for completing its initial Fraud Risk Assessment for the Office of Head Start by the end of 2021.

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ACF	GAO-19-519	Head Start: Action Needed to Enhance Program Oversight and Mitigate Significant Fraud and Improper Payment Risks	9/13/2019	3	The Director of OHS should establish procedures to monitor and evaluate OHS's new internal workflows for monitoring reviews, to include establishing a baseline to measure the effect of these workflows and identify and address any problems impeding the effective implementation of new workflows to ensure timeliness goals for monitoring reviews are met.	Non-Concur	2020	Awaiting Disposition	The Office of Head Start has examined its internal workflows to increase our responsiveness to findings and to improve our timelines for issuing reports. We have increased our responsiveness to findings and improved our timelines for issuing reports. During Fiscal Years (FY) FY19 and FY20, we issued 68% of all deficient reports prior to our workflow timeframe of 45 business days. The average number of business days from the end of the review to the date the report was signed was 42 days. Excluding reports containing multiple finding, complex fiscal issues and those reports leading to grantee termination or relinquishment, the average number of business days was an average of 34 business days. We consider this recommendation closed - implemented.
ACF	GAO-19-519	Head Start: Action Needed to Enhance Program Oversight and Mitigate Significant	9/13/2019	5	The Director of OHS should provide program-wide guidance on when a student's slot should be considered vacant due to absenteeism.	Concur	2021	In Progress	The Office of Head Start anticipated releasing policy guidance on vacant slots due to absenteeism, as well as a toolkit of resources on how to better track services pregnant enrollees receive in the community, by summer 2020. In light of the COVID-19 pandemic, we have had to redirect

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		Fraud and Improper Payment Risks							our focus to safely returning children and families to in-person services and to developing policies for virtual services, when required. For that reason, we have decided to postpose releasing policy guidance on vacant slots until it is practical to do so, (Recommendation 5), and releasing the tool kit until the end of 2021 (Recommendation 6)
ACF	GAO-19-519	Head Start: Action Needed to Enhance Program Oversight and Mitigate Significant Fraud and Improper Payment Risks	9/13/2019	6	The Director of OHS should develop and implement a method for grantees to document attendance and services under EHS pregnancy programs.	Concur	2021	In Progress	The Office of Head Start anticipated releasing policy guidance on vacant slots due to absenteeism, as well as a toolkit of resources on how to better track services pregnant enrollees receive in the community, by summer 2020. In light of the COVID-19 pandemic, we have had to redirect our focus to safely returning children and families to in-person services and to developing policies for virtual services, when required. For that reason, we have decided to postpose releasing policy guidance on vacant slots until it is practical to do so, (Recommendation 5), and releasing the tool kit until the end of 2021 (Recommendation 6)

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ACL	GAO-19-330	Older Americans Act: HHS Could Help Rural Service Providers by Centralizing Information on Promising Practices	6/24/2019	1	The Administrator of ACL should take steps to better centralize access to and promote awareness of information on promising practices or other useful information pertinent to serving rural older adults.	Concur	2021	In Progress	ACL has made it easier to find ACL funded resource centers on the ACL website. Resource centers can be found on the "For Partners, Researchers, and Professionals" page under the Technical Assistance Resources heading, and from the "Strengthening the Aging and Disability Networks" from the Program Areas page. ACL will continue to list all resource centers on its website so that anyone can find resources specific to any topic that is funded. A technology solution that would allow a user to search across resource centers funded by ACL, which are operated by grantees and contractors, is technically challenging and would require both funding and staff resources that are far beyond those available to ACL. Working with resource centers to more easily identify information related to serving rural older adults is the only feasible approach given current resources. Following issuance of the final report, the GAO report and recommendations were presented to ACL Center Directors during one of their regularly-scheduled bi-weekly meetings. The discussion included a full understanding of the

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									GAO findings and recommendations as well as methods by which ACL could implement. It was agreed that each Center would engage with existing Resource Centers about identifying promising practices and information specific to rural communities and to explore how best to highlight it to be more readily available. All program office directors have been informed and advised to implement this action with resource centers as grant and contract competitions are held to renew resource centers or establish new resource centers.

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ACL	A-05-18-00034	The Administration for Community Living Failed To Conduct Any of the Required Onsite Compliance Reviews of Independent Living Programs	8/12/2019	212-913-10-1	We recommend that the Administration for Community Living perform the required onsite compliance reviews of independent living programs.	Non-Concur	NA	Awaiting Disposition	The requirement to conduct onsite reviews to a set 15 percent of Centers for Independent Living was established at a time in which technology options did not allow for effective remote reviews. Today, email, video conferencing, data systems, and other tools allow for effective and efficient remote reviews. ACL agrees that a minimum of 15 percent of CIL grantees should undergo an effective remote review each year (and that all CILs should be reviewed annually for compliance). ACL does not have adequate funds to support these community-based organizations, which provide critical services to individuals with disabilities, and substantially increase onsite reviews. ACL is committed to and has taken actions to enhance appropriate compliance oversight. ACL has fully implemented the Compliance and Outcome Monitoring Protocol tool, which includes a Tier I review of all grantees annually. Throughout the year, ACL identifies high risk grantees for issues and events and conducts in-depth reviews - both onsite and virtually - as a result. Consequently, grantees may be

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									placed on restrictions should they need to resolve identified issues or areas of significant concern. To further ACL's position that compliance reviews should be conducted in a manner that is appropriate to the risk and issue of concern, ACL released an FY 2021 legislative proposal to remove the requirement in the Rehabilitation Act of 1973 that Center for Independent Living annual grantee compliance reviews be conducted "onsite."

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AHRQ	OEI-01-17-00420	Patient Safety Organizations: Hospital Participation, Value, and Challenges	9/25/2019	399-915-11-12-06083	Take steps to encourage PSOs to participate in the Network of Patient Safety Databases (NPSD), including accepting data into the NPSD in other formats in addition to the Common Formats	Concur	2021	In Progress	AHRQ will conduct a session at the PSO Annual Meeting to discuss the interest and feasibility of a campaign to encourage providers and PSOs to address a specific, high-priority type of patient safety event. After reviewing PSO input and considering other factors, such as availability of resources, AHRQ will determine if such a campaign is achievable. Additionally, AHRQ will seek feedback from PSOs at the PSO Annual Meeting as to whether they can identify specific clinical and patient-safety-related issues with certain Common Formats data elements that present barriers to use of the common formats and submission of data to the NPSD. AHRQ's Patient Safety Organization Privacy Protection Center (PSOPPC) contractor has expertise in assessing the viability of technologies to accept and analyze unstructured data in the NPSD. For example, the contractor has tested the application of Natural Language Processing (NLP) algorithms to mine and evaluate certain limited, specific "free text" data fields within the Common Formats. Our experience with this limited application of NLP confirms that it is not feasible

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									to include completely unstructured data in the NPSD for the foreseeable future. Going forward, on an annual basis, the PSOPPC contractor will assess whether new developments have evolved such that it may be feasible for AHRQ to revisit the possibility of including unstructured data in the NPSD. The AHRQ Contracting Officer Representative has added this annual review as a standing agenda item for a meeting during the last month of each contract year. During this meeting, the contractor will provide an overview of any relevant developments for AHRQ to consider.
AHRQ	OEI-01-17-00420	Patient Safety Organizations: Hospital Participation, Value, and Challenges	9/25/2019	399-915-11-12-06082	Develop and execute a communications strategy to increase hospitals' awareness of the program and its value to participants	Concur	2021	In Progress	AHRQ has approved a multi-component communications strategy developed by AHRQ's Office of Communications to increase hospitals' awareness of the PSO program and its value. As part of the strategy, AHRQ updated the primary existing outreach resource for providers, the "Choosing a Patient Safety Organization" brochure to: more clearly explain the unique

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									advantages of working with a PSO, highlight the Network of Patient Safety Databases (NPSD), and incorporate findings from the OIG Report regarding the value for hospitals of working with a PSO. AHRQ has completed its review of the PSO Program website and identified two areas for content update: 1) the "Choosing a Patient Safety Organization" brochure (completed), and 2) the "Work with a PSO" section of the website.
AHRQ	OEI-01-17-00420	Patient Safety Organizations: Hospital Participation, Value, and Challenges	9/25/2019	399-915-11-12-06084	Update guidance for PSOs on the initial and continued listing processes	Concur	2021	In Progress	AHRQ has determined that the Compliance Self-Assessment Guide is an appropriate tool to guide PSOs through the initial and continued listing processes and is revising the guide to make it more comprehensive and user-friendly. Areas for revision include: linking to helpful resources that can assist a PSO in determining if it is meeting a specific requirement; distinguishing related requirements at initial vs continued listing; clarifying requirements from best practices; and, improving readability.

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ASA	GAO-16-548	Federal Workforce: Opportunities Exist to Improve Data on Selected Groups of Special Government Employees	8/15/2016	1	To help ensure HHS has reliable data on SGEs not serving on federal boards, the Secretary of HHS should take steps to improve the reliability of data on SGEs not serving on boards. For example, the agency could reconcile human capital data with general counsel and ethics office data, or issue clarifying guidance to human capital staff on appropriately identifying SGEs in human capital databases.	Concur	2021	In Progress	ASFR is actively working to address this recommendation.
ASFR	GAO-14-84	Minority AIDS Initiative: Consolidation of Fragmented HIV/AIDS Funding Could Reduce Administrative Challenges	11/22/2013	1	In order to reduce the administrative costs associated with a fragmented MAI grant structure that diminishes the effective use of HHS's limited HIV/AIDS funding, and to enhance services to minority populations, HHS should consolidate disparate MAI funding streams into core HIV/AIDS funding during its budget request and allocation process.	Non-Concur	NA	Awaiting Disposition	OASH greatly appreciates GAO's input and recommendations. Over the last two fiscal years, OASH has worked to ensure that the Minority HIV/AIDS Fund (MHAF) functions to reduce new HIV infections, improve HIV-related health outcomes, and to reduce HIV-related health disparities for racial and ethnic minority communities by supporting innovation, collaboration, and the integration of best practices, effective strategies, and promising emerging models in the response to HIV among minority communities. In addition, the MHAF is focused on transforming HIV prevention, care, and

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									treatment for communities of color by bringing federal, state, and community organizations together to design and pilot innovative solutions that address critical emerging needs and work to improve the efficiency, effectiveness, and impact of federal investments in HIV programs, activities, and services for racial and ethnic minorities. In February 2019, HHS released Ending the HIV Epidemic (EHE): A Plan for America to address the hardest hit communities with the additional expertise, technology, and resources required to address the HIV epidemic in their communities. Phase 1 of the Ending the HIV Epidemic Plan focuses on the areas of the nation that comprised more than 50% of the new HIV diagnoses in 2016 and 2017, plus the seven states with rural areas that carry a disproportionately high burden of HIV. Through the use of the MHAF in service to the initiative, OASH is committed to providing leadership, management, oversight and support for, and collaboration and coordination among HHS agencies, operating divisions, and external stakeholders.

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ASFR	GAO-14-84	Minority AIDS Initiative: Consolidation of Fragmented HIV/AIDS Funding Could Reduce Administrative Challenges	11/22/2013	2	In order to reduce the administrative costs associated with a fragmented MAI grant structure that diminishes the effective use of HHS's limited HIV/AIDS funding, and to enhance services to minority populations, HHS should seek legislation to amend the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 or other provisions of law, as necessary, to achieve a consolidated approach.	Non-Concur	NA	Awaiting Disposition	OASH greatly appreciates GAO's input and recommendations. Over the last two fiscal years, OASH has worked to ensure that the Minority HIV/AIDS Fund (MHAF) functions to reduce new HIV infections, improve HIV-related health outcomes, and to reduce HIV-related health disparities for racial and ethnic minority communities by supporting innovation, collaboration, and the integration of best practices, effective strategies, and promising emerging models in the response to HIV among minority communities. In addition, the MHAF is focused on transforming HIV prevention, care, and treatment for communities of color by bringing federal, state, and community organizations together to design and pilot innovative solutions that address critical emerging needs and work to improve the efficiency, effectiveness, and impact of federal investments in HIV programs, activities, and services for racial and ethnic minorities. In February 2019, HHS released Ending the HIV Epidemic (EHE): A Plan for America to address the hardest hit communities with the

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									additional expertise, technology, and resources required to address the HIV epidemic in their communities. Phase 1 of the Ending the HIV Epidemic Plan focuses on the areas of the nation that comprised more than 50% of the new HIV diagnoses in 2016 and 2017, plus the seven states with rural areas that carry a disproportionately high burden of HIV. Through the use of the MHAF in service to the initiative, OASH is committed to providing leadership, management, oversight and support for, and collaboration and coordination among HHS agencies, operating divisions, and external stakeholders.
ASFR	OEI-04-11-00530	Vulnerabilities in the HHS Small Business Innovation Research Program	4/22/2014	299-910-11-30-03925	Ensure compliance with SBIR eligibility requirements	Concur	2022	In Progress	In January 2020, ASFR requested closure for this recommendation, however, OIG has indicated that further development of the SBIR training program is needed to implement this recommendation. HHS is reviewing the funding implications of moving the RGM grants workforce efforts to the Office of Grants within ASFR. The goal of this program is to develop and implement a department-wide financial assistance training and certification program to improve the functional effectiveness of the

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									financial assistance management workforce in the areas of internal controls and risk mitigation. The necessary training for the SBIR program would be rolled into this larger training program.
ASFR	OEI-04-11-00530	Vulnerabilities in the HHS Small Business Innovation Research Program	4/22/2014	299-906-10-30-03926	Improve procedures to check for duplicative awards	Concur	2022	In Progress	In January 2020, ASFR requested closure for this recommendation, however, OIG has indicated that further development of the SBIR training program is needed to implement this recommendation. HHS is reviewing the funding implications of moving the RGM grants workforce efforts to the Office of Grants within ASFR. The goal of this program is to develop and implement a department-wide financial assistance training and certification program to improve the functional effectiveness of the financial assistance management workforce in the areas of internal controls and risk mitigation. The necessary training for the SBIR program would be rolled into this larger training program.
ASFR	OEI-03-14-00230	Federal Marketplace: Inadequacies in	1/20/2015	510-901-11-30-04350	HHS should revise its guidance to include specific standards for conducting past performance reviews of companies under	Concur	2021	In Progress	ASFR is actively working to address this recommendation.

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		Contract Planning and Procurement			consideration during contract procurement				
ASFR	A-03-13-03002	HHS Did Not Identify and Report Antideficiency Act Violations	5/12/2017	500-900-10-1	Collaborate with ASFR to identify changes to UFMS to ensure that contract expenditures for each program year are paid using the appropriate program year obligations	Concur	2020	In Progress	The PSC change request (CR 0001163) requires the HHS procurement system (HCAS/PRISM) to pass the Period of Performance (POP) to UFMS. The UFMS management team is working on developing Web Services between UFMS and HCAS/PRISM to bring in necessary attributes (including POP). This work will be accomplished as part of the HHS E-Invoicing Implementation project, to be deployed by December, 2021.
ASFR	A-03-13-03002	HHS Did Not Identify and Report Antideficiency Act Violations	5/12/2017	509-908-10-1	Use product/service codes that accurately reflect the contract statement of work	Concur	2019	In Progress	Product service codes are at the discretion of the Contracting Officer but PSC will continue to work with Contracting Officers to ensure they choose the most appropriate code.
ASFR	A-03-13-03002	HHS Did Not Identify and Report Antideficiency Act Violations	5/12/2017	510-908-10-1	Use “no cost” contract extensions for severable services contracts only when they do not extend the period of performance for a program year to more than 12 months	Concur	2019	In Progress	Additional trainings for acquisitions workforce (contracting, budget, and program staff) implemented. Both online and in-person trainings are offered specific to "no cost" extensions for severable service contracts.

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ASFR	A-03-13-03002	HHS Did Not Identify and Report Antideficiency Act Violations	5/12/2017	512-000-02-2	Work with the HHS Office of the Secretary to report Antideficiency Act expenditure violations totaling $29,188,270	Concur	2021	In Progress	Working with OpDivs to accurately determine which issues Congress was constructively notified of in 2011, which are correctible errors, and which may require additional notifications under the Antideficiency Act.
ASFR	A-03-13-03002	HHS Did Not Identify and Report Antideficiency Act Violations	5/12/2017	512-000-02-1	Work with the HHS Office of the Secretary to report Antideficiency Act obligation violations totaling $20,256,755	Concur	2021	In Progress	Working with OpDivs to accurately determine which issues Congress was constructively notified of in 2011, which are correctible errors, and which may require additional notifications under the Antideficiency Act.
ASFR	GAO-17-738	Federal Contracting: Additional Management Attention and Action Needed to Close Contracts and Reduce Audit Backlog	9/28/2017	2	To enhance management attention to closing out contracts, the Secretary of Health and Human Services should develop a means for department-wide oversight into components' progress in meeting their goals on closing contracts and the status of contracts eligible for closeout.	Concur	NA	In Progress	HHS has developed a reporting format and instruction for quarterly reporting from the OPDIVs. The metrics monitored are contracts completed, contracts closed in a timely manner, contracts not closed timely, and total backlog for each quarter.

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ASFR	GAO-18-323	Railroad Retirement Board: Additional Controls and Oversight of Financial Interchange Transfers Needed	5/21/2018	8	The Secretary of HHS should, consistent with its existing statutory authority, take additional steps to provide oversight of financial interchange calculations at the individual-case level. If the Secretary concludes that there are limitations in its authority in this area, the Secretary should seek to obtain the necessary additional authority.	Non-Concur	NA	Awaiting Disposition	HHS has determined that the Secretary does not have the necessary statutory authority and the Office of the General Counsel has asked that CMS stop action related to this recommendation.
ASFR	GAO-18-491	Grants Workforce: Actions Needed to Ensure Staff Have Skills to Administer and Oversee Federal Grants	9/20/2018	3	The Secretary of HHS should establish a process to monitor and evaluate HHS's grants training at the central office level. This process should include (1) a method for identifying all employees working on grants across the agency, and (2) oversight procedures to evaluate the sufficiency of sub-agencies' grants training efforts including the incorporation of leading practices related to assessing competencies, training approaches, accountability, and training results.	Concur	2020	In Progress	Currently, efforts are underway through the ReInvent Grants Management (RGM) Initiative, part of ReImagine HHS, to develop and implement a department-wide financial assistance training and certification program to improve the functional effectiveness of the financial assistance management workforce in the areas of internal controls and risk mitigation. HHS met with GAO after the report was issued and provided an outline letting them know this was a long-term project Since then, HHS provided GAO with quarterly updates. As the RGM initiative comes to a close at the end of FY2020, HHS is working to transition grants workforce efforts

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									to Departmental owners. Specifically, HHS is reviewing the funding implications of moving this activity to the Office of Grants within ASFR.
ASFR	GAO-19-63	Information Technology: Agencies Need Better Information on the Use of Noncompetitive and Bridge Contracts	12/11/2018	2	The Secretary of Health and Human Services should direct the Associate Deputy Assistant Secretary for Acquisition to identify the reasons behind the high rate of miscoding for orders awarded under multiple award contracts and use this information to identify and take action to improve the reliability of the competition data entered into FPDS-NG.	Concur	2020	Awaiting Disposition	ASFR is actively working to address this recommendation.

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ASFR	GAO-19-17	Buy American Act: Actions Needed to Improve Exception and Waiver Reporting and Selected Agency Guidance	12/18/2018	4	The Secretary of Health and Human Services should provide guidance, training, or other instruction to help contracting officials: (1) Identify the factors that should be considered in order to determine the applicability of the Trade Agreements Act and waiver of the Buy American Act; (2) Document determinations of the use of Buy American exceptions for domestic non-availability and ensure the required approvals are obtained; and (3) Identify sources of information available for determining products' origins and the steps they should take to verify information that is inconsistent.	Concur	NA	Awaiting Disposition	ASFR is actively working to address this recommendation.
ASFR	GAO-19-112	Improper Payments: Selected Agencies Need Improvements in Their Assessments to Better Determine	1/10/2019	1	The Secretary of Health and Human Services should revise HHS's process for conducting improper payment risk assessments for Head Start to help ensure that it results in a reliable assessment of whether the program is susceptible to significant improper payments. This should	Concur	2020	Awaiting Disposition	In FY 2020, HHS revised its risk assessment process, including the questionnaire and scoring methodology, and implemented a new tool, the Risk Assessment Portal (RAP) to capture responses. The revised questionnaire and RAP tool facilitates a systematic approach to conducting a reliable assessment of any HHS program, including Head Start, to determine

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		and Document Risk Susceptibility			include preparing sufficient documentation to support its risk assessments.				whether the program is susceptible to significant improper payments. The RAP tool enables programs to add additional information through an expanded modal screen and allows users to attach supplemental documentation supporting their risk assessment and questionnaire responses. HHS also developed RAP User and Reference Guides for Divisions and ASFR, respectively. This documentation provides information to support the end user and documents the process HHS uses to provide a reasonable basis for making to risk determinations.
ASFR	GAO-19-112	Improper Payments: Selected Agencies Need Improvements in Their Assessments to Better Determine and Document Risk Susceptibility	1/10/2019	2	The Secretary of Health and Human Services should revise HHS's procedures for conducting improper payment risk assessments to help ensure that all programs and activities are assessed for susceptibility to significant improper payments at least once every 3 years, as required by IPIA.	Concur	2020	Awaiting Disposition	HHS has used its new, risk-based methodology for two years to recommend programs for assessment. The results of this methodology, and the coverage recommended each year, is documented annually. This information is used by the Program leads to make their selection. The HHS Office of Inspector General (OIG) reviewed the FY 2019 methodology as part of the Annual Inspector General review of HHS's improper payment reporting under the Improper Payments Elimination and Recovery Act of 2010 and provided no feedback or

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									recommendations for improvement.HHS plans to refine the methodology as needed and ensure annually that Program leads are aware of which programs are above the threshold and should be assessed for susceptibility to significant improper payments.
ASFR	GAO-19-243	Federal Contracting: Opportunities to Improve Compliance with Regulations and Enhance Tax Collections	5/15/2019	2	The Senior Procurement Executive for the Department of Health and Human Services (HHS) should review the contracts we identified as being awarded to contractors that reported qualifying federal tax debt under FAR § 52.209-11 and (1) determine whether the contracting officer was required to consider the contractor's reported tax debt; if so, (2) determine the reasons controls to identify and refer these contractors to the SDO before contract award did not operate effectively; and (3) design or modify controls to help ensure compliance with applicable regulations.	Concur	2021	Awaiting Disposition	ASFR is actively working to address this recommendation.

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ASFR	GAO-19-243	Federal Contracting: Opportunities to Improve Compliance with Regulations and Enhance Tax Collections	5/15/2019	7	The Senior Procurement Executive for HHS should review the contracts we identified as being awarded to contractors that reported qualifying federal tax debt under FAR § 52.209-5. Specifically, the Senior Procurement Executive should determine whether each contract value was expected to exceed the simplified acquisition threshold when the solicitation was issued and, if so, (1) determine the reasons controls to identify and notify the SDO of these contractors before contract award did not operate effectively and (2) design or modify controls to help ensure compliance with applicable regulation.	Concur	2021	Awaiting Disposition	ASFR is actively working to address this recommendation.

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ASPE	GAO-16-17	Health Care Workforce: Comprehensive Planning by HHS Needed to Meet National Needs	1/11/2016	1	To ensure that HHS workforce efforts meet national needs, the Secretary of Health and Human Services should develop a comprehensive and coordinated planning approach to guide HHS's health care workforce development programs--including education, training, and payment programs--that (1) includes performance measures to more clearly determine the extent to which these programs are meeting the department's strategic goal of strengthening health care; (2) identifies and communicates to stakeholders any gaps between existing programs and future health care workforce needs identified in the Health Resources and Services Administration's workforce projection reports; (3) identifies actions needed to address identified gaps; and (4) identifies and communicates to Congress the legislative authority, if any, the Department needs	Concur	NA	In Progress	As HHS has noted in the past, the legislative and budget cycles provide an annual opportunity for coordination of workforce issues across the Department with priorities identified through the Department's budget request and legislative program. Our legislative program and budget are informed by input from formal mechanisms such as statutory advisory committees and consultation with the Tribes and interactions that arise from Agency program and project activities. Our budget contains a major proposal restructuring CMS Graduate Medical Education (GME) programs into a discretionary grant program. Such a restructuring would allow the Department to set expectations for program performance in CMS GME and allow the kind of tracking HRSA has been able to implement in the Children's Hospital GME program and its Teaching Hospital GME program. However, Congress has not responded to this request . The Corona Aid, Relief, and Economic Security Act (CARES Act) at section 3402 requires the development of a comprehensive

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					to implement the identified actions.				and coordinated workforce plan, due one year after enactment (in March 2021) and a related report to Congress the following year that will, in coordination with other Federal departments, address topics raised in this recommendation. Work on the plan has begun under HRSA leadership.

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ASPE	GAO-18-240	Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding	3/29/2018	1	The Secretary of HHS should coordinate with federal agencies, including VA, that fund GME training to identify information needed to evaluate the performance of federal programs that fund GME training, including the extent to which these programs are efficient and cost-effective and are meeting the nation's health care workforce needs.	Concur	NA	In Progress	Section 3402 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act directs the Secretary of HHS to develop a comprehensive and coordinated plan for health workforce programs, which may include performance measures and the identification of gaps between the outcomes of such programs and relevant workforce projection needs. This plan is to be developed within one year of enactment (March 27, 2020) and is to be followed in a year with a report to Congress describing the plan and subsequent action. HRSA is directing the development of this plan. The plan and its related report to Congress call for coordination across Federal agencies and departments and should provide information called for in this recommendation.Further, as in previous years The President's FY 2022 budget contains a major proposal to restructure the Department's Graduate Medical Education (GME) programs located in the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) into a

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									single capped grant program. There has been no response from Congress on this request. Such a restructuring would allow the Department to set expectations for program performance in CMS's GME programs and allow the kind of tracking HRSA has been able to implement in the Children's Hospital GME program. However, Congress has not authorized this activity. More specifically, should necessary authorization language be passed, the Administration has assigned responsibility for reforming and administering GME jointly to CMS and HRSA. As specified in the Department's budget, this proposal would consolidate federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospital Graduate Medical Education Program into a single grant program for teaching hospitals. Total funds available for distribution in FY 2020 would equal the sum of Medicare and Medicaid's 2017 payments for graduate medical education, plus 2017 spending on Children's Hospital Graduate Medical Education, adjusted for inflation. This grant program would be

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									funded out of the general fund of the Treasury. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs (e.g., primary care, geriatrics) and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. Enactment of this proposal would give the Department new opportunities to monitor performance in its biggest GME investments. Should Congress decide to authorize this activity, CMS and HRSA can further consider how recommendations from GAO may be further addressed.

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ASPE	GAO-18-240	Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding	3/29/2018	2	The Secretary of HHS should coordinate with federal agencies to identify opportunities to improve the quality and consistency of the information collected within and across federal programs, and implement these improvements.	Concur	NA	In Progress	The plan and report to Congress required by the CARES Act will provide information from across federal departments to assist in identifying these opportunities. As noted in previous responses the capped grant program for GME proposed to Congress in the past several years would allow the Department to set expectations for program performance in CMS's GME programs and allow the kind of tracking HRSA has been able to implement in the Children's Hospital GME program and Teaching Health Center program.

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ASPR	GAO-17-187	Public Health Emergencies: HHS Needs to Better Communicate Requirements and Revise Plans for Assessing Impact of Personnel Reassignment	1/9/2017	1	To help ensure that HHS agencies and offices fully understand the requirements and processes for the temporary reassignment authority, their responsibilities under the authority, and that ASPR is adequately and comprehensively assessing the effect of the authority on public health emergency response and medical surge, the Secretary of HHS should direct ASPR to conduct outreach to HHS agencies and offices that administer programs eligible for the reassignment authority to inform them of their responsibilities and ASPR's expected time frames for reviewing and approving states' and tribes' requests for personnel reassignments, and inform them of their responsibilities and ASPR's expectations for reviewing states' and tribes' after-action reports.	Concur	NA	In Progress	At the beginning of the COVID-19 pandemic, ASPR reached out to HHS grant offices to inform them of the temporary reassignment authority and confirm the process for grant program review of temporary reassignment requests. ASPR identified POCs from each agency to route requests to the specific grant program and communicate decisions back to ASPR. On March 5, 2020, an overview of the temporary reassignment authority was presented during an Executive Committee on Grants Administration Policy meeting. Additionally, ASPR developed updated temporary reassignment guidance, which was posted on phe.gov.

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ASPR	GAO-18-211	Critical Infrastructure Protection: Additional Actions Are Essential to Assessing Cybersecurity Framework Adoption	2/15/2018	6	The Secretary of Health and Human Services, in cooperation with the Secretary of Agriculture, should take steps to consult with respective sector partner(s), such as the SCC, DHS and NIST, as appropriate, to develop methods for determining the level and type of framework adoption by entities across their respective sector.	Concur	2020/2021	In Progress	HHS's implementation of this GAO recommendation remains in progress. HHS has previously conferred with agencies and sector partners regarding methods to determine framework adoption and will work with appropriate entities to assist in sector adoption. HSHS supports sector adoption of the framework in numerous ways, including incorporating references to the framework in its guidance materials. For example, HHS's Summer 2020 Cybersecurity Newsletter discussed the importance of creating and maintaining an enterprise-wide IT asset inventory. In describing inventory components, the newsletter referred to the framework's Asset Management (ID.AM) category, including inventorying hardware (ID.AM-1), inventorying software (ID.AM-2), and mapping communication and data flows (ID.AM-3).OCR also notes that HIPAA covered entities and business associates can use the HIPAA Security Rule to NIST Cybersecurity Framework to assess their own adoption with the framework by leveraging their current HIPAA compliance posture.

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ASPR	A-04-16-03567	HHS Did Not Always Efficiently Plan and Coordinate Its International Ebola Response Efforts	8/12/2019	216-915-10-1	We recommend that HHS develop large-scale international response plans that include: working with OPM to develop guidelines that would allow HHS to request and receive direct hiring authority during an international health response; working with DoS to develop a process to streamline overseas deployment of HHS staff during an international health crisis; updating the training and preparation needed for certain HHS staff to be readily deployable for international emergencies—both DoS-required clearances and training on infectious diseases; updating the training course developed during this crisis to train Commissioned Corps staff in the handling of infectious diseases to prepare staff for future response efforts; working with OMB to determine the viability of a contingency fund for international response efforts when congressionally requested funds are not	Concur	NA	In Progress	HHS provided an update to OIG in October 2020. HHS is continuing to work on this recommendation.

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					immediately available; and establishing communication protocols for responding to an international crisis that (1) identify key communication resources needed by responders in the field, (2) develop a plan to provide these resources to staff, and (3) establish a single communication channel from which the public can obtain information.				

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ASPR	A-04-16-03567	HHS Did Not Always Efficiently Plan and Coordinate Its International Ebola Response Efforts	8/12/2019	216-919-10-1	We recommend that HHS develop department-wide objectives and a strategic framework for responding to international public health emergencies.	Concur	NA	In Progress	HHS provided an update to OIG in October 2020. HHS is continuing to work on this recommendation.
ASPR	A-04-16-03567	HHS Did Not Always Efficiently Plan and Coordinate Its International Ebola Response Efforts	8/12/2019	216-919-10-2	We recommend that HHS develop policies and procedures, along the lines of the NRF, that: define the roles and responsibilities of each component when responding to an international public health emergency, which will allow the components to respond using their core competencies; more clearly define the oversight body that monitors international response activities; and include in the transition plan for incoming administrations and department heads the operational authorities of HHS during international response efforts.	Concur	NA	In Progress	HHS provided an update to OIG in October 2020. HHS is continuing to work on this recommendation.

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ASPR	A-04-16-03567	HHS Did Not Always Efficiently Plan and Coordinate Its International Ebola Response Efforts	8/12/2019	216-919-10-3	We recommend that HHS work with other U.S. Government agencies to develop a flexible framework focusing on each agency's mission and define each agency's roles and responsibilities for responding to a multi-agency international public health emergency.	Concur	NA	In Progress	HHS provided an update to OIG in October 2020. HHS is continuing to work on this recommendation.
ASPR	A-04-16-03567	HHS Did Not Always Efficiently Plan and Coordinate Its International Ebola Response Efforts	8/12/2019	299-912-10-1	We recommend that HHS develop various means, including IPR, of obtaining and using quality data needed for effective decision making during a public health crisis.	Concur	NA	In Progress	HHS provided an update to OIG in October 2020. HHS is continuing to work on this recommendation.
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes in the U.S.	9/20/2019	1	ASPR should develop a response personnel strategy to ensure, at a minimum, a lead ASPR liaison officer is consistently at the local emergency operations center(s) during an emergency support functions (ESF) #8 response and another liaison, if not more, is at strategic location(s) in the area.	Concur	NA	Awaiting Disposition	The Incident Management Framework was signed by the ASPR in May 2019.

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		Virgin Islands and Puerto Rico							
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes in the U.S. Virgin Islands and Puerto Rico	9/20/2019	2	As ASPR finalizes its federal patient movement framework, the agency should exercise the framework with its National Disaster Medical System (NDMS) partners to ensure that patients evacuated through NDMS will be consistently tracked from the start of their evacuation. (Recommendation 2)	Concur	NA	In Progress	Exercising Patient Movement is subject to the availability of funds. Since this report, funding has not improved, and the other points made are still valid (e.g., JPATS/Patient Tracking training is still occurring). In fact, the NDMS baseline is below what is needed to fulfill essential requirements.
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent	9/20/2019	3	ASPR should put controls in place to ensure data on all NDMS evacuated patients are complete and accurate.	Concur	NA	In Progress	Since this report, we have hired a Nurse Consultant into NDMS who is the lead for the Case Management program. She is in the process of developing process & procedures and training for case managers. The plan is to develop case managers within NDMS and not become dependent on USPHS as those resources are not part of

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		Hurricanes in the U.S. Virgin Islands and Puerto Rico							ASPR and not always available when needed. Lastly, the Disaster Medical Information Suite (DMIS) contract, which includes JPATS, will be recompeted this next calendar year (2021).
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes in the U.S. Virgin Islands and Puerto Rico	9/20/2019	4	ASPR Region II should revise its Incident Response Plans for the territories to include strategies for providing chronic and primary care in isolated communities. These strategies could include the incorporation of Federally Qualified Health Centers and other local health clinics as part of a response.	Non-Concur	NA	Awaiting Disposition	HHS does not concur with this recommendation.
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes	9/20/2019	5	ASPR should work with support agencies to develop and finalize memorandums of agreement that include information on the capabilities and limitations of these agencies to meet ESF#8 core capabilities.	Non-Concur	NA	Awaiting Disposition	HHS does not concur with this recommendation.

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		in the U.S. Virgin Islands and Puerto Rico							
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes in the U.S. Virgin Islands and Puerto Rico	9/20/2019	6	ASPR should develop a strategy demonstrating how it ESF#8 core capabilities can be provided through HHS and ESF#8 support agencies if DOD's capacity to respond is limited.	Concur	NA	In Progress	HHS is continuing to work on this recommendation.
ASPR	GAO-19-592	Disaster Response: HHS Should Address Deficiencies Highlighted by Recent Hurricanes	9/20/2019	7	ASPR should take steps to ensure the perspectives of key external parties are incorporated in the development of HHS's after-action reviews, following future ESF#8 activations.	Concur	NA	In Progress	HHS is continuing to work on this recommendation.

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		in the U.S. Virgin Islands and Puerto Rico							

ASPR, CDC	GAO-13-278	National Preparedness: Improvements Needed for Measuring Awardee Performance in Meeting Medical and Public Health Preparedness Goals	5/22/2013	1	To help ensure that HHS is adequately and comprehensively assessing HPP and PHEP awardees' performance and progress in meeting the medical and public health preparedness goals of the cooperative agreements, the Secretary of Health and Human Services should direct ASPR and CDC to develop objective and quantifiable performance targets and incremental milestones that correspond to the new HPP and PHEP performance measures, against which HHS can gauge progress toward the medical and public health preparedness goals of the cooperative agreements and direct technical assistance, as needed.	Concur	NA	Awaiting Disposition	PHEP program performance is evaluated through a combination of performance measures, site visits, one-on-one consultations, and other metrics, including the Operational Readiness Review (see below for more information). DSLR sets targets for measures that have meaningful national comparisons but also collects specific performance metrics for individual recipient monitoring. Performance metrics inform individual program technical assistance needs and facilitate overall program improvements. As previously reported to GAO, effective July 2017, CDC established core capability measures to assess overall program performance and impact across six key public health emergency management domains: community resilience, biosurveillance, incident management, information sharing, medical countermeasures and mitigation, and surge management. In 2017, CDC started collecting outcome measures across the six domains to establish baseline data for each recipient. CDC collected data on some of these measures during the previous project period as well. CDC will use the measures as markers to determine the percent of recipients with programs in place that have the capacity to effectively respond to public health emergencies whose scale, rapid onset, or unpredictability stresses

									the public health system. CDC will use five performance measures to determine the ability of the nation to meet target times established for disease reporting and control, epidemiological and lab response, and critical information sharing among partners. CDC revised one measure that was previously collected on an annual basis throughout the past project period. This revised measure involves how disease reporting for E. coli (STEC) confirmed cases is reported to CDC. The revision will allow CDC to compare recipient reporting proficiency across the nation whereas past reporting was limited to monitoring individual recipient improvement without national comparison ability. CDC reviews annually the program targets, which include 90% of recipients meeting target times for each of the measures. This is PHEP 13.1 Disease Reporting, E. coli, STEC (Shiga Toxin-producing E coli). (Report within 7 days.) The additional measures that include targets are: 1. PHEP 3.1: Staff assembly - target time of 60 minutes 2. PHEP 12.2: 24/7 Emergency Contact Drill – target time of 45 minutes, which has remained unchanged for five years 3. PHEP 12.5: Proficiency Testing (LRN-C Additional Methods) 4. PHEP 12.6: Proficiency Testing (LRN-C Core Methods)

									CDC closed the previous five-year budget cycle and issued a new PHEP five-year cooperative agreement in 2019 that no longer combines program requirements with ASPR's HPP cooperative agreement. CDC also updated its 15 public health preparedness capabilities and revised its evaluation and performance measurement strategy. During the 2019-2024 performance period, CDC will use a new operational readiness assessment tool to evaluate PHEP recipient progress across all 15 public health preparedness and response capabilities. Currently, CDC's operational readiness review (ORR) is limited primarily to two capabilities regarding medical countermeasure distribution and dispensing. CDC will continue to monitor and assess PHEP recipient progress along a continuum. This operational readiness review (ORR) will evaluate whether recipients have documented progress in achieving a comprehensive set of data elements used to evaluate PHEP program planning and implementation. CDC expects PHEP recipients to continue to make substantial progress toward achieving operational readiness by the end of the performance period in June 2024.

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ASPR, CDC	GAO-13-278	National Preparedness: Improvements Needed for Measuring Awardee Performance in Meeting Medical and Public Health Preparedness Goals	5/22/2013	2	To help ensure that HHS is adequately and comprehensively assessing HPP and PHEP awardees' performance and progress in meeting the medical and public health preparedness goals of the cooperative agreements, the Secretary of Health and Human Services should ensure that performance measures and targets remain consistent across the 5-year project cycle and that any future measures be comparable to determine whether awardees are making progress toward meeting short- and long-term medical and public health preparedness goals of the cooperative agreements.	Concur	NA	Awaiting Disposition	Since GAO's feedback in 2017, CDC has continued to make progress toward implementing the recommendation:CDC evaluates and refines performance measures on an ongoing basis to maintain relevant, up-to-date program performance. CDC identified a core set of measures for which data were collected for at least three budget periods. Results from these measures establish baseline performance and inform the current five-year funding targets. The 2017 funding agreement (https://www.cdc.gov/phpr/readiness/00_docs/PHEP-Funding-CDC-RFA-TP17-1701.pdf) established a consistent set of targets and metrics for recipients over the course of the five-year project period. Similarly, PHEP guidance stipulates that all funded jurisdictions must achieve an operational readiness target goal of "established" by 2022, which is a consistent target across the project period.CDC closed the five-year budget cycle referenced in the 2017 GAO response and issued a new PHEP five-year cooperative agreement (https://www.grants.gov/web/grants/view-opportunity.html?oppId=310318)

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									in 2019 that no longer combines program requirements with ASPR's HPP cooperative agreement. CDC also updated its 15 public health preparedness capabilities and revised its evaluation and performance measurement strategy. During the 2019-2024 performance period, CDC will use a new operational readiness assessment tool to evaluate PHEP recipient progress across all 15 public health preparedness and response capabilities. Currently, CDC's operational readiness review (ORR) is limited primarily to two capabilities regarding medical countermeasure distribution and dispensing. CDC will continue to monitor and assess PHEP recipient progress along a continuum. This operational readiness review (ORR) will evaluate whether recipients have documented progress in achieving a comprehensive set of data elements used to evaluate PHEP program planning and implementation. CDC expects PHEP recipients to continue to make substantial progress toward achieving operational readiness by the end of the performance period in June 2024.

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ASPR, CDC	GAO-17-377	Public Health Information Technology: HHS Has Made Little Progress toward Implementing Enhanced Situational Awareness Network Capabilities	9/6/2017	1	To ensure progress is made toward the implementation of any IT enhancements needed to establish electronic public health situational awareness network capabilities mandated by PAHPRA, the Secretary of HHS should direct the Assistant Secretary for Preparedness and Response to task an integrated project team, made up of an IT project manager and business owner, with including specific actions in the Public Health and Medical Situational Awareness Strategy Implementation Plan for conducting all activities required to establish and operate the network.	Concur	NA	In Progress	ASPR is coordinating with CDC to address this recommendation.

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ASPR, CDC	GAO-17-377	Public Health Information Technology: HHS Has Made Little Progress toward Implementing Enhanced Situational Awareness Network Capabilities	9/6/2017	2	To ensure progress is made toward the implementation of any IT enhancements needed to establish electronic public health situational awareness network capabilities mandated by PAHPRA, the Secretary of HHS should direct the Assistant Secretary for Preparedness and Response to task the integrated project team with developing a project management plan that includes measurable steps--including a timeline of tasks, resource requirements, estimates of costs, and performance metrics--that can be used to guide and monitor HHS's actions to establish the network defined in the plans.	Concur	NA	In Progress	ASPR is coordinating with CDC to address this recommendation.

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ASPR, CDC	GAO-17-377	Public Health Information Technology: HHS Has Made Little Progress toward Implementing Enhanced Situational Awareness Network Capabilities	9/6/2017	3	To ensure progress is made toward the implementation of any IT enhancements needed to establish electronic public health situational awareness network capabilities mandated by PAHPRA, the Secretary of HHS should direct the Assistant Secretary for Preparedness and Response to conduct all IT management and oversight processes related to the establishment of the network in accordance with Enterprise Performance Life Cycle Framework guidance, under the leadership of the HHS CIO.	Concur	NA	In Progress	ASPR is coordinating with CDC to address this recommendation.

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CDC	GAO-16-337	Workplace Safety and Health: Additional Data Needed to Address Continued Hazards in the Meat and Poultry Industry	5/25/2016	3	The Secretary of Health and Human Services should direct the Director of the Centers for Disease Control and Prevention to have NIOSH conduct a study of the injuries and illnesses these workers experience, including their causes and how they are reported. Given the challenges to gaining access to this population, NIOSH may want to coordinate with OSHA to develop ways to initiate this study.	Concur	NA	Awaiting Disposition	CDC continues to meet with the National Chicken Council (NCC) and US Egg & Poultry Association on the study of peracetic acid (PAA) exposure in the poultry processing industry. CDC representatives conducted a walkthrough of a poultry processing facility in April 2019 that was facilitated by the NCC – this walkthrough allowed CDC's National Institute for Occupational Safety and Health (NIOSH) representatives to update knowledge on current issues in that workplace. As mentioned previously, OSHA entered into an Alliance with the National Chicken Council, National Turkey Federation, and US Poultry and Egg Association in September 2019 – a primary intent of that alliance included "to share information, guidance and access to training resources that will help further improve the significant gains made in poultry worker safety over the past 25 years. Specifically, the organizations will share available injury, illness and hazard exposure data to help identify areas of emphasis for training, outreach and communication activities." A meeting to present CDC (NIOSH)

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									field and lab activities was held with these industry associations in February 2020 and areas of mutual interest in this research area were discussed. These industry associations expressed interest in the potential for collaborating on assessing new NIOSH PAA measurement methods in poultry plants. However, the advent of COVID-19 and challenges have limited plans for field studies for FY20. During the COVID-19 epidemic CDC's NIOSH representatives have: (1) created guidelines with OSHA https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html; and (2) performed more than 30 meat and poultry worksite evaluations focusing on the prevention of SARS-CoV2. CDC continues to have interest in learning more about and providing assistance to minimize various types of illnesses and injuries that may be occurring among meat and poultry sanitation workers. At some point in the future (time frame uncertain based on the COVID-19 epidemic), the hope is to “re-initiate” interactions with

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									stakeholders such as the NCC and US Egg & Poultry Association on the study of PAA exposure in the poultry processing industry. However we do expect that the challenges NIOSH representatives have had in the past related to gathering data in these workplaces will remain in the future.

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CDC	A-04-16-04044	The Ministry of Health and Social Welfare National AIDS Control Program Did Not Always Manage and Expend PEPFAR Funds in Accordance With Award Requirements	8/10/2017	016-005/01-1	We recommended that the Ministry work with CDC to determine the allowability of the $1,548,664 in personnel costs awarded to the Ministry during the audit period.	Concur	2020	In Progress	The recipient filed an appeal, which is currently under review.
CDC	A-04-16-04044	The Ministry of Health and Social Welfare National AIDS Control Program Did Not Always Manage and	8/10/2017	099-009-17-1	We recommended that the Ministry refund to CDC $495,379 of unallowable expenditures from our sample review that it could not adequately support.	Concur	2020	In Progress	The recipient filed an appeal, which is currently under review.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		Expend PEPFAR Funds in Accordance With Award Requirements							
CDC	A-04-16-04051	The National Institute of Health in Mozambique Did Not Always Manage and Expend the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements	4/10/2018	077-009-01-1	We recommend that the Institute, work with CDC to obtain VAT reimbursement from the Government of Mozambique.	Concur	2020	Awaiting Disposition	Payment received to fully resolve this recommendation. CDC considers this recommendation closed.

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CDC	A-04-16-04051	The National Institute of Health in Mozambique Did Not Always Manage and Expend the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements	4/10/2018	099-009-01-1	We recommend that the Institute refund to CDC $431,458 of unallowable expenditures: $379,243 that it could not adequately support and $52,215 that it used to support non-PEPFAR activities.	Concur	2020	Awaiting Disposition	Payment received to fully resolve this recommendation. CDC considers this recommendation closed.
CDC	A-04-17-01002	The South African National Department of Health Did Not Always Manage and Expend the President's Emergency Plan for	5/16/2018	077-009-01-1	We recommend that the Ministry work with CDC to obtain $343,930 of VAT reimbursement from the South African Government.	Concur	2020	Awaiting Disposition	This audit was sent to debt collection in FY 20. A letter is being sent to the recipient and the recipient will have 30 days to respond with payment. Recipient confirmed that this matter is taking longer than expected due to COVID-19 challenges. CDC considers this recommendation closed.

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		AIDS Relief Funds in Accordance With Award Requirements							
CDC	A-04-17-01002	The South African National Department of Health Did Not Always Manage and Expend the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements	5/16/2018	077-919-10-1	We recommend that the Ministry develop and implement policies and procedures to ensure that it obtains VAT reimbursement.	Concur	2020	Awaiting Disposition	Recipient provided documentation indicating full implementation. Implementation confirmed during the November 2019 site visit. CDC considers this recommendation closed

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CDC	A-04-17-01002	The South African National Department of Health Did Not Always Manage and Expend the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements	5/16/2018	077-919-10-2	We recommend that the Ministry implement training on the VAP process.	Concur	2020	Awaiting Disposition	This audit was sent to debt collection in FY 20. A letter is being sent to the recipient and the recipient will have 30 days to respond with payment. Recipient confirmed that this matter is taking longer than expected due to COVID-19 challenges. CDC considers this recommendation closed.
CDC	OEI-04-15-00431	Entities Generally Met Federal Select Agent Program Internal Inspection Requirements But CDC Could Do	6/25/2018	399-915-11-05-05595	Clarify the requirement for internal inspections.	Concur	2021	In Progress	Waiting on publication of NPRM to respond to OIG. NPRM is tentatively scheduled for publication in 2021.

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		More To Improve Effectiveness							
CDC	GAO-18-145	High-Containment Laboratories: Coordinated Actions Needed to Enhance the Select Agent Program's Oversight of Hazardous Pathogens	10/31/2017	10	To improve technical expertise and overcome fragmentation, the CDC director of the Select Agent Program should work with APHIS to develop a joint workforce plan that assesses workforce and training needs for the program as a whole. This assessment should be done in conjunction with the development of the strategic plan.	Concur	2021	Awaiting Disposition	Response document under FSAP Director review and approval prior to submission to GAO.

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CDC, FDA, NIH, OS	GAO-16-305	High–Containment Laboratories: Comprehensive and Up-to-Date Policies and Stronger Oversight Mechanisms Needed to Improve Safety	4/19/2016	19	To ensure that federal departments and agencies have comprehensive and up-to-date policies and stronger oversight mechanisms in place for managing hazardous biological agents in high-containment laboratories and are fully addressing weaknesses identified after laboratory safety lapses, the Secretary of Health and Human Services should develop department policies for managing hazardous biological agents in high-containment laboratories that contain specific requirements for training and inspections for all high-containment component agency laboratories and not just for their select-agent-registered laboratories; or direct the Director of CDC to provide these requirements in agency policies.	Concur	NA	Awaiting Disposition	CDC condensed the training requirements in the High Containment Laboratory Inspection, Reporting, and Training Policy to ensure the policy focus is on HCL Inspection and Reporting. CDC considers this recommendation closed.

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CDC, FDA, NIH, OS	GAO-16-305	High–Containment Laboratories: Comprehensive and Up-to-Date Policies and Stronger Oversight Mechanisms Needed to Improve Safety	4/19/2016	23	To ensure that federal departments and agencies have comprehensive and up-to-date policies and stronger oversight mechanisms in place for managing hazardous biological agents in high-containment laboratories and are fully addressing weaknesses identified after laboratory safety lapses, the Secretary of Health and Human Services should direct the Director of NIH and the Commissioner of FDA to require routine reporting of the results of agency laboratory inspections--and in the case of FDA, require routine reporting of select agent inspection results--to senior agency officials.	Concur	NA	In progress	FDA standardized laboratory inspection checklists in 2019 and plan to aggregate the findings from these inspections and share the results with FDA leadership.

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CDC, FDA, NIH, OS	GAO-16-305	High–Containment Laboratories: Comprehensive and Up-to-Date Policies and Stronger Oversight Mechanisms Needed to Improve Safety	4/19/2016	18	To ensure that federal departments and agencies have comprehensive and up-to-date policies and stronger oversight mechanisms in place for managing hazardous biological agents in high-containment laboratories and are fully addressing weaknesses identified after laboratory safety lapses, the Secretary of Health and Human Services should develop department policies for managing hazardous biological agents in high-containment laboratories that contain specific requirements for reporting laboratory incidents to senior department officials, including the types of incidents that should be reported, to whom, and when, or direct the Director of CDC and the Commissioner of FDA to incorporate these requirements into their respective policies.	Concur	NA	In progress	CDC expects to finalize its Occupational Safety and Health Training Policy in 2021. The pending policy clarifies roles and responsibilities and levels of mandatory training from task and site specific to overarching. The update also includes HHS annual training reporting requirements.

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CDC, FDA, NIH, OS	GAO-16-305	High–Containment Laboratories: Comprehensive and Up-to-Date Policies and Stronger Oversight Mechanisms Needed to Improve Safety	4/19/2016	22	To ensure that federal departments and agencies have comprehensive and up-to-date policies and stronger oversight mechanisms in place for managing hazardous biological agents in high-containment laboratories and are fully addressing weaknesses identified after laboratory safety lapses, the Secretary of Health and Human Services should require routine reporting of the results of agency and select agent laboratory inspections to senior department officials.	Concur	NA	In Progress	HHS is now working to establish a process for reporting laboratory inspections to senior HHS officials.
CDC, FDA, NIH, OS	GAO-16-305	High–Containment Laboratories: Comprehensive and Up-to-Date Policies and Stronger Oversight Mechanisms Needed	4/19/2016	24	To ensure that federal departments and agencies have comprehensive and up-to-date policies and stronger oversight mechanisms in place for managing hazardous biological agents in high-containment laboratories and are fully addressing weaknesses identified after laboratory safety lapses, the Secretary of Health and Human Services should require routine reporting of incidents	Concur	NA	In progress	In August 2016, HHS reported that its Biosafety and Biosecurity Council was working to establish incident reporting requirements for CDC, FDA, and NIH but did not provide an anticipated completion date. In August 2019, FDA reported that it continues to work with the Biosafety and Biosecurity Coordinating Council to establish a process for the routine reporting of these results but had not yet completed its actions

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		to Improve Safety			at CDC, FDA, and NIH laboratories to senior department officials.				
CDC, NIH	GAO-16-642	High-Containment Laboratories: Improved Oversight of Dangerous Pathogens Needed to Mitigate Risk	9/21/2016	2	To understand the extent to which incomplete inactivation occurs and whether incidents are being properly identified, analyzed, and addressed, the Secretary of Health and Human Services should direct the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to develop clear definitions of inactivation for use within their respective guidance documents that are consistent across the Select Agent Program, NIH's oversight of recombinant pathogens, and the Biosafety in Microbiological and	Concur	2020	Awaiting Disposition	The 6th edition of the Biosafety in Microbiology and Biomedical Laboratories (BMBL) has been released. CDC and NIH consider this recommendation closed.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
					Biomedical Laboratories manual.				
CDC, NIH	GAO-16-642	High-Containment Laboratories: Improved Oversight of Dangerous Pathogens Needed to Mitigate Risk	9/21/2016	8	To help ensure that inactivation protocols are scientifically sound and are effectively implemented, the Secretary of Health and Human Services should direct CDC and NIH to create comprehensive and consistent guidance for the development, validation, and implementation of inactivation protocols--to include the application of safeguards--across the Select Agent Program, NIH's oversight of recombinant pathogens, and the Biosafety in Microbiological and	Concur	2020	Awaiting Disposition	The 6th edition of the Biosafety in Microbiology and Biomedical Laboratories (BMBL) has been released. CDC and NIH consider this recommendation closed.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
					Biomedical Laboratories manual.				
CDC, NIH	GAO-16-642	High-Containment Laboratories: Improved Oversight of Dangerous Pathogens Needed to Mitigate Risk	9/21/2016	9	To help ensure that dangerous pathogens can be located in the event there is an incident involving incomplete inactivation, the Secretary of Health and Human Services should direct the Directors of CDC and NIH, when updating the Biosafety in Microbiological and Biomedical Laboratories manual, to include guidance on documenting the shipment of inactivated material.	Concur	2020	Awaiting Disposition	The 6th edition of the Biosafety in Microbiology and Biomedical Laboratories (BMBL) has been released. CDC and NIH consider this recommendation closed.

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CMS	A-03-00-00216	Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers	9/11/2001	099-912-10-1	We recommended that CMS provide States with definitive guidance for calculating the upper payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data.	Concur	2020	In Progress	Regulation under development
CMS	GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2002	3	To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human services should better ensure that valid methods are used to demonstrate budget neutrality, by developing and implementing consistent criteria for consideration of section 1115 demonstration waiver proposals.	Non-Concur	NA	Awaiting Disposition	In May 2018 CMS responded to request for information and source documents related to Budget Neutrality Methods. CMS has continued to provide additional information in 2019 and we awaiting further discussion with GAO.
CMS	OEI-05-03-00170	Status of the Rural Health Clinic Program	8/1/2005	307-915-13-02-01120	CMS should seek legislative authority or administratively require RHC applicants to document need and impact on access to health care in rural underserved areas.	Concur	2020	In progress	Working internally with CMS Office of Legislation for resolution.

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CMS	OEI-03-02-00771	Use of Modifier 59 to Bypass Medicare's National Coding Initiative Edits	11/1/2005	303-915-11-02-00242	CMS should ensure that the carriers' claims processing systems only pay claims with modifier 59 when the modifier is billed with the correct code.	Concur	2018	Awaiting Disposition	CMS believes the spirit of this recommendation to have been met and has not performed any further actions.
CMS	GAO-07-214	Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency	3/30/2007	2	To enhance the transparency of CMS oversight and clarify and communicate the types of allowable state financing arrangements, the Administrator of CMS should provide each state CMS reviews under its initiative with specific and written explanations regarding agency determinations on the allowability of various arrangements for financing the nonfederal share of Medicaid payments and make these determinations available to all states and interested parties.	Concur	2020	In progress	Regulation under development

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CMS	GAO-08-529	Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities	5/23/2008	2	To help states identify and address quality-of-care concerns among individuals with developmental disabilities receiving Medicaid HCBS waiver services, the Administrator of CMS should encourage states to (1) include death as a critical incident and conduct mortality reviews if they do not already do so and (2) broaden their mortality review processes if they already include death as a critical incident and conduct mortality reviews.	Concur	2020	In progress	CMS is engaging internally with leadership regarding the desired approach to monitoring and reporting of suspicious deaths in HCBS waivers and possibility of new guidance.
CMS	OEI-03-07-00380	Medicare Drug Plan Sponsor's Identification of Potential Fraud and Abuse	10/1/2008	313-915-11-02-00844	Use this required information to help determine the effectiveness of sponsors' fraud and abuse programs.	Concur	2021	In progress	This report will assist us in ensuring that Sponsors are conducting their own internal investigations and taking appropriate corrective actions in response to those investigations.
CMS	OEI-03-07-00380	Medicare Drug Plan Sponsor's Identification of Potential Fraud and Abuse	10/1/2008	313-915-11-02-00842	Determine whether the Part D sponsors that identified fraud and abuse initiated inquiries and corrective actions as required by CMS and made referrals for further investigation as recommended by CMS.	Concur	2021	In progress	We concur and will forward the findings to the MEDICs for further investigation.

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CMS	A-05-07-00077	Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	4/20/2009	312-010-02-1	We recommend that CMS consider adjusting the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, which may reduce payments by an estimated $97.6 million	Non-concur	NA	Awaiting Disposition	CMS continues to non concur; No additional action has taken place.
CMS	A-05-07-00077	Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	4/20/2009	312-920-10-1	We recommended that CMS consider adjusting the estimated number of evaluation and management (E&M) services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries or using the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule..	Non-concur	NA	Awaiting Disposition	CMS continues to non concur; No additional action has taken place.

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CMS	OEI-02-08-00460	Medicare Part D Reconciliation Payments for 2006 and 2007	9/1/2009	399-915-11-02-01542	Hold sponsors more accountable for inaccuracies in the bids	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
CMS	OEI-03-08-00480	Average Sales Prices: Manufacturer Reporting and CMS Oversight	2/12/2010	399-915-11-02-01579	Develop an automated system for the collection of ASP data.	Concur	2021	In progress	The system is expected to be open for business for April submissions due April 30, 2019. CMS is planning dual submissions (manufacturers will report in the system and the former way). If all goes well, July reporting will be solely in the system, therefore, expected completion date of August 2020.
CMS	OEI-03-08-00030	Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors	5/1/2010	303-916-11-02-01575	Require that PSCs, ZPICs, and claims processors have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found.	Concur	2020	In progress	CMS provided new technical direction to both the MACs and UPICs to utilize a standard overpayment referral form to coordinate overpayment collection activities. For the UPICs, CMS sent a technical direction letter on June 10, 2019, requiring the UPICs to utilize the "Overpayment Referral to MAC" form and to ensure the Joint Operating Agreements with each MAC accounts for the use of this form. The UPICs are required to include the overpayment record number generated from the Unified Case Management (UCM) system

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									on the form. This process update helps to ensure consistent reporting across all contractors and also alleviates timely recovery of overpayments since all contractors are reporting overpayments in the same manner.
CMS	OEI-07-09-00290	CMS Reporting to the Healthcare Integrity and Protection Data Bank	9/1/2010	399-908-11-02-01791	CMS should report all adverse actions as required.	Concur	2020	In progress	CMS is continuing to coordinate the testing of the NPDB processes which now includes clarifying the applicable policies with HRSA/NPDB. CMS has been testing responses with the NPDB and has identified challenges, but has only recently received comprehensive clarification of the types of actions (both exclusionary and administrative) that are to be reported by CMS from the Branch Chief of Policy and Disputes, NPDB/HRSA. The delayed clarification has impacted CMS's ability to test the submission process. CMS will be developing an Interagency Data Exchange Agreement with the HHS/Health Services and Resources Administration (HRSA) which administers the NPDB. Therefore the projected implementation date

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									has been delayed to the 1st quarter of 2020. October 2019 update: CMS is in the process of establishing an MOU/IEA between HRSA and CMS; therefore, we anticipate that NPDB reporting will begin by the end of the second quarter of FY 20.
CMS	GAO-11-96	Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns	11/30/2010	3	To enhance the provision of dental care to children covered by Medicaid and CHIP, and to help ensure that HHS's Insure Kids Now Web site is a useful tool to help connect children covered by Medicaid and CHIP with participating dentists who will treat them, the Secretary of HHS should require states to verify that dentists listed on the Insure Kids Now Web site have not been excluded from Medicaid and CHIP by the HHS-OIG, and periodically verify that excluded providers are not included on the lists posted by the states.	Concur	2020	In progress	CMS will explore the viability of adding a task to our IKN data quality contract to compare excluded provider lists. 11/12/2019 CMS provided closure justification update. Currently awaiting GAO response.

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CMS	OEI-03-09-00510	Medicare Payments for Newly Available Generic Drugs	1/10/2011	332-905-13-02-01811	CMS work with Congress to require manufacturers of first generics to submit monthly ASP data during the period of initial generic availability.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	GAO-11-365	End-Stage Renal Disease: CMS Should Assess Adequacy of Payment When Certain Oral Drugs Are Included and Ensure Availability of Quality Monitoring Data	3/23/2011	1	To help ensure that Medicare beneficiaries have access to high-quality dialysis care, the Administrator of CMS should assess the extent to which the bundled payment for dialysis care will be sufficient to cover an efficient dialysis organization's costs to provide such care when the bundled payment expands to cover oral-only ESRD drugs. The Administrator should conduct this assessment before implementing this expanded bundled payment.	Concur	2025	In progress	CMS actively working on closure, will have update after 2022.

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CMS	GAO-11-293R	Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement	4/5/2011	2	In light of the need for accurate and complete information on children's access to health services under Medicaid and CHIP, the requirement that states report information to CMS on certain aspects of their Medicaid and CHIP programs, and problems with accuracy and completeness in this state reporting, the Administrator of CMS should work with states to identify additional improvements that could be made to the CMS 416 and CHIP annual reports, including options for reporting on the receipt of services separately for children in managed care and fee-for-service delivery models, while minimizing reporting burden, and for capturing information on the CMS 416 relating to children's receipt of treatment services for which they are referred.	Concur	2022	In progress	CMS and GAO on 8/12/2019. GAO stated that they understand that referral data cannot be captured and will remove that portion of the criteria for closure

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CMS	GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	1	To ensure that information entered into CMS's complaints database is reliable and consistent, the Administrator of CMS should identify issues with data quality and clarify guidance to states about how particular fields in the database should be interpreted, such as what it means to substantiate a complaint.	Concur	2021	In progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 06/30/2021. CMS will review how particular fields in the database should be interpreted and issue clarifying guidance, including what it means to substantiate a complaint. In addition, through the State Performance Standards System, CMS is reviewing data trends to improve State performance, including looking at substantiation rates (i.e., citation rates) during complaint investigations.

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CMS	GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	2	To strengthen CMS's assessment of state survey agencies' performance in the management of nursing home complaints, the Administrator of CMS should conduct additional monitoring of state performance using information from CMS's complaints database, such as additional timeliness measures.	Concur	2021	In progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 07/31/2021
CMS	GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	5	To strengthen and increase accountability of state survey agencies' management of the nursing home complaints process, the Administrator of CMS should clarify guidance to the state survey agencies about the minimum information that should be conveyed to complainants at the close of an investigation.	Concur	2021	In progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 06/30/2021Section 5080 of the State Operations Manual describes the minimum information that should be conveyed to complainants. CMS will revise the minimum

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									information to guide States to inform complainants if their complaint was substantiated.
CMS	GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	6	To strengthen and increase accountability of state survey agencies' management of the nursing home complaints process, the Administrator of CMS should provide guidance encouraging state survey agencies to prioritize complaints at the level that is warranted, not above that level.	Concur	2021	In progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 06/30/2021. CMS will include guidance that we expect SAs to triage complaints and facility-reported incidents at the appropriate level.
CMS	OEI-07-08-00150	Medicare Atypical Antipsychotic Drug Claims for Elderly	5/4/2011	399-900-11-02-02091	CMS should facilitate access to information necessary to ensure accurate coverage and reimbursement determination	Non-concur	NA	Awaiting Disposition	We do not concur with OIGs recommendation. Currently, diagnosis information is not a required data element on pharmacy billing transactions nor is it generally included on prescriptions.

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		Nursing Home Residents							As such, this information is not readily available to dispensing pharmacists.
CMS	OEI-03-09-00410	States' Collection of Medicaid Rebates for Physician-Administered Drugs	5/6/2011	333-909-11-02-01951	Take action against States that do not meet the DRA's requirement to collect rebates on physician-administered drugs.	Concur	2020	In Progress	Clinical guidance is not under Division of Pharmacy purview; however, a national meeting for all states was held 1/2020 and MCO specific meeting held 2/2020 with a follow-up discussion 4/2020 to provide best practices and answer questions.
CMS	OEI-03-09-00410	States' Collection of Medicaid Rebates for Physician-Administered Drugs	5/6/2011	333-909-11-02-01952	Ensure that all State agencies are accurately identifying and collecting physician-administered drug rebates owed by manufacturers.	Concur	2020	In Progress	A national meeting for all states was held 1/2020 and MCO specific meeting held 2/2020 with a follow-up discussion 4/2020 to provide best practices and answer questions.
CMS	OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	303-915-10-02-02034	Revise the requirements in the local coverage determination.	Non-concur	NA	Awaiting Disposition	Per OIG May 2019 Response Memo- We will keep this recommendation open pending future research that may help CMS clarify the definitions of beneficiaries' potential functional levels in the local coverage determination, which would help to better ensure that prostheses are matched to beneficiaries' needs. We will consider this recommendation implemented when CMS provides more clarity in

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									this area in the local coverage determination. However, we will no longer request Annual Status Updates. When CMS has documentation please, send it to us so we can consider the recommendation implemented.
CMS	OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	307-915-11-02-02035	Enhance screening for currently enrolled suppliers of lower limb prostheses.	Concur	2017	Awaiting Disposition	Per May 2019 Response Memo- We will keep this recommendation open pending future research that may help CMS clarify the definitions of beneficiaries' potential functional levels in the local coverage determination, which would help to better ensure that prostheses are matched to beneficiaries' needs. We will consider this recommendation implemented when CMS provides more clarity in this area in the local coverage determination. However, we will no longer request Annual Status Updates. When CMS has documentation please, send it to us so we can consider the recommendation implemented.
CMS	OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	303-915-10-02-02033	Implement requirements for a face-to-face encounter with the referring physician.	Concur	2020	In progress	CMS issued its Workgroup consensus statement in September 2017. The Workgroup considered the use of prior authorization in order to ensure the provision of the most appropriate prosthesis to the Medicare beneficiary. The Workgroup concluded that pre-

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									authorization of lower limb prosthetics should be allowed in the Medicare population and provided guidance on the prior authorization requirements.
CMS	GAO-11-791	Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care	9/23/2011	1	As HHS implements its current and forthcoming efforts to make transparent price information available to consumers, HHS should determine the feasibility of making estimates of complete costs of health care services available to consumers through any of these efforts.	Concur	2021	Awaiting Disposition	This recommendation is addressed to the department and CMS is not tracking. Per discussion with GAO, this recommendation is closed but GAO website has not been updated.
CMS	GAO-11-791	Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to	9/23/2011	2	As HHS implements its current and forthcoming efforts to make transparent price information available to consumers, HHS should determine, as appropriate, the next steps for making estimates of complete costs of health care services available to consumers.	Concur	2021	Awaiting Disposition	This recommendation is addressed to the department and CMS is not tracking. Per discussion with GAO, this recommendation is closed but GAO website has not been updated.

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		Receiving Care							
CMS	OEI-03-10-00500	Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors	12/1/2011	212-915-11-02-02532	Require all benefit integrity contractors to report monetary impact, when calculable, in a consistent format	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. In some cases, CMS may be able to determine the monetary impact; however, requiring all benefit integrity contractors to report the monetary impact for each vulnerability and use it in a consistent methodology would prove challenging.

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CMS	OEI-06-09-00091	Hospital Incident Reporting Systems Do Not Capture Most Patient Harm	1/5/2012	399-915-11-02-02553	CMS should provide guidance to accreditors regarding survey or assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs.	Concur	2021	Awaiting Disposition	Given the recent Supreme Court Allina decision, we are unable to provide a timeline for the release of sub regulatory guidance updates. However, because all Medicare-certified hospitals must comply with the hospital conditions of participation, specifically the detailed requirements within QAPI - even though guidance has been delayed, all accreditation organizations with CMS approved deemed status hospital programs are required to survey to standards which meet or exceed these CMS of hospital efforts to track and analyze events continue to happen with our without CMS sub regulatory guidance. Additionally, CMS is actively involved in working through several strategies to improve communication between Accrediting Organizations (AOs) and State Agencies in order to improve overall health and safety of patients. Through our oversight of AOs, CMS must ensure that providers and suppliers that are accredited under an approved AO accreditation program meet the minimum patient safety and quality standards required by Medicare. We are working with AOs whose facilities

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									show an apparent lack of accountability and oversight from the hospital's governing body. The regulatory expectation of a hospital's governing body is to lead and direct quality within their organizations. CMS is working with AOs to improve facility oversight by developing a consistent process for coordinating communications between AOs and the State Agency, Regional Office and Central Office. Given that most of what we are doing requires reg. change now due to Allina, we should at least have an NPRM out for comment that will show GAO we're working on the issue by December 2020.
CMS	GAO-12-51	Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices	1/12/2012	1	To help ensure appropriate payments to MA plans, the Administrator of CMS should take steps to improve the accuracy of the adjustment made for differences in diagnostic coding practices between MA and Medicare FFS. Such steps could include, for example, accounting for additional beneficiary characteristics, including the most current data available, identifying and accounting	Concur	2021	Awaiting Disposition	We are continuing to work on this additional pierce requested by GAO and are working to have more information by end of the first quarter of 2021.

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					for all years of coding differences that could affect the payment year for which an adjustment is made, and incorporating the trend of the impact of coding differences on risk scores.				
CMS	GAO-12-81	Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations	1/18/2012	1	The Administrator of CMS should take steps to better align Medicare beneficiary use of preventive services with Task Force recommendations, including providing coverage of services with an 'A" or 'B" grade for the recommended population and at the recommended frequency, as she determines is appropriate considering cost-effectiveness and other criteria.	Concur	2020	Awaiting Disposition	We continue to maintain our position that this recommendation should be closed. The Medicare benefit for bone mass measurement is a statutorily-defined benefit dating back to the Balanced Budget Act of 1997. The USPSTF recommends screening for osteoporosis in women aged 65 years or older and in younger women whose facture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors. In the preambles of both the 1998 interim final rule and the 2006 final rule that implemented coverage for bone mass measurement, we stated that we allowed the treating physician or other treating

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									practitioner the discretion and flexibility to determine whether a female beneficiary is estrogen-deficient and at clinical risk for osteoporosis. While current Medicare coverage for women 65 and older could be interpreted as more restrictive than the updated USPSTF recommendations since the coverage regulation specifies one of five criteria to qualify for the screening test (one of the five criteria includes estrogen-deficient women), we believe that our current policy reaches virtually any post-menopausal woman, which obviously includes women younger than 65. Men also are covered if they qualify based on one of the other criteria.
CMS	OEI-05-10-00200	Early Assessment of Review Medicaid Integrity Contractors	2/21/2012	399-915-11-02-02431	CMS should improve the quality of data that Review MICs can access for conducting data analysis.	Concur	2020	Awaiting Disposition	This recommendation was closed in FY 2021
CMS	OEI-03-10-00310	Medicare Advantage Organizations' Identification of	2/24/2012	313-915-10-02-02452	Review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation.

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		Potential Fraud and Abuse			and Part D fraud and abuse incidents and inquiries				
CMS	OEI-01-10-00460	Limited Oversight of Home Health Agency OASIS Data	2/27/2012	399-904-11-02-02613	Develop clear guidelines that delineate expectations for States regarding timely and accurate OASIS data	Non-Concur	NA	Awaiting Disposition	We do not concur. The OIG survey pertaining to OASIS assistance was sent to the State OASIS Automation Coordinator (OAC) with the suggestion to enlist the State OASIS Education Coordinator (OEC). There is no way of knowing if the OAC did in fact enlist the OEC. The OASIS Submission System is intended to connect HHAs to their respective State Agencies for the purpose of electronic interchange of data, reports, and other information. The system supports the transfer of OASIS data from HHAs to their respective State Agency, provides authentication and validation of OASIS records received from HHAs, provides feedback to HHAs indicating acknowledgment of the transmission of the data and specifying the status of record validation, and provides storage of OASIS records in the database repository within the State Agency. The system as designed is technical in nature and looks for technical

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									submission errors. Fatal record error messages are generated when submitted individual records violate the current CMS data specifications and are rejected by the OASIS Submission system. The individual record or assessments that have fatal errors are completely removed from the database for data integrity purposes. "Minor errors" or "warning error" messages are generated when the individual record submitted violates some of the CMS data specifications and can still be accepted by the OASIS Submission System. Warning error messages do not pose a significant threat to the integrity of the data. The OIG report failed to identify the magnitude of costs associated with additional workload on State agencies to monitor error messages. While error messages do show inconsistencies with data submitted, most would require additional survey visits to determine severity of the issue. The OIG report failed to identify other sources of assistance for HHAs needing help with OASIS data accuracy and transmission. Providers are given the option of

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									getting assistance from multiple sources.

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CMS	OEI-01-10-00460	Limited Oversight of Home Health Agency OASIS Data	2/27/2012	303-909-11-02-02612	Establish and implement enforcement actions for HHAs that submit OASIS data after the 30-day deadline	Non-Concur	NA	Awaiting Disposition	The CMS does not concur. Most HHAs submit OASIS data within 30 days of the OASIS assessment completion date. The report indicates that 85 percent reported data within 30 days of the assessment and an addition 10 percent submitted the days within the next 10 days. The findings in the report failed to note that the error code for late submissions included all OASIS data submissions that included corrections. Recent revisions to the OASIS submission error messages will enable surveyors to differentiate true "late submissions" from submissions with corrections. The surveyor worksheet completed prior to survey entrance will be revised to emphasize the error for late OASIS submissions.HHAs are surveyed every 3 years. The current survey process looks at OASIS data submission and targets late data submissions as part of the pre-survey task. Standard level deficiencies are issued to providers that fail to submit OASIS data in a timely manner. In 2010, 116 such deficiencies were issued. HHAs submit a plan of correction to correct this deficiency. The deficiencies that would result from

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									increased surveyor scrutiny would be cited at the standard level, and HHAs that have only standard level deficiencies are still found to be in substantial compliance with the Conditions of Participation (CoP) and would not be terminated from the Medicare program. CMS is in the process of developing an Alternative Sanction regulation suggested by the Omnibus Reconciliation Act of 1987 to develop alternative sanctions for HHAs that have condition level deficiencies and may impose these sanctions on HHAs that are not in compliance with the CoP, including submission of OASIS data.
CMS	GAO-12-333	Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-	4/3/2012	4	To improve the effectiveness of the MSP program and process for NGHPs, and to improve the agency's communication regarding the MSP process for situations involving NGHPs, the Acting Administrator of CMS should develop guidance regarding liability	Concur	2020	In progress	CMS is in the process of rulemaking to address the finding. An NPRM is in process and subsequently a final rule.

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		Group Health Plans			and no-fault set-aside arrangements.				
CMS	A-05-09-00053	Wisconsin Physicians Service Insurance Corporation Claimed Unallowable Medicare Part B Administrative Costs for Fiscal Year 2013	5/1/2012	312-010-02-1	We recommend that CMS adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $49 million	Concur	2021	In Progress	CMS working to consider these services for inclusion in the potentially misvalued codes initiative.
CMS	A-05-09-00053	Wisconsin Physicians Service Insurance Corporation Claimed Unallowable Medicare Part B Administrative Costs	5/1/2012	312-920-10-1	We recommend that CMS use the results of this audit during the annual update of the physician fee schedule.	Concur	2023	In Progress	CMS working to consider these services for inclusion in the potentially misvalued codes initiative.

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		for Fiscal Year 2013							
CMS	A-05-09-00054	Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	5/1/2012	312-010-02-1	We recommend that CMS adjust the estimated number of E&M services within cardiovascular global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $14.6 million	Concur	2021	In Progress	CMS in progress
CMS	A-05-09-00054	Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	5/1/2012	312-920-10-1	We recommend that CMS use the results of this audit during the annual update of the physician fee schedule.	Concur	2023	In Progress	CMS in progress

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CMS	OEI-02-08-00170	Oversight of Quality of Care in Medicaid Home and Community Based Services Waiver Programs	6/21/2012	399-915-11-02-02838	CMS Should Require At Least One Onsite Visit Before a Waiver Program is Renewed and Develop Detailed Protocols for Such Visits	Concur	NA	Awaiting Disposition	Per OIG, status is unimplemented, but updates are no longer required and CMS considers the recommendation closed. OIG continues to hold this recommendation on their outstanding recommendation list. This should be closed/unimplemented CMS is taking no further actions and updates are not required by the OIG.

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CMS	OEI-02-09-00605	Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills	9/26/2012	313-915-10-02-02892	CMS should exclude Schedule II refills when calculating payments to sponsors.	Non-concur	NA	Awaiting Disposition	The CMS concurs with the OIG that edits should be in place to prevent the billing of Schedule II drugs as refills and will explore modifying PDE edits to alert Part D sponsors to inappropriate refill of a Schedule II drug. However, there are technical issues that may prevent establishing a full reject edit. CMS has begun the process of developing code and examining the various technical issues that could limit our PDE editing. The CMS does not concur with excluding Schedule II drugs billed as refills when calculating payments to sponsors. First, this OIG provides no proof that these PDEs should be rejected. As we have already stated, we believe these claims more likely represent legally dispensed partial fills as opposed to illegal refills, thus the plan payment were legitimate. Furthermore, the OIG assumes that its findings have reconciliation implications, but the report does not provide that evidence. Without a PDE analysis to determine reconciliation implications, CMS will not exclude Schedule II drugs billed as refills when calculating payments to sponsors. CMS will, however, cite the results of this

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									report in guidance to plans requiring the submission of adjustment or deletion PDEs to be submitted when appropriate. Once that is done reconciliation implications can be assessed. Moreover, as indicated above, CMS will examine placing PDE edits to alert part D sponsors to inappropriate refills of Schedule II drugs. This should eliminate any future reconciliation issues associated with the billing of Schedule II drugs as refills. Per discussion with OEI and per January 2020 SRPR report while no longer requiring updates from CMS the recommendation is still considered open.Closed as unimplemented per OIG past recommendation report
CMS	OEI-02-09-00605	Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills	9/26/2012	313-915-11-02-02894	CMS should follow up on sponsors and pharmacies with high numbers of refills.	Non-Concur	2020	Awaiting Disposition	This recommendation was closed in FY 2021

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CMS	OEI-03-12-00070	Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments	9/27/2012	399-915-12-02-03078	CMS should implement the HHA surety bond requirement.	Concur	2020	In progress	The CMS concurs that implementing a surety bond requirement for Home Health Agencies (HHAs) may help reduce potential program vulnerabilities. CMS is currently evaluating its options in implementing this requirement. The surety bond rule would be a significant rule and thus subject to the Executive Order "Reducing Regulation and Controlling Regulatory Costs" issued by the President on January 30, 2017. Any further actions regarding a surety bond rule would be undertaken in that context.
CMS	GAO-12-966	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	1	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should insert a self-referral flag on its Medicare Part B claims form and require providers to indicate whether the advanced imaging services for which a provider bills Medicare are self-referred or not.	Non-Concur	NA	Awaiting Disposition	The CMS position remains the same: The CMS does not concur. We note that our multiple procedure payment reduction policy for advanced imaging already captures efficiencies inherent in providing multiple advanced imaging services by the same physician or group practice in the same session irrespective of whether those services are self-referred or not. Moreover, we do not believe a differential payment reduction would be effective for two reasons. First, a differential payment reduction would not address the underlying conflict of interest that is believed to result in

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									overutilization and higher program costs. At best, a differential payment reduction would merely reduce, but not eliminate, the financial incentive to refer for these services; at worst, it would incentivize physicians to maintain their income from such services by referring for even more imaging services, resulting in little or no change in program costs and possibly reduced quality of care. Second, such a payment reduction could be easily avoided if one physician in a practice were to order the service while another physician in the same practice were to furnish the service. Finally, we question our statutory authority to impose the payment reduction suggested by GAO. The Medicare statute prohibits paying a differential by physician specialty for the same service. While the multiple payment procedure reduction reduces payment for all physicians when they perform multiple services in a single session, GAO's recommendation would make different payment for a single service based on whether a physician has a financial interest in

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									the service being referred and ordered.
CMS	GAO-12-966	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	2	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should determine and implement a payment reduction for self-referred advanced imaging services to recognize efficiencies when the same provider refers and performs a service.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.

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CMS	GAO-12-966	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	3	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should determine and implement an approach to ensure the appropriateness of advanced imaging services referred by self-referring providers.	Non-Concur	NA	Awaiting Disposition	CMS continues to non concur with this recommendation, as stated in the CMS budget justification.
CMS	OEI-02-10-00040	CMS Response to Breaches and Identity Theft	10/9/2012	399-915-11-02-02994	CMS should develop a method for ensuring that beneficiaries who are victims of medical identity theft retain access to needed services.	Non-Concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation. CMS' major concern is that CMS' adjustment of beneficiary billing records could have a negative impact on criminal and civil prosecutions and on the underlying integrity of the Medicare claims processing system. If Trust Fund dollars were paid, adjusting beneficiary history to reflect otherwise (in the absence of established processes such as claim denials resulting from post pay review), could have damaging effects on beneficiaries' deductible and coinsurance status and on the accuracy of CMS' internal accounting systems such as

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									Healthcare Integrated General Ledger Accounting System. It seems questionable whether an United States Assistant Attorney would indict and prosecute cases in which CMS has adjusted beneficiary billing histories. CMS recommends that OIG-OEI discuss the implications of its beneficiary history correction recommendation with its Office of Investigations and the Department of Justice. The CMS will consider the insertion of an indicator in the beneficiary claim record which would exclude certain claims from future frequency and utilization driven edits to allow payment of legitimate claims for beneficiaries victimized by identity theft.
CMS	OEI-07-10-00410	CMS Has Not Promulgated Regulations To Establish Payment Requirements for Prosthetics and Custom-	10/10/2012	399-915-12-02-03079	CMS should promulgate regulations to implement the BIPA payment requirements.	Concur	2020	Awaiting Disposition	On January 12 2017, CMS published a proposed rule addressing this recommendation. The publlc comment period for thls regulation closed on March 13, 2017. On October 4, 2017, the proposed rule was wlfhdrawnin order to assure agency flexlbility ln reexamlnlng the lssues and explorlng optlons and alternatlves with stakeholders. CMS is currently exploring its options.

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		Fabricated Orthotics							
CMS	OEI-02-10-00340	Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals	11/14/2012	399-915-11-02-03118	OMHA and CMS should standardize case files and make them electronic	Concur	2020	Awaiting Disposition	The electronic interface with OMHA will not be fully functioning until ECAPE is implemented. OMHA apprises CMS of the status of the ECAPE project at monthly Medicare Appeals System (MAS) Operation Board meetings. CMS and OMHA have made progress in implementing electronic case file functionality. CMS and the Qualified Independent Contractors (QICs) use the electronic case file environment of the Medicare Appeals System (MAS). CMS onboarded the remainder of Part A MACs to MAS in April 2017. As funding permits, CMS will continue to work with the system owner to determine the optimal approach to achieving consistent data at Level 1 of the appeals process, and the possibility of onboarding Part B and DME MACs to MAS in the future. CMS

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									defers to OMHA for the progress of the ECAPE implementation.
CMS	OEI-02-10-00340	Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals	11/14/2012	399-915-13-02-03122	OMHA and CMS should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary	Concur	2018	Awaiting Disposition	The electronic interface with OMHA will not be fully functioning until ECAPE is implemented. OMHA apprises CMS of the status of the ECAPE project at monthly Medicare Appeals System (MAS) Operation Board meetings. CMS and OMHA have made progress in implementing electronic case file functionality. CMS and the Qualified Independent Contractors (QICs) use the electronic case file environment of the Medicare Appeals System (MAS). CMS onboarded the remainder of Part A MACs to MAS in April 2017. As funding permits, CMS will continue to work with the system owner to determine the optimal

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									approach to achieving consistent data at Level 1 of the appeals process, and the possibility of onboarding Part B and DME MACs to MAS in the future. CMS defers to OMHA for the progress of the ECAPE implementation.
CMS	OEI-12-12-00210	Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B	11/21/2012	313-915-13-02-03091	We recommend that CMS consider seeking legislative authority to implement Least Costly Alternative (LCA) policies for Part B drugs under appropriate circumstances.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	OEI-03-11-00600	Medicare Supplier Acquisition Costs for L0631 Back Orthoses	12/18/2012	312-915-12-02-03132	CMS should lower the fee schedule amount for the L0631 back orthosis.	Concur	2020	In progress	CMS agrees that Medicare should establish an appropriate price for L0631 back orthoses. CMS will examine this issue closely as it considers next steps in the area of DME payment.

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CMS	OEI-03-11-00310	MEDIC Benefit Integrity Activities in Medicare Parts C and D	1/9/2013	399-915-11-02-03179	CMS should explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action.	Concur	2020	In progress	CPI earlier closed this recommendation related to Part D cases. The OIG noted that it will consider the recommendation implemented when CMS provided documentation showing that it has developed and implemented a mechanism to recover Part C payments when law enforcement agencies do not accept cases involving inappropriate services for further action. Consequently, CMS should develop some process or mechanism to recover some portion of payments when law enforcement chooses to no longer pursue a case and there may be the possibility of an administrative recovery. To remedy this issue with respect to Part C, CMS will issue a Technical Direction Letter (TDL) to the MEDIC by the end of calendar year 2019 which directs the MEDIC to address cases in which the MEDIC is aware of referrals being declined by law enforcement. In those situations, the MEDIC would alert Plan Sponsors about law enforcement's decision to decline a referral, and convey to Sponsors that they should take administrative action "to the extent possible" to address the issue originally identified.

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CMS	A-07-12-01113	Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011	1/23/2013	299-009-10-1	We recommend that CMS work with the Medicare contractors to ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
CMS	OEI-03-12-00670	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	2/6/2013	399-915-13-02-03215	Consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both ASPs and AMPs.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation at this time. The President's budget does not include any proposals specific to this issue.
CMS	GAO-13-287	End-Stage Renal Disease: CMS Should Improve Design and	3/1/2013	2	To reduce the incentive for facilities to restrict their service provision to avoid reaching the LVPA treatment threshold, the Administrator of CMS should consider revisions	Concur	2022	In progress	we had extensive discussions with MedPAC regarding their suggestions for modifying the low-volume payment adjustment (LVPA). In addition, analysis of the LVPA methodology has been incorporated into the research we

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		Strengthen Monitoring of Low-Volume Adjustment			such as changing the LVPA to a tiered adjustment.				are doing on potential refinements to the ESRD PPS which includes opportunities to obtain stakeholder feedback.
CMS	OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions	3/4/2013	313-902-11-02-03233	CMS should 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.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with OIG's recommendation that minimum standards be established requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the P&T committee. As noted above, the statute did not direct CMS to establish such standards. Moreover, corporations-including private drug plans are able to obtain a competitive edge in the marketplace by managing their most valuable asset, their employees. For instance, we understand that in P&T committees operated by hospitals, it is an accepted industry standard that employees should act with their employers' best interests in mind. CMS believes that a minimum standard requirement would detract from the competitive nature of the Part D program. Per OIG September 2015 Response Memo- OIG continues to consider

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									this recommendation unimplemented. CMS will not be taking any further action.
CMS	OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions	3/4/2013	313-902-12-02-03232	CMS should define Pharmacy Benefit Managers (PBM) as entities that could benefit from formulary decisions.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with OIG's recommendation that PBMs be defined as entities that could benefit from formulary decisions. We believe that our current formulary review process confers appropriate protections to beneficiaries from any potential adverse effects of conflicts of interest. As discussed above, CMS has devoted extensive resources to the oversight of plan formularies and audit of P&T committee proceedings to ensure that they comply with industry best practices for development and management, and ensure beneficiaries' access to clinically appropriate therapies.Per OIG September 2015 Response Memo- OIG continues to consider this recommendation unimplemented. CMS will not be

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									taking any further action.P&T committees must first base their clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomicstudies, outcomes research data, and other such information as it determines appropriate, consistent with the program goal of maintaining a competitive market. Therefore, given that sponsors must balance both quality and costs in developing formularies, and that PBMs are the entities that negotiate for price concessions on behalf of sponsors, we believe the PBM should have an interest in formulary decisions.
CMS	OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions	3/4/2013	313-902-11-02-03236	CMS should oversee compliance with Federal P&T committee conflict-of-interest requirements and guidance.	Non-concur	NA	Awaiting Disposition	CMS has indicated that it believes its previous actions have addressed OIG's recommendation and that CMS does not plan to take any new actions. Therefore, the OIG will treat CMS's response as its notice of final action for this recommendation. However, OIG will continue to consider this recommendation unimplemented. No annual follow up is required.

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CMS	OEI-03-11-00350	Surety Bonds Remain an Underutilized Tool To Protect Medicare From Supplier Overpayments	3/21/2013	301-915-12-02-03301	CMS should consider using the legislative authority given by the Affordable Care Act to require increased surety bonds based on suppliers' billing volume.	Concur	2020	In progress	Pending regulation (publication of the Surety Bond proposed rule). As of October 2018, CMS is currently assessing approaches to implementing a surety bond requirement while avoiding undue provider burden. At present, there is no timeline for preliminary CPI or CMS decisions on whether or how to proceed on this issue.
CMS	GAO-13-246	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	1	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should determine the content of and publish minimum national standards for the accreditation of ADI suppliers, which could include specific qualifications for supplier personnel and requiring accrediting organization review of clinical images.	Concur	2020	Awaiting Disposition	It is our position that the language of 42 USC 1395(m)(e)(2)(c), and §1834(e) of the Social Security Act do not give CMS the authority to establish health and safety standards for the ADI setting. We say this because §1834(e) of the Social Security Act and 42 USC 1395(m)(e)(3) states the following: "The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality…."

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									We believe that this statute requires CMS to develop "procedures" to ensure that the accreditation standards used by the ADI AOs are adequate, but that this statue does not actually give us the statutory authority to establish our own such standards. CMS consider this recommendation closed.

CMS	GAO-13-246	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	2	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should develop an oversight framework for evaluating accrediting organization performance, which could include collecting and analyzing information on accreditation results and conducting validation audits.	Concur	2020	Awaiting Disposition	In August, 2019, leadership reviewed the CMS regulation related to AOs in general and ADI AOs in specific, including 42 USC 1395(m)(e)(2)(c), §1834(e) and §1865 of the Social Security Act ("the Act"), and 42 CFR §414.68. From this review, it was determined that because of the language of section 1834(e)(3) of the Act, which states "The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization". CMS was not required to establish health and safety regulations for the ADI setting. Leadership then consulted the Office of General Counsel (OGC) for a legal opinion. The OGC counsel stated the following: "For whatever reason, the statute requires the Secretary only to ensure that the AO establishes standards in the list specific to each modality (presumably, by reviewing an application for deeming authority). It does not require the Secretary to set up his/her own standards. Arguably, there is no statutory authority for the Secretary to issue substantive standards." We do not believe that 42 USC 1395(m)(e) imposes any new or additional requirement from those contained in section 1834(e)(3) of the Act. We believe that the

									language used in 42 USC 1395(m)(e)(3) and §1834(e)(3) of the Act is actually the same. 42 USC 1395(m)(e)(3) states the following: "The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality…." Section 1834(e)(3) of the Act states the following: "(3) CREDIT FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—" CMS consider this recommendation closed.

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CMS	GAO-13-246	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	3	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should develop more specific requirements for accrediting organization mid-cycle audit procedures and clarify guidance on immediate-jeopardy deficiencies to ensure consistent identification and timely correction of serious care problems for the duration of accreditation.	Concur	2020	Awaiting Disposition	There is nothing in the statutes and CMS regulations related to the ADI setting, including §1834(e) of the Act and 42 USC 1395(m)(e)(3)(F), that would give CMS the statutory authority, to develop specific regulations related to mid-cycle audit procedures.42 USC 1395(m)(e)(3) states the following:"The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality…."We believe that this statute requires CMS to develop "procedures" to ensure that the accreditation standards used by the ADI AOs are adequate, but that this statue does not actually give us the statutory authority to establish our own such standards.We developed the Immediate Jeopardy (IJ) policy and reporting form in 2016 (policy and form attached). During the development process we sent the draft form to the ADI AOs for review and comment. After the policy and reporting form were

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									finalized the policy and form were sent out to the ADI AOs with instructions to report IJs to CMS on the reporting form as per the terms and requirements of the IJ policy. The IJ policy and IJ Investigation Report were also provided to the ADI AO staff during the April 26, 2016 ADI AO quarterly meeting. The ADI IJ policy and instructions to complete the IJ report form was discussed (see attached agenda and minutes from the April 2016 ADI AO quarterly meeting).CMS consider this recommendation closed.
CMS	OEI-07-12-00250	Replacement Schedules for Medicare Continuous Positive Airway	6/24/2013	312-915-11-02-03360	CMS should review the CPAP supply replacement schedule and revise the national coverage determination for CPAP therapy for OSA or request that the DME MACs revise their LCDs as appropriate	Non-concur	NA	Awaiting Disposition	Non Concur. In order to determine if CPAP supply refill frequency can be reduced, analysis of Medicare beneficiary CPAP use similar to that performed in the Veterans Health Administration study is needed.

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		Pressure Supplies							
CMS	OEI-03-11-00670	Medicare's Currently Not Collectible Overpayments	7/1/2013	331-922-10-02-03372	CMS should ensure that the HIGLAS variable for provider type is populated for all overpayments.	Non-concur	NA	Awaiting Disposition	OIG will no longer require annual updates for this recommendation but will continue to consider it unimplemented. CMS considered closed 2017
CMS	OEI-03-11-00670	Medicare's Currently Not Collectible Overpayments	7/1/2013	301-904-10-02-03373	CMS should ensure that demand letters are mailed to the contacts and addresses identified by the provider.	Non-concur	NA	Awaiting Disposition	The CMS non-concurs with this recommendation because demand letters are already mailed to the addresses identified by the providers.
CMS	GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	2	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should insert a self-referral flag on Medicare Part B claim forms and require providers to indicate whether the anatomic pathology services for which the provider bills Medicare are self-referred or not.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.

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CMS	GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	1	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should determine and implement an approach to ensure the appropriateness of biopsy procedures performed by self-referring providers.	Non-Concur	NA	Awaiting Disposition	The CMS does not concur since the President's Fiscal Year 2014 Budget proposal included a provision to exclude certain services from the in-office ancillary services exception to the physician self-referral law. It seems anatomic pathology services may share some characteristics with the services mentioned in the President's proposal. The proposal notes the in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services and that some of these services, such as radiation therapy and advanced imaging, are rarely performed on the same day as the related physician office visit. The proposal is designed to encourage more appropriate use of certain services by excluding them from the in-office ancillary services exception to the prohibition against physician self-referrals except in cases where a practice meets certain accountability standards.

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CMS	GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	3	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should develop and implement a payment approach for anatomic pathology services that would limit the financial incentives associated with referring a higher number of specimens--or anatomic pathology services--per biopsy procedure.	Concur	2019	Awaiting Disposition	The CMS plans no further action. CMS has communicated to GAO recommendation has been addressed. PFS rates are determined based upon the resources involved in furnishing a service. To the extent that the payment rates are higher than the cost of resources used in furnishing the services, an incentive may exist to provide additional services. We have looked at Current Procedural Terminology code 88305 (the most commonly furnished anatomic pathology service) as a potentially misvalued code and revalued it accordingly in calendar year 2013. As we have reduced payment for this service by approximately 30 percent, we have significantly reduced the financial incentives associated with self-referral for these procedures.
CMS	GAO-13-384	Medicaid Demonstrations Waiver: Approval Process Raises Cost Concerns and Lacks	7/18/2013	2	To improve the transparency of the process for reviewing and approving spending limits for comprehensive section 1115 demonstrations, the Secretary of Health and Human Services should reconsider adjustments and costs used in setting the spending limits for the Arizona and Texas	Non-Concur	2020	In progress	CMS is in the process of responding to additional questions received from GAO in November 2020.

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		Transparency			demonstrations, and make appropriate adjustments to spending limits for the remaining years of each demonstration.				
CMS	GAO-13-525	Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny	8/1/2013	1	The Administrator of CMS should insert a self-referral flag on its Medicare Part B claims form, require providers to indicate whether the IMRT service for which a provider bills Medicare is self-referred, and monitor the effects that self-referral has on costs and beneficiary treatment selection.	Non-Concur	NA	Awaiting Disposition	The CMS does not concur. We do not believe this recommendation will address overutilization that occurs as a result of self-referral. We believe that adding a self-referral flag on the Medicare Part B claims form and requiring physicians to indicate whether the service is self-referred will be complex to administer and may have unintended consequences. We believe other payment reforms will better address overutilization than a new checkbox on the claim form. If a claim indicated that a service was self-referred, there would not be any information about whether such self-referral met the criteria for being an acceptable referral. For example, when a referral occurs outside the physician group or clinic context, the claim could indicate that the

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									service was not "self-referred," but it nevertheless could be a referral that potentially violated the physician self-referral law.Further, the President's Fiscal Year 2014 Budget proposal included a provision to exclude certain services from the in-office ancillary services exception to the physician self-referral law. The proposal notes the in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services and that some of these services, such as radiation therapy and advanced imaging, are rarely performed on the same day as the related physician office visit. The proposal is designed to encourage more appropriate use of certain services by excluding them from the in-office ancillary services exception to the prohibition against physician self-referrals, except in cases where a practice meets certain accountability standards.
CMS	OEI-05-12-00080	Most Critical Access Hospitals Would Not Meet the Location Requireme	8/14/2013	313-915-13-02-03433	CMS should seek legislative authority to revise the CAH Conditions of Participation to include alternative location-related requirements	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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		nts If Required To Re-enroll in Medicare							
CMS	OEI-05-12-00080	Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare	8/14/2013	313-915-13-02-03432	CMS should seek legislative authority to remove Necessary Provider CAHs' permanent exemption from the distance requirement, thus allowing CMS to Reassess these CAHs.	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	OEI-12-12-00260	Medicare Could Collect Billions If Pharmaceutical Manufacturers Were Required To Pay Rebates for Part B Drugs	9/9/2013	313-915-13-02-03472	CMS should examine the additional potential impacts of establishing a prescription drug rebate program under Medicare Part B and, if appropriate, seek legislative change.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. We appreciate the OIGs analysis of the situation and the clear identification of several significant issues that would require resolution before a Part B rebate program could be implemented. The Presidents Budget does not currently include such a proposal. A comprehensive examination and analysis of the impact of a Part B rebate program, including the effects of making a fundamental change to the Part B claims payment system to include

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									NDCs, the impact on providers, and the impact on access to care, would require significant resources. We do not believe that CMS should devote significant administrative resources at this time to a proposal that is neither a provision of current law or actively under consideration.
CMS	OEI-05-12-00610	Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System	9/18/2013	399-915-11-02-03497	CMS Should Establish a Deadline for When National T-MSIS Data Will Be Available	Concur	2020	In Progress	ASU target date 12/2019
CMS	OEI-01-12-00150	The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness	10/2/2013	509-919-10-02-03532	We recommend that CMS use the Medicare Appeals System (MAS) to monitor contractor performance.	Concur	2022	In progress	Currently, progress is being made towards Part B and DME MAS data consistency with the implementation the Data Collection Pilot (DCP), set to go live by the end of August 2020. However, this recommendation will remain open until MAS is fully implemented across all MACs.

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CMS	A-07-12-06038	Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011	10/30/2013	306-009-10-1	We recommend that CMS develop and implement controls to ensure that Medicare does not pay for prescription drugs for unlawfully present beneficiaries by preventing enrollment of unlawful beneficiaries, disenrolling any currently enrolled unlawful beneficiaries, and automatically rejecting PDE records submitted by sponsors for prescription drugs provided to this population.	Concur	2021	In progress	CMS and SSA reached a decision to enter into Information Exchange Agreements (IEAs) instead of Computer Matching Agreements (CMAs) to obtain the necessary data to fulfill the corrective action. CMS has fully executed two IEAs that will provide all data necessary. Systems modifications have also been implemented and are in the final testing stages. The disenrollments will be effectuated beginning in March of 2021.
CMS	OEI-06-10-00520	Medicare Hospital Outlier Payments Warrant Increased Scrutiny	11/13/2013	303-915-11-02-03657	CMS should instruct Medicare contractors to increase monitoring of outlier payments	Concur	2019	Awaiting Disposition	CMS believes that its existing guidelines fulfill the recommendation and does not plan to take any new actions, OIG treated CMS' s response as its notification of final action for this recommendation. OIG considers this recommendation unimplemented.
CMS	A-05-13-00024	Medicare Contractors Nationwide Overpaid Millions to Providers for Full	11/27/2013	303-919-10-4	We recommended that CMS review other multiuse-vial drugs to determine whether system edits are needed to prevent incorrect billings.	Non-concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.

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		Vials of Herceptin							
CMS	OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology	12/9/2013	399-915-11-02-03635	Audit logs be operational whenever EHR technology is available for updates or viewing.	Concur	2016	Awaiting Disposition	CMS actions are complete. Per ASU Response Memo November 2016 - OIG is treating CMS's response as its notification of final action but continue to consider the recommendation unimplemented
CMS	OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology	12/9/2013	399-915-11-02-03637	ONC and CMS strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.	Concur	2019	Awaiting Disposition	CMS feels actions in response to this recommendation are complete and plans to take no further action. OIG stated, "As CMS does not plan to take any action, we will treat its response as its Notification of Final Action. OIG will continue to consider the recommendation unimplemented."

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CMS	GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	2	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should direct CMS to establish a requirement for qualified CDRs to demonstrate improvement on key measures of quality and efficiency for their target populations.	Concur	2022	In progress	We are currently working to implement MIPS Value Pathways (MVPs), where clinicians may report on a pathway pertaining to their given specialty. Potentially beginning with the 2022 performance period, measurement through a pathway will allow for year over year performance comparison. QSOG will provide response for the action requested to establish a requirement for qualified clinical data registries to demonstrate improvement on key measures of quality and efficiency for their target populations. Also to establish a requirement to demonstrate improvement. NLT November 29th, by Noon. In the MIPS program, we are currently capable of calculating improvement for quality, this calculation is done at the performance category level, and not the measure level. Target Date of Completion: 01/31/2022

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CMS	GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	3	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should direct CMS to establish a process for monitoring compliance with requirements for qualified CDRs that draws on relevant expert judgment. This process should assess CDR performance on each requirement in a way that takes into account the varying circumstances of CDRs and their available opportunities to promote quality and efficiency improvement for their target populations.	Concur	2019	In progress	Processes to monitor QCDR compliance is currently implemented. QCDRs who have failed to comply with program requirements have been placed on remedial action (probation) and have been requested to provide a corrective action plan (CAP) or have been terminated at our discretion. CMS to provide GAO clarifying information pointing to which parts of the documents displays implementation for each recommendation. • In the 2019 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/168/2019%20Self-Nomination%20Resources_Updated.zip, found in the Quality Payment Program Resource Library, we include a QCDR and Qualified Registry self-nomination fact sheet that outlines the requirements and the self-nomination process. On Page 10 of the QCDR Self-Nomination Fact Sheet (Page 7 of the qualified registry self-nomination fact sheet), we outline our monitoring criteria, and consequences for those that fail to comply with our requirements (probation or possible preclusion).

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									• On Page 12-13 of the 2019 QCDR/Qualified Registry Fact Sheet (updates based on the rule): https://qpp-cm-prod-content.s3.amazonaws.com/uploads/396/2019%20QPP%20Final%20Rule%20Updates%20for%20QCDRs_Registries.pdf, we discuss 2019 updates to our probation/preclusion policies against third party intermediaries. • On Page 3 of the 2019 Data Validation Criteria Fact Sheet: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/436/2019%20MIPS%20Data%20Validation%20Criteria.zip, we discuss data validation criteria as it pertains to QCDRs and Qualified Registries.

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CMS	GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	4	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should determine and implement actions to reduce barriers to the development of qualified CDRs, such as (1) developing guidance that clarifies Health Insurance Portability and Accountability Act requirements to promote participation in qualified CDRs; (2) working with private sector entities to make relevant multipayer cost data available to qualified CDRs; (3) testing one or more models of shared savings between Medicare and qualified CDRs that achieve reduced Medicare expenditures with improved quality of care, and (4) providing technical assistance to qualified CDRs.	Concur	2020	In progress	We have available resources for the 2020 performance period to help support entities in their efforts with attaining QCDR status. The 2020 Self-Nomination Tool Kit is available in the QPP Resource Library: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip. In addition, we hosted a self-nomination application demo and virtual office earlier in the year to assist QCDR candidates with application questions. The recordings of the webinars are available in the QPP Resource Library:https://qpp.cms.gov/about/webinars. We intend to also host additional educational webinars in January 2020 regarding QCDR measure development. CMS to provide clarifying information pointing to which parts of the documents displays implementation for each recommendation.

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CMS	GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	5	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should determine key data elements needed by qualified CDRs--such as those relevant for a required core set of measures--and direct Office of the National Coordinator for Health Information Technology and CMS to include these data elements, if feasible, in the requirements for certification of EHRs under the EHR incentive programs.	Concur	2019	In progress	We are providing updated links to the resources to support our reply, because the links previously provided are outdated and reflect our legacy program, PQRS. Please see below for updated links and descriptions: • Information on required data elements and submission methods, can be found on the developer's page of the QPP Resource Library: https://qpp.cms.gov/developers. There are a few resources that address data submission and required data elements such as the Submissions Application Programming Interface (API), XML and JSON Schemas, and the QRDA III conversion tools. • The 2019 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/168/2019%20Self-Nomination%20Resources_Updated.zip, as indicated in the Self-Nomination Fact Sheets for QCDRs and Qualified Registries, they may opt to support reporting of the Promoting Interoperability Performance Category, which would require that they support

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									data submission on the Promoting Interoperability measures that are relate to the use of CEHRT. • The 2020 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip, as indicated in the Self-Nomination Fact Sheets for QCDRs and Qualified Registries, they may opt to support reporting of the Promoting Interoperability Performance Category, which would require that they support data submission on the Promoting Interoperability measures that are relate to the use of CEHRT. • The 2019 Promoting Interoperability Measure Specifications: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/343/2019%20Promoting%20Interoperability%20Measure%20Specifications.zip provide technical specifications for the Promoting Interoperability measures that QCDRs and Qualified Registries

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									must use if they intend on reporting on these measures.

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CMS	OEI-01-11-00550	The ESRD Beneficiary Grievance Process	12/20/2013	331-915-11-02-03655	The OIG recommends that CMS work with AHRQ to add a question to CAHPS to assess beneficiaries' fear of reprisal. Once facilities transition to the CARPS survey, it is unlikely that they will also conduct their own surveys. As a result, far fewer facilities will capture data from beneficiaries regarding fear of reprisal. CMS could work with AHRQ on adding a small number of questions designed to capture this information. CMS would then be able to better measure the extent to which ESRD beneficiaries throughout the country fear reprisal for voicing grievances about their care.	Non-concur	2020	In progress	CMS has added the ability to monitor downloads of the patient and staff tools from the NCC website. Between April and August 2020there were 35 downloads of the material from the NCC website and ten reports of patients that felt they had been retaliated against. The ten patients were provided with information to follow-up with the appropriate Network for assistance. Monitoring of this information will continue. CMS considers this the final report and the recommendation completed.
CMS	A-05-12-00053	CMS Should Improve Oversight for the Transfer of True Out-of-Pocket Costs Between	12/23/2013	303-904-10-1	We recommended that CMS implement controls to ensure the TrOOP facilitator initiates FIR transactions to transfer TrOOP balances from (1) plans providing services to non-enrollees and (2) previously rejected FIRs that have since been corrected.	Concur	2020	Awaiting Disposition	This recommendation was closed in FY 2021

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		Part D Plans							
CMS	OEI-01-11-00500	Local Coverage Determinations Create Inconsistency in Medicare Coverage	1/7/2014	303-915-11-02-03668	CMS should establish a plan to evaluate new LCDs for national coverage consistent with MMA requirements.	Concur	2016	Awaiting Disposition	CMS feels actions in response to this recommendation are complete and plans to take no further action. OIG has responded that they will still consider the recommendation unimplemented but no longer track it for followup.
CMS	OEI-07-12-00710	State Medicaid Program Efforts to Control Costs for Disposable Incontinence Supplies	1/24/2014	399-915-11-02-03680	CMS should encourage State Medicaid programs to seek further cost savings for disposable incontinence supplies.	Concur	2020	In Progress	ASU target date 12/2019
CMS	OEI-05-12-00480	Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window	2/18/2014	399-915-13-02-03744	CMS should seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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		Were Expanded							
CMS	OEI-05-12-00480	Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded	2/18/2014	399-915-13-02-03745	CMS seek legislative authority to expand the DRG window to include other hospital ownership arrangements, such as affiliated hospital groups.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	OEI-03-11-00720	CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited	3/3/2014	399-915-11-02-03780	CMS should determine whether outlier data values submitted by MA contracts reflect inaccurate reporting or atypical performance.	Non-concur	NA	Awaiting Disposition	Update as provided in the 2019 status update, this recommendation is no longer relevant to the focus to the current reporting requirements. Per OIG July 2019 Response Memo: Because CMS does not plan to take any new actions to address these recommendations, we will treat CMS's Revised Management Decision as its Notification of Final Action.

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CMS	OEI-03-11-00720	CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited	3/3/2014	399-915-11-02-03781	CMS should use appropriate Part C data as part of its reviews of MA contracts' performance.	Non-concur	NA	Awaiting Disposition	Update as provided in the 2019 status update, this recommendation is no longer relevant to the focus to the current reporting requirements. Per OIG July 2019 Response Memo: Because CMS does not plan to take any new actions to address these recommendations, we will treat CMS's Revised Management Decision as its Notification of Final Action.
CMS	OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	399-915-11-02-03784	CMS should provide Part D plan sponsors with specific guidelines on how to define and count incidents of potential fraud and abuse, related inquiries, and corrective actions.	Concur	2020	In progress	The OIG has asked CMS to develop criteria that specifies how plan sponsors should report and count related inquiries, and corrective actions. Each year, CMS issues a Medicare part D Reporting Requirements document to sponsors which includes elements that should be reported for fraud and abuse incidents and how to define such incidents. Compliance program guidance was also issued in July 2012 as part of revisions of Chapter 9 of the Prescription Drug Benefit Manual. Although the plan sponsors have many training tools available to them provided by CMS (e.g., at webinars, training meetings) to assist in identifying and investigation FWA, the OIG has

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									not closed this recommendation as they view it as tied to mandatory FWA reporting requirements for Part C and D plan sponsors. Status is unclear at this time on all recommendations calling for mandatory reporting pending further direction from the OA and the Secretary of HHS. CMS believes that the Agency's ability to fully implement the OIG's recommendation is directly tied to other recommendations that the OIG has made on the mandatory reporting of fraud, waste and abuse by Medicare Part D Plan sponsors. CMS's Center for Program Integrity (CPI) has consulted with the Agency's leadership and we have initiated the process to modify the current standard of the voluntary reporting of fraud, waste and abuse by Medicare Parts C and D plans to mandatory reporting. Mandatory reporting of fraud, waste and abuse by plan sponsors requires federal rulemaking.

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CMS	OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	399-915-11-02-03786	CMS should share Part D plan sponsors' data on potential fraud and abuse with all sponsors and law enforcement.	Concur	2021	In progress	CMS submitted summary status on this audit to OEI/OL/OIG May 6, 2016 as part of a Part D Portfolio review. The Plato reporting system is available to all plans and data reported into Plato is available to all plans that have access and report. Information about fraud incidents and investigations are also shared with all plan sponsors at periodic training held by CMS and fraud alerts are shared with all plans. The OIG has tied closure of this recommendation to mandatory reporting, the status of which is unclear at this time.CMS believes that the Agency's ability to fully implement the OIG's recommendation is directly tied to other recommendations that the OIG has made on the mandatory reporting of fraud, waste and abuse by Medicare Part D Plan sponsors. CMS's Center for Program Integrity (CPI) has consulted with the Agency's leadership and we have initiated the process to modify the current standard of the voluntary reporting of fraud, waste and abuse by Medicare Parts C and D plans to mandatory reporting. Mandatory reporting of fraud, waste and abuse by plan sponsors requires federal rulemaking.

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CMS	OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	399-915-11-02-03785	CMS should review data from Part D plan sponsors to determine why certain sponsors reported especially high or low numbers of incidents of potential fraud and abuse, related inquires, and corrective actions.	Concur	2021	In progress	CMS believes that this recommendation is directly tied to other recommendations that the OIG. CMS has made the mandatory reporting of fraud waste and abuse by Medicare Part C and D Plan Sponsors. Modifying the current voluntary reporting of fraud, waste and abuse by Medicare Part C and D Plans to one that would be mandatory in nature would require rulemaking. CMS conducted a voluntary pilot on the effectiveness of reporting Medicare Part C and D plans fraud, waste and abuse efforts.
CMS	OEI-03-13-00570	Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2012	3/14/2014	399-915-12-02-03801	CMS should expand the price substitution policy to include HCPCS codes with partial AMP data.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. Our price substitution policy is limited to only those situations where ASP and AMP comparisons are based on the same set of national drug codes (NDCs) for a billing code and AMP data is available for each NDC; our policy that we finalized through rulemaking does not utilize proxy data. CMS continues to believe that a distinction between "complete" and "partial" data is necessary because we remain concerned that partial AMP data comparisons may not adequately account for market-related drug price changes and may lead to the

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									substitution of inaccurate volume-weighted prices. Substitutions, even when using conservative approaches such as substitution of missing AMP data with WAC values, may impact physician and beneficiary access to drugs.
CMS	OEI-03-12-00550	Update: Medicare Payments for End Stage Renal Disease Drugs	3/24/2014	399-915-11-02-03861	CMS should distinguish payments in the ESRD base rate between independent and hospital-based dialysis facilities.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. Section1881(b)(14)(A)(i) of the Act requires that CMS implement a payment system under which a single payment is made to a provider of services or a renal dialysis facility for renal dialysis services. As a result, the ESRD PPS applies a single base rate that reflects the average cost of a dialysis treatment across all ESRD facility types. The ESRD PPS includes several patient-level payment adjusters for those patients who are more expensive to treat, including case-mix adjusters and an outlier policy. In addition, the ESRD PPS includes several facility-level adjusters, including one to enhance payment for those facilities that are at a disadvantage because of size, such as the low volume payment

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									adjustment. It is important to note that section 632 of ATRA requires that no later than January 1, 2016, CMS bundle in the cost of oral only ESRD related drugs, conduct an analysis of the case-mix payment adjustments, and make appropriate revisions to such case mix payment adjustments. This statutory authority gives us the opportunity and flexibility to review the appropriateness of all of the payment adjusters as a whole. At that time, CMS will consider appropriate modifications to the payment system to improve the accuracy of Medicare's payment for renal dialysis services, including drugs and biologicals included in the payment bundle.
CMS	OEI-07-13-00480	Iowa Has Shifted Medicare Cost-Sharing for Dual Eligibles to the Federal Government	4/4/2014	399-915-11-02-03904	CMS should require States to submit more detailed eligibility information	Non-concur	NA	Awaiting Disposition	The report directs its recommendations at CMS and recommends a statutory change. However, as the report notes, the Social Security Administration (SSA) confirmed in 2003 that the $1 supplement satisfied the relevant SSA criteria for state supplements, and as it is SSA criteria on which CMS bases its Federal Financial Participation-for-Part-B-premiums authority under 42 CFR 431.625d, we believe that the report should be

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									directing its recommendations at SSA and the statute underlying SSA's determination.
CMS	OEI-07-13-00480	Iowa Has Shifted Medicare Cost-Sharing for Dual Eligibles to the Federal Government	4/4/2014	399-915-13-02-03903	CMS should seek legislative change to prevent States from using State Supplementary Payments to shift Medicare Part B premium costs for FBDEs to the Federal Government.	Non-concur	NA	In progress	The report directs its recommendations at CMS and recommends a statutory change. However, as the report notes, the Social Security Administration (SSA) confirmed in 2003 that the $1 supplement satisfied the relevant SSA criteria for state supplements, and as it is SSA criteria on which CMS bases its Federal Financial Participation-for-Part-B-premiums authority under 42 CFR 431.625d, we believe that the report should be directing its recommendations at SSA and the statute underlying SSA's determination.
CMS	A-07-13-01127	Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who	4/7/2014	322-009-10-1	We recommend that CMS implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to entitlement-terminated beneficiaries in cases when entitlement termination information is received on previously paid Medicare claims.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.

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		Received Services During 2010 Through 2012							
CMS	A-07-13-01127	Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012	4/7/2014	322-009-10-2	We recommend that CMS identify improper payments made on behalf of entitlement-terminated beneficiaries after our audit period but before implementation of policies and procedures and ensure that Medicare contractors recoup those improper payments.	Concur	2020	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.

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CMS	A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	332-915-02-1	develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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CMS	A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	332-915-11-1	Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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CMS	A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	332-915-13-1	Seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully	4/23/2014	322-009-10-1	We recommend that CMS implement policies and procedures, consistent with those in effect under its FFS program, to notify MA organizations of unlawful-presence information and thereby prevent enrollment in MA organizations, disenroll beneficiaries	Concur	2021	Awaiting Disposition	CMS has implemented regulations and guidance. CMS has also fully executed two Information Exhange Agreements that will provide all data necessary to implement te corrective action. Systems modifications have also been implemented and are in the final testing stages. The disenrollments

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		Present Beneficiaries for 2010 Through 2012			already enrolled, and recoup any improper payments.				will be effectuated beginning in March of 2021
CMS	A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012	4/23/2014	322-009-10-2	We recommend that CMS identify and recoup improper payments made to MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented that would ensure Medicare no longer pays for unlawful beneficiaries.	Concur	2021	Awaiting Disposition	CMS has implemented regulations and guidance. CMS has also fully executed two Information Exhange Agreements that will provide all data necessary to implement te corrective action. Systems modifications have also been implemented and are in the final testing stages. The disenrollments will be effectuated beginning in March of 2021.
CMS	A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present	4/23/2014	322-009-01-1	We recommend that CMS recoup the $26,150,043 in improper payments in accordance with legal requirements.	Non-concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any further action.

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		Beneficiaries for 2010 Through 2012							
CMS	OEI-03-13-00270	Compounded Drugs Under Medicare Part B: Payment and Oversight	4/29/2014	399-915-10-02-03928	CMS should explore the possibility of requiring providers to identify on the Part B claim the pharmacy that produced the compounded drug.	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. Generally, Medicare only collects information on a claim that is needed for payment. CMS does not need to identify the dispensing compounding pharmacy in order to pay the physician that is billing for the drugs. It is not clear that authority exists under the statute to collect the suggested information as that information is not necessary to determine the amount of payment. Changes to Medicare claims processing systems to accommodate the inclusion of dispensing pharmacy information would be significant and would compete for administrative resources with statutorily required payment methodology changes that necessitate system changes. Claims payment systems changes needed to implement statutorily required policy changes are the priority for the Agency.

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									The OIG's recommendation is motivated by a 2012 outbreak of fungal meningitis linked to contaminated injectable compounded drugs. OIG's recommendation is intended to assist CMS and the MAC in stopping payment for drugs manufactured in violation of the Federal Food, Drug and Cosmetic Act (FFDCA). We do not believe that stopping Medicare payment for compounded drugs produced in violation of the FFDCA will be a reliable tool for addressing public safety issues that motivated the OIG's report. By the time the MAC receives the claim, it will be too late to do anything to prevent the patient from receiving a tainted drug. Moreover, we believe information needed for public safety purposes (e.g., to track patients that received a tainted drug) could be obtained from the pharmacy and the administering physician once a public safety problem has been identified without requiring it on the Medicare claim.
CMS	OEI-03-13-00270	Compounded Drugs Under Medicare	4/29/2014	399-915-11-02-03929	CMS should explore the possibility of conducting descriptive analyses of Part	Concur	2022	In Progress	The CMS concurs with this recommendation. Concurrence is conditioned upon the successful implementation of the first

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		Part B: Payment and Oversight			B claims for compounded drugs.				recommendation. Further, we would only undertake such analyses if it were for a program-related purpose such as Medicare program integrity, analysis of spending trends, or new coverage, or payment policy.
CMS	GAO-14-362	Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations	5/22/2014	1	To assist states that rely on or are planning to contract with an MCO to administer Medicaid prescription benefits, and to help provide effective oversight of psychotropic medications prescribed to children in foster care, the Secretary of Health and Human Services should issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs.	Concur	2020	In progress	CMS in progress. CMS to provide documentation of the first annual DURs.

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CMS	OEI-04-12-00490	Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals	6/3/2014	399-915-11-02-03964	CMS should conduct additional analysis to determine the extent to which financial incentives influence LTCH readmission decisions	Non-concur	NA	Awaiting Disposition	The CMS non-concurs with this recommendation at this time. While we agree that LTCH Prospective Payment System (PPS) policies should not provide incentives for LTCH readmission decisions that are based on the hospital's financial benefit rather than the patients' clinical needs, CMS cannot agree/disagree that such analyses are warranted until OIG provides us with identifying information to enable additional financial review. The establishment of the interrupted stay policy, which has been in existence since the start of the LTCH PPS (fiscal year (FY) 2003) is predicated on the following three essential facts: (1) That LTCHs do not provide a full range of acute care services; (2) That during the long stays typical of LTCH patients, with multiple comorbidities, it is not uncommon that a patient requires an acute intervention that can best be furnished at a short-term acute care hospital; and (3) That following the acute intervention, the patient may still require the hospital-level of care provided by the LTCH. In order to analyze what is suggested as potentially

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									inappropriate patient shifting for financial gain, we would need to investigate ownership and/or control relationships between referring IPPS hospitals and the LTCHs in question as well as to evaluate whether there is a pattern of behavior (i.e., that the same behavior has occurred over several years with the same hospitals). We would need further information from OIG suggesting that Medicare payment policy is influencing LTCH readmission decisions to determine whether such an analysis is warranted.
CMS	OEI-12-13-00040	Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs	7/21/2014	399-915-10-02-04086	CMS should finalize the implementation of automated ASP-related procedures by using AMP-related processes as a model, and subsequently require all manufacturers to submit ASPs through the automated system.	Concur	2020	In progress	CM has procured a contractor to independently test the system.

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CMS	GAO-14-627	Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection	7/29/2014	1	The Administrator of CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy, including (1) in the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments, and (2) in the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the	Non-Concur	NA	Awaiting Disposition	FMG developed an NPRM, Medicaid Fiscal Accountability rule published in the FR on 11/18/2019 that once finalized, will address source of funds data. https://www.federalregister.gov/documents/2019/11/18/2019-24763/medicaid-program-medicaid-fiscal-accountability-regulation

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					nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high risk Medicaid payments.				

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CMS	GAO-14-571	Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use	9/2/2014	1	To ensure that MA encounter data are of sufficient quality for their intended purposes, the Administrator of CMS should establish specific plans and time frames for using the data for all intended purposes in addition to risk adjusting payments to MAOs.	Concur	2021	In progress	Currently coordinating with other components in response to the additional GAO follow up questions. CMS has completed the tasks described in our response. Specifically, we have developed and implemented a protocol based on the EQR Protocol 4 Validation of Encounter Data as suggested. We have used various venues to communicate with MAOs about data completeness and quality and have initiated a compliance effort. We continue to assess our system and take an approach of continuous improvement to both our systems and our guidance. CMS has released the data to various entities, including the Medicare Payment Advisory Commission (MedPAC), and the Office of the Assistant Secretary for Preparedness (ASPR), which is using the data for emergency response purposes. Within the agency, we have made the data available through the CMS Integrated Data Repository (IDR) – CMS' internal data warehouse. The Center for Program Integrity (CPI) has accessed the data, as well as the Medicare Drug and Health Plan Contract Administration Group

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									(MCAG), which plans to use the data for development of its care coordination measures. CMS is also preparing to release the data to researchers, a timeframe for release will be vetted with senior CMS leadership at the data governance board (DGB).
CMS	GAO-14-571	Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use	9/2/2014	2	To ensure that MA encounter data are of sufficient quality for their intended purposes, the Administrator of CMS should complete all the steps necessary to validate the data, including performing statistical analyses, reviewing medical records, and providing MAOs with summary reports on CMS's findings, before using the data to risk adjust payments or for other intended purposes.	Concur	2021	In progress	The submission timeframe for the first year of encounter data has recently been completed. Our primary focus now is to analyze the completeness and validity of this first year of data and to provide feedback to plans on these statistical analyses. We will expand upon our process of determining how comprehensive the data are as more data are submitted to CMS. CMS appreciates the GAO's reference to EQR Protocol 4 Validation of Encounter Data Reported by the MCO? (Report), which outlines steps used by the Medicaid Program to facilitate the collection of complete and accurate data. We

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									are referencing this Report, as we work with the encounter data submitted to CMS by the MA organizations.
CMS	A-05-12-00086	CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries	9/5/2014	331-900-11-1	To improve protection provided to Medicaid hospice beneficiaries, we recommend that CMS work with the State agency and the Ohio Department of Health to ensure that hospices meet the State licensure requirements for hospice workers.	Concur	2020	Awaiting Disposition	CMS does not have the authority to enforce or direct State policies. Once this last contact is made the corrective action plan should be considered complete. Additional conversations between the RO and the state are expected by the end of winter.
CMS	OEI-05-13-00290	CMS Has Yet To Enforce a Statutory Provision Related to	9/11/2014	399-915-12-02-04183	CMS should issue regulations to ensure that RHCs determined to be essential providers remain certified as RHCs.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation and plans no further actions.

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		Rural Health Clinics							
CMS	A-06-12-00038	Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs	9/15/2014	312-930-12-1	We recommend that CMS amend current regulations to decrease the Part B payment rates for dispensing and supplying fees to rates similar to those of other payers, such as Part D and Medicaid.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
CMS	OEI-02-11-00320	State Standards for Access to Care in Medicaid Managed Care	9/25/2014	399-915-11-02-04223	CMS should strengthen its oversight of State standards and ensure that States develop standards for key providers.	Concur	2021	In progress	Delayed due to COVID prority - Ongoing development of continuous improvement actions discussed in the meeting is in development 2021 projected.
CMS	OEI-02-11-00320	State Standards for Access to Care in	9/25/2014	399-915-11-02-04224	CMS should strengthen its oversight of States' methods to assess plan compliance and ensure that States	Concur	2021	In progress	Delayed due to COVID prority - Ongoing development of continuous improvement actions

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		Medicaid Managed Care			conduct direct tests of access standards.				discussed in the meeting is in development 2021 projected.
CMS	OEI-02-11-00320	State Standards for Access to Care in Medicaid Managed Care	9/25/2014	399-915-11-02-04225	CMS should improve States' efforts to identify and address violations of access standards.	Concur	2021	In progress	Delayed due to COVID prority - Ongoing development of continuous improvement actions discussed in the meeting is in development 2021 projected.
CMS	OEI-05-12-00085	Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals	10/7/2014	399-915-13-02-04243	CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at Critical Access Hospitals.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	OEI-02-13-00670	Access to Care: Provider Availability in Medicaid Managed Care	11/8/2014	399-915-11-02-04304	CMS should work with States to assess the number of providers offering appointments and improve the accuracy of plan information.	Concur	2020	In progress	CMS met with OIG 9/18/19 and revised ASU to include the highlights of the ongoing development of continuous improvement actions discussed in the meeting is in development.
CMS	OEI-02-13-00670	Access to Care: Provider	11/8/2014	399-915-11-02-04306	CMS should work with States to ensure that plans are complying with existing	Concur	2020	In progress	CMS met with OIG 9/18/19. Revised ASU to include the highlights of actions that will meet

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		Availability in Medicaid Managed Care			State standards and assess whether additional standards are needed.				closure consideration requirements as discussed in the meeting.
CMS	OEI-02-13-00670	Access to Care: Provider Availability in Medicaid Managed Care	11/8/2014	399-915-11-02-04305	CMS should work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees.	Concur	2020	In progress	CMS met with OIG 9/18/19. Revised ASU to include the highlights of actions that will meet closure consideration requirements as discussed in the meeting.
CMS	GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	2	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to organize cost and quality information in the CMS Compare websites to facilitate consumer identification of the highest-performing providers, such as by listing providers in order based on their performance.	Concur	2021	In progress	The Care Compare Experience successfully launched on 09/02/2020. There is no further action needed or planned, CMS considers recommendation implemented.

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CMS	GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	3	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to include in the CMS Compare websites the capability for consumers to customize the information presented, to better focus on information relevant to them.	Concur	2020	In progress	The Care Compare Experience successfully launched on 09/02/2020. There is no further action needed or planned, CMS considers recommendation implemented.
CMS	GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	4	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to develop specific procedures and performance metrics to ensure that CMS's efforts to promote the development and use of its own and others' transparency tools adequately address the needs of consumers.	Concur	2020	In progress	CMS working on closure submission. CMS has integrated data-driven and user-centered design practices into the development of all web-based products, including any tools designed to promote price transparency. Each tool or product has identified Objectives & Key Results (OKRs) that describe success in terms of impact on the user and how well the product is addressing pain points in the user experience. The measurement of these (OKRs) is supported by Google Analytics, Qualtrics surveys (page level feedback and overall site satisfaction), user testing, and other available data sources. Feedback on OKR performance is shared at regular

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									intervals with the product teams, who use that data to further improve their products and tools to better meet the needs of consumers. Performance on OKRs are also regularly reported to OC leadership and the Administrator.
CMS	GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	1	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to include in the CMS Compare websites, to the extent feasible, estimated out-of-pocket costs for Medicare beneficiaries for common treatments that can be planned in advance.	Concur	2020	In progress	The Care Compare Experience successfully launched on 09/02/2020. There is no further action needed or planned, CMS considers recommendation implemented.
CMS	A-05-12-00046	Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-	3/16/2015	332-915-13-1	We recommend that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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		Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates							
CMS	GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	1	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should take steps to ensure that states report accurate provider-specific payment data that include accurate unique national provider identifiers (NPI).	Concur	2020	In progress	We are in the process of developing guidance that is scheduled for release later this year
CMS	GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	2	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should develop a policy establishing criteria for when such payments at the provider level are economical and efficient.	Concur	2020	In progress	We are in the process of developing guidance that is scheduled for release later this year

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CMS	GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	3	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should, once criteria are developed, develop a process for identifying and reviewing payments to individual providers in order to determine whether they are economical and efficient.	Concur	2020	In progress	We are in the process of developing guidance that is scheduled for release later this year
CMS	GAO-15-239	Medicaid Demonstrations: Approval Criteria and Documentation Need Clarity to Illuminate How Spending Furthers Medicaid Objectives	5/13/2015	1	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, the Secretary of Health and Human Services should issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives.	Concur	2020	In progress	5/7/19 - GAO requests target date for the first draft of written protocols outlining the step-by-step process for application review and preparation of approval documents for section 1115 demonstrations

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CMS	GAO-15-239	Medicaid Demonstrations: Approval Criteria and Documentation Need Clarity to Illuminate How Spending Furthers Medicaid Objectives	5/13/2015	2	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, the Secretary of Health and Human Services should ensure the application of these criteria is documented in all HHS's approvals of section 1115 demonstrations, including those approving new or extending or modifying existing expenditure authorities, to inform internal and external stakeholders, including states, the public, and Congress, of the basis for the agency's determinations that approved expenditure authorities are likely to promote Medicaid objectives.	Concur	2020	In progress	5/7/19 - GAO requests target date for the first draft of written protocols outlining the step-by-step process for application review and preparation of approval documents for section 1115 demonstrations

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CMS	GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	2	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should develop a process for informing the public of potentially misvalued services identified by the RUC, as CMS already does for potentially misvalued services identified by CMS or other stakeholders.	Concur	2020	Awaiting Disposition	This project will fund the contract that will provide CMS with critical analyses, modeling, and data required to propose to update the GPCIs in CY 2020. This will include evaluating the current methodologies for calculating the GPCIs and considering whether to make changes to how the underlying data are analyzed in FY 2019. These changes would then be considered for potential inclusion in rulemaking during CY 2020.
CMS	GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	3	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.

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CMS	GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	1	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions.	Concur	2020	In progress	CMS is developing a means of displaying the direct PE inputs in a consistent manner that will allow for greater transparency and documentation of the process of developing of PE Relative Value Units (RVUs), including CMS' review of RUC recommendations. Due to the complex nature of the process, it will take some time to finalize but we anticipate completion by November 5, 2019.
CMS	A-04-14-04029	Providers Did Not Always Reconcile Patient Records With Credit Balances and Report and Return the Associated Medicaid Overpayments to State Agencies	8/26/2015	322-347-12-1	We recommended that CMS issue Medicaid regulations to clarify the requirements of the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.	Concur	2020	In progress	Pending regulation and the development of a Medicaid overpayment rule mirroring recent 6037-F. GMG continues to study this recommendation, pending regulation; submitted OCD 9/30/16. CMS is still in the discussion phase and there is no timeline for preliminary CPI or CMS decisions on whether or how to proceed on this issue.

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CMS	OEI-09-12-00351	Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports	9/28/2015	399-915-11-02-04699	CMS should require ambulance suppliers to include the National Provider Identifier of the certifying physician on transport claims that require certification	Concur	2020	In Progress	CMS remains cognizant of the problem that some ambulance suppliers are questionably billing for non emergency basic life support transports and that physicians who certify these transports cannot be identified in the claims data. CMS is considering future regulatory means, such as proposed provisions in CMS-6058-F relating to NPIs on claims for Parts A and B.
CMS	GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	1	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS augment MA network adequacy criteria to address provider availability.	Concur	2019	Awaiting Disposition	Although CMS does not include provider availability in the HSD tables, CMS does require the provider directory to notate whether the provider is accepting new patients. CMS requires the provider directory to be updated within 30 days of notification of a change. CMS believes this is the appropriate place to notate it since provider availability can change. The HSD tables are submitted to CMS only when we request them, which provides a snapshot of the network at that time. Because of this aspect, the HSD tables would not provide the most current, up to date information for provider availability.

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CMS	GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	2	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS verify provider information submitted by MAOs to ensure validity of the Health Services Delivery data.	Concur	2019	Awaiting Disposition	CMS currently has one method of verifying the accuracy of the data and is developing a second one. First, during CMS' online provider directory reviews, we asked MAOs if they use the same underlying database for HSD tables as they do for provider directories. Over 95% of MAOs apparently use the same underlying database for both HSD tables and provider directories. Since MAOs use the same database for both, CMS findings of inaccurate provider directories identifies errors in their HSD tables, resulting in verification of HSD tables. CMS is also looking at using the National Plan and Provider Enumeration System (NPPES) as a common source that MAOs can access for provider information. CMS' goal is to have providers update only one source, NPPES, which should result in an update to a single source of data for MAOs to use. With a single source, MAOs can download this data to utilize for their provider directory which can also be utilized for their HSD tables.

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CMS	GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	4	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS set minimum requirements for MAO letters notifying enrollees of provider terminations and require MAOs to submit sample letters to CMS for review.	Concur	2019	Awaiting Disposition	In an effort to reduce burden for MAOs CMS has decided to not use rulemaking to establish mandatory language for enrollee notices. However, CMS has furnished model language for MAOs to use when notifying enrollees of provider terminations which is available in Chapter 4 at section 110.1.2.3 of the Medicare Managed Care Manual available at the web link below: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

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CMS	OEI-01-14-00200	CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services	9/29/2015	399-915-11-02-04693	CMS should establish a more reliable control for identifying active treatment	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. CMS has the authority to ensure Part D sponsors' compliance with the operational requirements of the Part D program. CMS takes seriously plans obligations to submit timely and error-free bids. CMS conducts an aggressive bid desk review to ensure that bids are thoroughly reviewed before they are accepted, and conducts audits of selected bids after they have been accepted. To the extent that bid audit findings reflect a sponsor's substantial failure to comply with program requirements, including those related to annual bid submissions, CMS will pursue compliance (e.g., request corrective action plan) or enforcement (e.g., sanctions or contract termination) actions against those sponsors. In addition, if CMS uncovers deliberate misrepresentations or fraud during the bid audits, it will report such findings to the appropriate authority.The CMS does not have the authority to adjust plan sponsors' bid amounts, payments to plan sponsors, or beneficiary premiums once a bid has been accepted. In fact, once the bid is accepted and used to set plan

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									premiums and payment levels, there is no legal authority to revise the accepted bid amount for any purpose, including adjusting plan payments. Even if CMS had the authority to adjust a bid after it is accepted, doing so could result in a variety of unintended consequences. For example, changing a plan's bid would require retroactively changing the premium under the Part D rules, in that plan. If the bid is revised at the end of a plan year then all premiums may be revised throughout the plan year. This means that the beneficiary would receive a bill from the plan sponsor for the difference in premiums, if the premium went up after revision. Due to Part D requirements relating to premium calculation, changing one plan's bid also has the potential to affect premiums charged to all Part D beneficiaries. Such a structure would be contrary to CMS' goals of promoting a benef
CMS	OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities	9/29/2015	399-915-11-02-04704	CMS should change the method of paying for therapy	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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		Needs To Be Reevaluated							
CMS	OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	399-915-11-02-04705	CMS should adjust Medicare payments to eliminate the effect of case mix-creep	Concur	2020	In progress	CMS issued an Advanced Notice of Proposed Rulemaking on April 27, 2017 to solicit public comments on options it may consider for revising certain aspects of the existing skilled nursing facility (SNF) prospective payment system methodology. In particular, CMS sought comments on the possibility of replacing the current SNF payment system with a new case-mix model. CMS signaled that it intends to propose case mix refinements in the fiscal year (FY) 2019 SNF prospective payment system proposed rule.
CMS	OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	399-915-13-02-04703	CMS should evaluate the extent to which Medicare payment rates for therapy should be reduced.	Concur	2020	In progress	CMS reports that it continues to explore and consider various approaches to adjust SNF payments. These approaches include potentially using its statutory authority to adjust payment rates if CMS determines that overall payments to SNFs have changed across the SNF payment system that are unrelated to beneficiaries' characteristics. CMS also believes that the possible, new case-mix model would greatly enhance its ability to identify and

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									eliminate case mix creep from the SNF prospective payment system.
CMS	GAO-16-53	Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds	10/23/2015	1	To improve the effectiveness of its oversight of eligibility determinations, the Administrator of CMS should conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.	Concur	2021	In progress	Results for the first cycle of states under review will be reported in November 2019. The first cycle of the revised PERM program included two states where there were federal eligibility determinations, but no FFE samples were selected for PERM review.
CMS	GAO-16-125	End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis	11/16/2015	3	To ensure that patients with chronic kidney disease receive objective and timely education related to this condition, the Administrator of CMS should examine the Kidney Disease Education benefit and, if appropriate, seek legislation to revise the categories of providers and patients eligible for the benefit.	Non-Concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with GAO recommendation.

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CMS	GAO-16-125	End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis	11/16/2015	1	To determine the extent to which Medicare payments are aligned with costs for specific types of dialysis treatment and training, the Administrator of CMS should take steps to improve the reliability of the cost report data for treatment and training associated with specific types of dialysis.	Concur	2020	In progress	CMS is exploring ways to improve the current cost report instructions and data collection to increase the accuracy of the information submitted.
CMS	OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	399-915-11-02-04824	Develop benchmarks for dental services and require States to create mandatory action plans to meet them	Non-concur	NA	Awaiting Disposition	CMS considers applicable actions complete. OIG will treat CMS's response as its notifications of final action, and updates are no longer required. However, OIG will continue to consider the following recommendations open-unimplemented. 11/16/16 - This should be closed/unimplemented CMS is taking no further actions and updates are not required by the OIG.
CMS	OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required	1/20/2016	399-915-11-02-04830	Work with States to track children's utilization of required dental services	Non-concur	NA	Awaiting Disposition	CMS considers applicable actions complete. OIG will treat CMS's response as its notifications of final action, and updates are no longer required. However, OIG will continue to consider the following recommendations open-unimplemented. 11/16/16 - This should be closed/unimplemented CMS is taking no further actions

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		Dental Services							and updates are not required by the OIG.
CMS	OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	399-915-11-02-04828	Work with States to analyze the effects of Medicaid payments on access to dental providers	Concur	2020	In progress	CMS will be conducting an analysis to understand the impact of Medicaid payment on access to dental providers.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	2	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to track the value of advance premium tax credit and cost-sharing reduction (CSR) subsidies that are terminated or adjusted for failure to resolve application inconsistencies, and use this information to inform assessments of program risk and performance.	Concur	2019	Awaiting Disposition	CMS considers this recommendation CLOSED. The Attorney General of the United States has provided the Department of Health and Human Services and the Department of the Treasury with a legal opinion regarding CSR payments made to issuers of Qualified Health Plans. In light of that opinion, and the absence of any other appropriation that could be used to fund CSR payments, CSR payments to issuers were stopped as of October 2017. Therefore, CSR payments are currently prohibited unless and until a valid appropriation exists. At this time, CMS is unable to issue new CSR regulations or make CSR payments under the Department of Justice interpretation; as such, tracking CSR subsidies is no longer a relevant recommendation due to programmatic changes.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	4	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them.	Concur	2019	Awaiting Disposition	CMS considers this recommendation CLOSED. CMS deployed modify/update SSN functionality in April 2017 that now allows resolution of a SSN. Additional clarification was provided on 8/9/18 to support closure of this recommendation.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	5	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to reevaluate CMS's use of Prisoner Update Processing System (PUPS) incarceration data and make a determination to either (a) use the PUPS data, among other things, as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage, or (b) if no suitable process can be identified to verify	Concur	2020	Awaiting Disposition	CMS believes this recommendation should be CLOSED. At the present time, it is not practical for CMS to use the information from the Social Security Administration (SSA) Prisoner Update Processing System (PUPS) as an indicator of further research required as contemplated in the GAO recommendation. When actively processing incarceration inconsistencies based on the information, we found there to be a high degree of false positives. Additionally, we do not have a readily available source through which to conduct follow-up investigation. The eligibility support systems (ESS) are a closed system from which eligibility support workers are not typically permitted to access outside systems. CMS maintains this secure environment as part of our security protocols for the protection of personally identifiable consumer information. DHS' Systematic Alien Verification for Entitlements system is an example of one outside system that has reliable information that eligibility support workers are allowed to query for information to follow-up on application inconsistencies. We have not identified a similar system

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					incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with other information that may indicate incarceration, and forego the inconsistency process.				for incarceration. For that reason, we do not believe the information returned from the PUPS database should be used as an indicator for further research. At this time we are accepting attestation in alignment with the GAO recommendation. We are not conducting the formal inconsistency process. It would require resources that are better spent on other Marketplace priorities to NOT set the incarceration inconsistencies at all.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	6	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to CMS's documents processing contractor.	Concur	2019	Awaiting Disposition	We believe this recommendation is CLOSED. CMS developed and implemented a tool that the call center reps can use to look up the current status of an individual when they call the marketplace. This tool is called Marketplace Consumer Record (MCR) and was implemented in 2017.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	8	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.	Concur	2019	Awaiting Disposition	CMS believes this recommendation is CLOSED. Each year CMS publishes its Notice of Benefit and Payment Parameters (i.e., 'Payment Notice') in draft, and then in final. This regulation provides a comprehensive description of major proposed Marketplace changes that allows CMS to document prior to implementation and in a public forum, any significant decisions on qualified health plan enrollment and eligibility matters, including such information as policy objectives, supporting analysis, scope, and expected costs and impact. The draft regulation provides an opportunity for both the public and government oversight entities to review and comment on these proposals prior to the rule being issued in final.

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CMS	GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	3	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to, in the case of CSR subsidies that are terminated or adjusted for failure to resolve application inconsistencies, consider and document, in conjunction with other agencies as relevant, whether it would be feasible to create a mechanism to recapture those costs, including whether additional statutory authority would be required to do so; and for actions determined to be feasible	Concur	2021	Awaiting Disposition	CMS considers this recommendation CLOSED. The Attorney General of the United States has provided the Department of Health and Human Services and the Department of the Treasury with a legal opinion regarding CSR payments made to issuers of Qualified Health Plans. In light of that opinion, and the absence of any other appropriation that could be used to fund CSR payments, CSR payments to issuers were stopped as of October 2017. Therefore, CSR payments are currently prohibited unless and until a valid appropriation exists. At this time, CMS is unable to issue new CSR regulations or make CSR payments under the Department of Justice interpretation. As such, this is no longer a relevant recommendation due to programmatic changes. Current statute and regulations prevent the recovery of any CSRs already paid. Per existing Federal statute/regulation , consumers are eligible for CSR subsidy while in an inconsistency period. CMS would need to acquire new statutory authority and subsequently re-regulate in order to

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					and reasonable, create a written plan and schedule for implementing them.				recapture CSR subsidies terminated or adjusted for inconsistency expiration.
CMS	GAO-16-238	Nonemergency Medical Transportation: Updated Medical Guidance Could Help States	3/3/2016	1	To ensure states have appropriate and current guidance to assist them in designing and administering Medicaid NEMT, the Secretary of HHS should direct CMS to assess current Medicaid NEMT guidance and update that guidance as needed.	Concur	2021	In progress	Determining leaderships opinion regarding the desired approach to NEMT and the necessity and appropriateness of guidance.

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CMS	GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	3/7/2016	1	To promote consistency in the distribution of supplemental payments among states and with CMS policy, the Administrator of CMS should issue written guidance clarifying its policy that requires a link between the distribution of supplemental payments and the provision of Medicaid-covered services.	Concur	2020	In progress	CMS has issued guidance to States
CMS	GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	3/7/2016	2	To promote consistency in the distribution of supplemental payments among states and with CMS policy, the Administrator of CMS should issue written guidance clarifying its policy that payments should not be made contingent on the availability of local funding.	Concur	2020	In progress	CMS has issued guidance to States
CMS	GAO-16-265	Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls	3/23/2016	1	To improve the oversight of privacy and security controls over the state-based marketplaces, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to define procedures for overseeing	Concur	2019	Awaiting Disposition	CMS submitted documentation for closure. CMS created a document to describe requirements for states to monitor the privacy and security of their state-based marketplaces, and to capture the significant enhancements CMS has made to monitor states' compliance.

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					state-based marketplaces, to include day-to-day activities of the relevant offices and staff.				
CMS	GAO-16-265	Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls	3/23/2016	3	To improve the oversight of privacy and security controls over the state-based marketplaces, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to require continuous monitoring of the privacy and security controls over state-based marketplaces and the environments in which those systems operate to more quickly identify and remediate vulnerabilities.	Concur	2018	Awaiting Disposition	CMS submitted documentation for closure. CMS created a document to describe CMS's requirements for states to monitor the privacy and security of their state-based marketplaces, and to capture the significant enhancements CMS has made to monitor states' compliance.
CMS	A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawa	3/29/2016	205-922-10-1	We recommend that CMS require States to reconcile total Federal Medicaid funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines.	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements

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		ls of Federal Medicaid Funds							
CMS	A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	205-925-10-1	We recommend that CMS issue guidance that clarifies existing requirements and provides further interpretation of the "as needed" language in 42 CFR § 430.30(d)(3) as it relates to the withdrawal of Medicaid funds	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements
CMS	A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	205-930-10-1	We recommend that CMS publish and enforce formal guidance based on the November 8, 2011, email, so that States are aware of the appropriate PMS account from which to withdraw or return fund	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements
CMS	A-06-14-00068	Opportunities for Program Improvements	3/29/2016	205-930-12-1	We recommend that CMS publish regulations that are consistent with the Treasury provisions in 31 CFR part 205 and educate States.	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements

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		Related to States' Withdrawals of Federal Medicaid Funds							
CMS	OEI-09-14-00440	Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments	4/15/2016	399-915-11-02-04871	CMS should take appropriate action to ensure that States fully implement the NCCI edits	Concur	2020	In progress	CMS is committed to improving the Medicaid NCCI and will work with the states to support their implementation of the NCCI edits. In addition, CMS will explore the use of incentives and other efforts to bring states into compliance.
CMS	OEI-03-13-00050	Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results	4/27/2016	399-915-11-02-04917	CMS should revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational	Concur	2020	In progress	The current National Site Visit Contract (NSVC) is in an extension period until December 2018, therefore; CMS is preparing to engage in an Indefinite/Delivery Indefinite Quantity Contractor (IDIQ) procurement. CMS has drafted the Statement of Work for the IDIQ and will submit to OAGM for final approval. After awarding the IDIQ contract and onboarding a new site visit contractor, CMS will update the site visit form. CMS drafted new NSVC form in November 2016 and submitted an

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									NFA to the OIG. In response to the response memo, CMS has revised its CAP. Effective August 2016, questions 5 and 6 have been removed from the site visit form and is the process of a new procurement and a set of new tools.

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CMS	GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	1	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments and to improve the accuracy of CMS's calculation of coding intensity, the Administrator should modify that calculation by taking actions such as the following: (1) including only the three most recent pair-years of risk score data for all contracts; (2) standardizing the changes in disease risk scores to account for the expected increase in risk scores for all MA contracts; (3) developing a method of accounting for diagnostic errors not coded by providers, such as requiring that diagnoses added by MA organizations be flagged as supplemental diagnoses in the agency's Encounter Data System to separately calculate coding intensity scores related only to diagnoses that were added through MA organizations'	Non-Concur	2021	In progress	CMS concurred with this recommendation when the report was published, however upon further analysis and review CMS does not concur with this recommendation. We are gathering documentation to present to GAO and close this recommendation, including the coding intensity study.

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					supplemental record review (that is, were not coded by providers); and (4) including MA beneficiaries enrolled in contracts that were renewed from a different contract under the same MA organization during the pair-year period.				

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CMS	GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	2	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should modify CMS's selection of contracts for contract-level RADV audits to focus on those contracts most likely to have high rates of improper payments by taking actions such as the following: (1) selecting more contracts with the highest coding intensity scores; (2) excluding contracts with low coding intensity scores; (3) selecting contracts with high rates of unsupported diagnoses in prior contract-level RADV audits; (4) if a contract with a high rate of unsupported diagnoses is no longer in operation, selecting a contract under the same MA organization that includes the service area of the prior contract; and (5) selecting some contracts with high enrollment that also have either high rates of	Concur	2021	Awaiting Disposition	CMS believes that the updated contract-level RADV methodology addresses the elements of this recommendation, therefore the recommendation should be closed. We are gathering documentation to present to GAO and close this recommendation, the CON14 redacted methodology paper.

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					unsupported diagnoses in prior contract-level RADV audits or high coding intensity scores.				

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CMS	GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	3	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should enhance the timeliness of CMS's contract-level RADV process by taking actions such as the following: (1) closely aligning the time frames in CMS's contract-level RADV audits with those of the national RADV audits the agency uses to estimate the MA improper payment rate; (2) reducing the time between notifying MA organizations of contract audit selection and notifying them about the beneficiaries and diagnoses that will be audited; (3) improving the reliability and performance of the agency's process for transferring medical records from MA organizations, including assessing the feasibility of updating Electronic Submission of Medical Documentation for use in	Concur	2021	In progress	CMS improved the RADV process timing to be more efficient and effective. We are gathering documentation to present to GAO and close this recommendation. CMS has accelerated the contract-level RADV audits to catch up with the National audits. Resource constraints limit the number of contract level audits that can be completed in a calendar year to two payment years. We expect to have the audits aligned by calendar year 2023. I would suggest we include the announcements of the payment year 14 and 15 audits to show we are doing at least two per year. The period between plan notification and beneficiary selection is seven weeks and is the minimum based on time required for MA organizations to receive initial training, identify points of contact and populate credentials template, establish credentials in CDAT, and final submission training. The system of record for RADV is the Central Data Abstraction Tool (CDAT). In addition to collecting the records, CDAT is the central portal for providing audit findings in real-time back to the MA organizations as the record reviews progress, facilitates actual medical

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					transferring medical records in contract-level RADV audits; and (4) requiring that CMS contract-level RADV auditors complete their medical record reviews within a specific number of days comparable to other medical record review time frames in the Medicare program.				record reviews, portal for plans to receive audit reports, and facilitates appeals submission. These functions are outside the scope of the ESMD. We have made upgrades to CDAT to improve the process for evaluating medical records and provide faster feedback to MA organizations on the validity of their submissions in real-time.

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CMS	GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	4	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should improve the timeliness of CMS's contract-level RADV appeal process by requiring that reconsideration decisions be rendered within a specified number of days comparable to other medical record review and first-level appeal time frames in the Medicare program.	Concur	2021	In progress	RADV appeal Reconsideration decisions are adjudicated by a contractor and are required to finalized in four to six weeks. MA organizations are afforded a three-level administrative appeals process per 42 C.F.R. § 422.311. The first level of appeal is called Reconsideration (formerly known as Medical Record Dispute). The second level of appeal is currently housed in the CMS Office of Hearings (OH). If the findings of the OH are unsatisfactory to MA organizations, they may appeal the findings to level three, or the CMS Administrator's Office. The findings of the Administrator are considered final, and conclude the administrative portion of the Risk Adjustment Data Validation (RADV) appeal.
CMS	GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial	5/9/2016	5	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should ensure that CMS develops specific plans and a timetable for incorporating a RAC in the MA program as mandated by	Concur	2021	In progress	As part of the A-19 process, CMS is seeking to remove authority requiring CMS to expand the recovery audit program to Medicare Part C program. The FY 2020 budget included a proposal to remove the requirement for HHS to expand the RAC program to Medicare Part C. The primary corrective action on Part C payment error has been the Risk

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		Amounts of Improper Payments			the Patient Protection and Affordable Care Act.				Adjustment Data Validation (RADV) audits.

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CMS	GAO-16-137	Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans	5/11/2016	1	Assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita country Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS under its existing data use agreement or by other means as necessary.	Non-concur	2021	Awaiting Disposition	CMS non-concurs with GAO's recommendation. We have considered GAO's recommendation in light of the data that would be necessary to conduct such an assessment, as well as the infeasibility of executing the application of an adjustment in payment if it were determined an adjustment is warranted.There are a number of significant limitations that impede our ability to conduct an analysis of veteran versus nonveteran payments to MA plans. In order to complete the assessment we would need person level VA-dual eligible information for multiple years. If we are to conduct a thorough assessment, we would need utilization and diagnoses data. In addition, as explained above, it will be very challenging to accurately price the VA utilization data. We expect that it will take several years to both collect and then analyze the data as needed.In addition, there are a host of data, operational, and financial challenges that will need to be overcome in the process of implementing such an adjustment, if in fact we determine that one is actually needed. For example, we would need a continuous monthly

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									person-level file identifying every VA-dual beneficiary. The VA would have the added burden of providing the monthly stream of data, which would need to be in sync with the tight schedule we have in place to ensure timely monthly payments. In the event we are able to establish a continuous stream of data, our systems would require the creation of new eligibility fields and a reengineering of the operational payment system to ingest the data, process it, incorporate it into payment and maintain secure storage of the data, as well as updates to monthly reports to plans that would provide the new details of how their monthly payment was calculated. In addition to the operational challenges of developing, establishing, and maintaining a secure continuous stream of VA data to CMS, re-engineering the payment processing systems will require significant budget increases for CMS and also the VA.

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CMS	GAO-16-137	Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans	5/11/2016	2	If CMS makes an adjustment to the benchmark to account for VA spending on Medicare-covered services, the agency should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans.	Non-Concur	2021	Awaiting Disposition	GAO stated that, "if CMS determines that an adjustment to the benchmark to account for VA spending is needed and the adjustment results in payments to MA plans that are too high for veterans, additional adjustments to payments to MA plans could be necessary." Currently, we do not know if the resulting benchmarks are too high or too low for veterans. Without the utilization and diagnoses data, such an assessment is not possible. In addition, we note that if CMS were to determine that such a payment adjustment were necessary, the agency would need, not just a one-time data transfer, but would also need to develop an ongoing data feed between the VA and CMS. This data feed would require an enormous system development effort for both the VA and CMS, including secure connections, data infrastructure development, increase in data storage capacity, and security certifications, which would be a resource-intensive process.

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CMS	GAO-16-394	Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data	5/13/2016	1	In order to better ensure proper Medicare payments and protect Medicare funds, CMS should seek legislative authority to allow the RAs to conduct prepayment claim reviews.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Currently, MACs, ZPICs, and PSCs conduct prepayment claim reviews. In addition, HHS has implemented programs, including FPS, prior authorizations models, and categorical risk-based screening of Medicare providers and suppliers, to move beyond "pay and chase" operations and pay claims properly the first time. The Fiscal Year 2017 President's budget does not include a legislative proposal to allow RAs to conduct prepayment claims reviews.
CMS	OEI-04-11-00590	Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure	5/20/2016	399-915-11-02-04957	CMS should require State Medicaid programs to verify the completeness and accuracy of provider ownership information	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Although CMS does agree that verifying the completeness and accuracy of provider ownership information is ideal, CMS cannot achieve this ideal state due to the fact that the resources required for successful task completion are not available

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CMS	OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	399-915-11-02-04967	CMS should assist States in overcoming challenges in conducting site visits	Concur	2020	In progress	CMS supplied information to the OIG to close this recommendation based on the following activity. CMS has provided site visit guidance to the State Medicaid Agencies (SMAs) in the Medicaid Provider Enrollment Compendium (MPEC) and training at the Medicaid Integrity Institute (MII) in September 2016. Site visits have been regularly discussed on the monthly Provider Enrollment Technical Assistance Group (PE TAG) calls in 2017 with all states (including all states that have not implemented an FCBC or site visit process as yet. CMS provides a data compare service which allows states the option to easily rely on CMS's site visits conducted by Medicare. Recently, CMS reported to the OIG that 47 out of 50 States are conducting site visits and that targeted assistance was being provided to these states. This assistance includes monthly calls with States, direct access to CMS Business Function Leads, and CMS site visits to states. The OIG responded that it is not yet prepared to close this recommendation and CMS is evaluating its response. 8.27.19 Update:CMS will provide

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									our plan for State-specific targeted assistance on site visit to the remaining States that have not implemented. Furthermore, CMS is updating the Medicaid Provider Enrollment Compendium (MPEC) to revise the site visit requirement to permit activities that are not on-site visits to constitute site visits. CMS expects the actions of this recommendation to be completed by the first quarter of FY20.

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CMS	OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	399-915-11-02-04966	CMS should assist States in implementing fingerprint-based criminal background checks for all high-risk providers	Concur	2020	In progress	In an effort to close this recommendation, CMS reported that 38 out of 50 States have implemented fingerprint-based criminal background checks (FCBC). The remaining States have yet to implement because of lack of authority or lack of funding at the State level. CMS supplied evidence of assistance provided to three unimplemented States: Arkansas, Idaho, and Maine. CMS also indicated that it has assisted States by providing use of its service that compares States' provider enrollment information to Medicare provider enrollment information so that states can rely on Medicare screening results for those providers dually enrolled. CMS indicated that it cannot compel States to implement the FCBC, however it has detailed guidance provided to State Medicaid Agencies (SMAs) in the Medicaid Provider Enrollment Compendium (MPEC) and training at the Medicaid Integrity Institute (MII); how FCBC and site visits have been regularly discussed on monthly Provider Enrollment Technical Assistance Group (PE TAG) calls with all states (including all states that have not

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									implemented an FCBC or site visit process as yet). The OIG, however, believes that this recommendation is still open and CMS is evaluating its response. 8.27.19 Update: CMS will provide our plan for State-specific targeted assistance on the FCBC to the remaining States that have not implemented federal requirements. CMS expects the actions of this recommendation to be completed by the first quarter of FY20.

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CMS	OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	399-915-11-02-04969	CMS should develop a central system where States can submit and access screening results from other States	Concur	2019	In progress	CMS awarded a contract in October 2016 to develop a centralized system for SMAs to share information, which will allow SMAs to report their provider terminations when the system is available. This system could potentially be used to share screening results among SMAs, though a decision concerning this has not been finalized.8.27.19 Update: The Data Exchange System (DEX) allows SMAs and CMS to exchange information and files related to Medicaid enrollment termination and Medicare enrollment revocation. CMS cannot use DEX to allow States to share enrollment information as it is out of the contractual scope of the system and is not in line with the intent of the system. Further, CMS does not have the authority to require states to use a centralized system and there would not be consequences for states who choose not to use the centralized system CMS agrees with the OIG that a centralized system where States can submit and access screening results from other States would be ideal, but launching and compelling use of such a system is impractical. For example, in order for States to

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									utilize and benefit from a centralized system it would require resource-constrained States to have more sophisticated data systems with advanced data querying capabilities. More specifically, states with separate Medicaid Management Information System (MMIS) and enrollment systems that do not interface with one another would not benefit from a centralized system. Most importantly, CMS does not believe that establishing authority requiring use of a system and development of a system is the best use of CMS resources to meet the requirements of the recommendation.Instead, CMS provides states with contact information for the individuals within each SMA who can provide screening and enrollment information. States are asked to reach out to those individuals when it is necessary to access screening results from another State. Further, CMS has issued guidance on this topic in the Medicaid Provider Enrollment Compendium as of its original publication date in 2016 (MPEC, section 1.5.3). CMS is aware that States utilize this process quite frequently by contacting other states via email

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									and phone to confirm screening results. This process is currently the most feasible solution. CMS has not created any subgroups, but encourages States to create subgroups amongst themselves to discuss best practice ideas. These types of collaborative tools and processes are routinely encouraged through monthly PE TAG calls, provider enrollment conferences, and other conversations with the States. Further, allowing states the flexibility to communicate regarding screening is in line with the CMS strategic goal to usher in a new era of state flexibility and local leadership that provides states and local communities' flexibility so they can design innovative programs that best meet their citizens' unique needs.

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CMS	OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	399-915-11-02-04970	CMS should strengthen minimum standards for fingerprint-based criminal background checks and site visits	Concur	2020	In progress	CMS has concluded its review of FCBC regulations found at 42 CFR §455.434, sub-regulatory guidance in the MPEC Section 1.5.5.4, site visit regulations found at 42 CFR §455.432, and sub-regulatory guidance in the MPEC Section 1.5.5.3. CMS concluded that it does not feel it is necessary to strengthen minimum standards. CMS reported to the OIG that it would be premature to make changes to the fingerprint process given that the compliance deadline was July 1, 2018, and that no assessment of the effectiveness of these policies has been conducted. Further, CMS indicated that setting site visit and FCBC standards too narrowly would call into question the use of live video conferencing technology in States where on-site visits are not possible because of geographic barriers. The OIG disagrees with CMS and believes that the setting of miniumum standards is still necessary. CMS is evaluating its response. 8.27.19 Update: CMS is currently updating the Medicaid Provider Enrollment Compendium (MPEC) to revise the site visit requirement to permit activities that are not on-

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									site visits to constitute site visits. CMS expects the actions of this recommendation to be completed by August 2019. In regards to FCBC, majority of States that submitted the FCBC compliance plan stated they would be conducting national background checks. CMS will work one-on-one with the states that reported using local background checks to reiterate the importance of conducting national checks. CMS recommended in the final rule that States do a federal/FBI background check, but States have discretion to decide what databases to check against. This state flexibility is in line with the CMS strategic goal to usher in a new era of state flexibility and local leadership that provides states and local communities flexibility so they can design innovative programs that best meet their citizens' unique needs. CMS agrees with the OIG that minimum standards for FCBC and site visit would be ideal, but CMS does not have the regulatory authority to require states to follow those standards without further rulemaking. The current process represents the best use of CMS' resources on this issue.

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CMS	OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	399-915-11-02-04971	CMS should work with States to develop a plan to complete their revalidation screening in a timely way	Concur	2020	In progress	States have participated in a discussion of revalidation regulation and policy at the MII and on PE TAG calls since 2015. CMS has provided revalidation guidance to SMAs in the MPEC. CMS has visited various states and reviewed revalidation procedures, progress and has assisted states in addressing barriers. CMS provides a data compare service which allows states the option to easily rely on provider and supplier revalidation screenings conducted by Medicare. CMS recently reported to the OIG that 17 out of 50 States have not finished revalidation. CMS also indicated that five of the States reported systems limitations as a barrier and are in the process of implementing a new Medicaid Management Information System that will help them with the revalidation requirement. efforts. Based on this work and ongoing support, CMS moved to close this recommendation. The OIG responded that it would keep this recommendation open and CMS is evaluating its response. 8.27.19 Update: CMS will provide our plan for targeted assistance to

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									the remaining States that have not completed their revalidation screenings. CMS expects the actions of this recommendation to be completed by the first quarter of FY 20.
CMS	OEI-05-14-00430	State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates	6/16/2016	399-915-13-02-04975	CMS should require the use of claim level methods to identify 340B claims	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS does not have the authority to require the use of claim-level methods to identify 340B claims, however, states may develop their own billing instructions in accordance with requirements in the Public Health Service Act. In addition, CMS provides technical assistance to the states on their Medicaid Drug Rebate Programs, and CMS will consider this report and its findings when working with states on this in the future.

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CMS	OEI-04-12-00380	CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain	6/16/2016	399-915-11-02-05096	CMS should require hospitals to submit attestations for all their provider-based facilities	Concur	2020	In progress	CMS is exploring regulatory and subregulatory ways for hospitals to submit information to CMS for all off-campus provider-based services that are paid the higher OPPS payment rates.
CMS	OEI-04-12-00380	CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain	6/16/2016	399-915-11-02-05098	CMS should take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements	Concur	2021	In progress	CMS working with the MACs to determine providers referred by the OIG are out of compliance with the provider-based requirements.

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CMS	OEI-06-14-00110	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	399-915-11-02-05003	AHRQ and CMS should collaborate to create and promote a list of potential rehab hospital events	Concur	2021	In progress	CMS and AHRQ have discussed this recommendation and it is CMS' understanding that AHRQ will do the required research to generate the list of harms applicable to the rehabilitation hospital setting. It is also CMS' understanding that this commitment has been relayed to the OIG through the appropriate AHRQ channels. Additionally, The QIIG has initiated a Hospital Improvement and Innovation Network Special Project to better understand the harms that occur in inpatient rehabilitation hospitals by studying "high performing" inpatient rehabilitation facilities and culling effective strategies, change concepts and actionable items that will serve as a starting point for quality improvement efforts in these facilities. CMS will share those results with AHRQ for further development of the harms list. CMS and AHRQ are also working to expand the development of the Quality Safety Review System (QSRS) which once implemented will allow for an accurate national sample of harms in IRFs. This system is in development and it is not anticipated that the version

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									inclusive of the IRF setting will be ready in time for the next HIIN contract cycle launch. However, this should support the combined commitment of CMS and AHRQ to reduce harm in the IRF setting in the future and does not preclude the HIIN network from beginning their quality activities.
CMS	OEI-06-14-00110	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	399-915-11-02-05002	AHRQ and CMS should raise awareness of adverse events in rehab hospitals and work to reduce harm to patients	Concur	2021	In progress	The QIIG intends to broaden harm reduction efforts to other hospital settings inclusive of Inpatient Rehabilitation Hospitals and Long Term Care Hospitals among others pending OMB approval. In anticipation of approval, DQIIMT, the division that has oversight of the Hospital Improvement Innovation Network will hold an "All Partners Meeting" in June 2019. This meeting represents national private, Federal and HIIN partners who are working towards all cause harm reduction. DQIIMT will expand efforts to include important IRF partners and thoughts leaders with a focus on elevating the larger patient safety communities understanding of

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									harm in this setting. Additionally, the QIIG, DQIIMT has initiated a Hospital Improvement and Innovation Network Special Project to better understand the harms that occur in inpatient rehabilitation hospitals by studying "high performing" inpatient rehabilitation facilities and culling effective strategies, change concepts and actionable items that may serve as a starting point for quality improvement efforts in these facilities. There are plans to include harm reduction work in the IRF as part of the HIIN during the next contract cycle pending OMB approval.

CMS	OEI-06-14-00110	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	399-915-11-02-05004	CMS should include information about potential events and patient harm in its quality guidance to rehab hospitals	Concur	2021	In progress	CMS-CCSQ Components met in response to continued questions and have coordinated to ensure that the correct component is responding to this request. The Quality Safety and Oversight Group (QSOG) provides guidance to CMS Surveyors for their use. Guidance related to the Quality Assessment Performance Improvement (QAPI) in IRFs has not been released and would need to be cleared by the CMS Administrator. However, other supportive work of this recommendation occur in other parts of the agency. As part of the background work for measures developed and/or implemented in the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), CMS and its contractors take into consideration gaps in quality, including those associated with adverse events. Within its materials posted for public, stakeholder and provider use, we explain the importance of each measure and the quality gap it is designed to address, such as falls with injuries, preventable readmissions, and healthcare acquired infections. Such materials are posted on CMS's websites which are used by providers for various purposes, including understanding the measures used in the program. Materials related to the IRF QRP can be found on the various tabs of the IRF QRP webpages at

									https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html. For example, information regarding the measures included on the confidential feedback reports (quality measure (QM) reports) is available on the IRF QRP Measures information webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf. In addition, an example of the type of information related to measure specifications, including the purpose and rationale for a quality measure, can be found in the following document available on our webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Final-Specifications-for-IRF-QRP-Quality-Measures-and-Standardized-Patient-Assessment-Data-Elements-Effective-October-1-2018.pdf. Additional documents for the various quality measures are available in the Archives tab of the IRF QRP webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-

									Reporting-Archives.html. The materials contain information on the data and reports that providers can review related to the IRF QRP quality measures to help drive quality improvement in their facilities. Specifically, providers can download confidential feedback reports to review how they are performing with the measures for use in quality improvement activities, including measures that address adverse events such as falls with major injury. Further, as part of the background on those measures that we propose to use through rule making, we explain in detail the importance, including empirical evidence, to support the need for a given quality measure, including those that address adverse events. The public reporting component (IRF Compare) of the IRF QRP was implemented December, 2016. This website displays quality measurement results on patient safety measures such as pressure ulcers and falls. The IRF QRP is used by both patients and providers to better understand the quality provided in each facility. Within the IRF Compare site there is information provided aimed to support quality improvement, such as information that pertains to healthcare associated infections. In addition, the IRF Compare website provides links to additional information about these infections

									at https://www.cdc.gov/hai/prevent/prevention.html. The Compare website also includes a link for patient safety information at https://www.cdc.gov/hai/patientsafety/patient-safety.html.

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CMS	GAO-16-594	Medicare Part B: CMS Should Take Additional Steps to Verify Accuracy of Data Used to Set Payment Rates for Drugs	8/1/2016	1	CMS should periodically verify the sales price data submitted by a sample of drug manufacturers by requesting source documentation from manufacturers to corroborate the reported data, either directly or by working with the HHS Office of Inspector General as necessary.	Concur	2019	Awaiting Disposition	CMS current activities include routine quality checks on all ASP data that is used for each quarter's pricing files. The checks include a comparison of price changes across quarters, a comparison against current WAC and a comparison against AMP (done by the OIG). These activities verify the underlying accuracy of the manufactures' data by directly comparing ASPs to other pricing indicators. Findings from these activities are used to identify situations where a referral to OIG for potential misreporting is warranted (if a direct inquiry to the manufacturer does not resolve CMS' concerns).
CMS	GAO-16-568	Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs	8/1/2016	2	To ensure efficient use of federal resources, the Administrator of CMS should account for Medicaid payments a hospital has received that offset uncompensated care costs when determining hospital uncompensated care costs for the purposes of making Medicare UC payments to individual hospitals.	Concur	2021	In progress	CMS position remains the same. The total aggregate Medicare uncompensated care payments available are primarily determined according to a methodology prescribed in statute. HHS has proposed to begin to use the uncompensated care data reported by hospitals in a relative sense to distribute the available aggregate amount available for uncompensated care payments. Because the compensated care data reported by hospitals is only used in a relative sense, it is not clear

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									that it would be appropriate to offset the Medicare uncompensated care payments by the Medicaid uncompensated care payment.
CMS	OEI-03-13-00450	MACs Continue to Use Different Methods to Determine Drug Coverage	8/9/2016	399-915-11-02-05035	CMS should assign a single entity to assist MACs with making coverage determinations	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS has taken a number of steps to achieve more consistency among the MACs and the LCDs developed by them. CMS convenes regular meetings with the MACs to discuss best practices and effective approaches to making coverage determinations. Additionally, in order to measure and ensure increased collaboration among the MACs, CMS has added requirements related to LCD collaboration to the MAC Award Fee metric.Per OIG August 2017 Response Memo: we will treat CMS's response as its notification of final action. However, OIG will continue to consider this recommendation unimplemented.
CMS	OEI-03-13-00450	MACs Continue to Use Different Methods to Determine	8/9/2016	399-915-11-02-05036	CMS should evaluate the cost-effectiveness of edits and medical reviews that are designed to ensure appropriate payments for	Concur	2020	In progress	PCG study to determine the cost-effectiveness of different types of review on Part B drugs complete.

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		Drug Coverage			covered uses on Part B drug claims				
CMS	OEI-02-10-00492	Hospices Should Improve Their Election Statements and Certifications of Terminal Illness	9/15/2016	399-915-11-02-05118	CMS should provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care.	Non-concur	NA	Awaiting Disposition	CMS will monitor patient revocations and discharges and provide additional guidance to hospices, if needed. CMS recognizes that the decision to elect the Medicare hospice benefit can be difficult and strives to maintain access to this important benefit. Section 1812(d)(2) of the Social Security Act, allows patients to stop receiving hospice care, at any time, and for any reason and re-elect the hospice benefit for any other benefit period for which he or she is eligible.
CMS	GAO-16-700	Skilled Nursing Facilities: CMS Should Improve Accessibility and Reliability of Expenditure Data	10/6/2016	1	To improve the accessibility and reliability of SNF expenditure data, the Acting Administrator of CMS should take steps to improve the accessibility of SNF expenditure data, making it easier for public stakeholders to locate and use the data.	Concur	2019	Awaiting Disposition	CMS currently posts raw SNF expenditure data on the CMS website, where it is available for public stakeholders to view and use. This complies with HHS' legislative requirement to make information on SNFs' expenditures "readily available to interested parties upon request." CMS has determined the costs to the program of reformatting this data to implement GAO's recommendation would outweigh the benefits of doing so. This effort would be a significant burden upon staff, and

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									HHS has not received requests from public stakeholders to make the data more readily accessible. We consider this recommendation closed – not implemented.
CMS	GAO-16-700	Skilled Nursing Facilities: CMS Should Improve Accessibility and Reliability of Expenditure Data	10/6/2016	2	To improve the accessibility and reliability of SNF expenditure data, the Acting Administrator of CMS should take steps to ensure the accuracy and completeness of SNF expenditure data.	Non-Concur	NA	Awaiting Disposition	CMS position of non concurring has not changed. CMS collects SNF expenditure data in cost reports for general information purposes. HHS takes a risk-based approach to determining priorities and allocation of resources. The amount of time and resources that may be required to verify the accuracy and completeness of SNF expenditure data could be substantial, without the potential of creating a significant benefit to the agency or the public.
CMS	OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	399-915-11-02-05139	CMS should assist IHS in its oversight efforts by conducting more frequent surveys of hospitals, informing IHS leadership of deficiency citations, and continuing to provide technical assistance and training	Concur	2021	In progress	All non-deemed IHS hospitals are currently on a three-year certification cycle, with the next round of recertification surveys scheduled for 2021. Also, senior IHS leadership are directly and routinely informed by email of any survey activity in IHS facilities. Supporting documentation to be submitted to outline the expectations of the ROs and demonstrating the frequency of the revised recertification survey

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									schedule. Target Date of Completion 01/31/2021
CMS	GAO-17-5	Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures	10/13/2016	2	To make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, the Secretary of HHS should direct CMS to comprehensively plan, including setting timelines, for how to target its development of new, more meaningful quality measures on those that will promote greater alignment, especially measures to strengthen the core measure sets that CMS and private payers have agreed to use.	Concur	2020	In progress	CMS works to provide technical support to the Core Quality Measures Collaborative (CQMC) which includes CMS collaboration with private payers is currently in Option Year One of the task order with a performance period of 9/14/2019 through 9/13/2020. The Statement of Work for this CQMC task order includes a goal "To achieve widespread adoption of parsimonious CQMC measure sets, diverse constituencies must collaborate to find opportunities for alignment, identify critical gaps, and support the adoption of aligned measure sets. With this, the CQMC aims at providing direction to align industry efforts (e.g. harnessing new, efficient data sources)." The activities planned out within the project period include finalizing measure selection criteria for new and existing core sets, approaches for prioritization of new core sets, analysis of gap areas and variation of measure specifications, and the

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									creation of 1-2 new core measure sets. This is more complicated. We have the plans, but much depends on funding and other factors as to how quickly key elements can be implemented. We expect that by end of 2020 we will have made substantive progress on aligning measures with VA/DOD and AHIP, but it would be VERY difficult to be more specific at this holistic high level.
CMS	GAO-17-61	Nursing Homes: Consumers Could Benefit from Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System	11/18/2016	2	To help improve the Five-Star System's ability to enable consumers to understand nursing home quality and make distinctions between high- and low-performing homes, the Administrator of CMS should add information to the Five-Star System that allows consumers to compare nursing homes nationally.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Although two of the three components of the Nursing Home Compare Five-Star Quality Rating System are based on comparisons to national norms, the Health Inspection Rating is, by design, based upon the relative performance of facilities within each state. Each state survey agency follows HHS protocols in assessing whether or not nursing homes meet Federal requirements, however, there are state to state variations in the outcomes of those surveys that make national comparisons misleading. HHS believes that state-level rating systems provide a valid measure of a nursing homes performance

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									relative to other nursing homes in a particular location. Additionally, the Five-Star Rating System is just one of many factors to be used when choosing a nursing home.
CMS	OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	399-906-11-02-05255	Conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy	Concur	2020	In progress	The SOW requires the BFCC-QIO to analyze and gather data from a variety of sources which includes OIG and GAO reports. CMS will ensure that the OIG recommendations are incorporated in the QIO's claims selection strategy (IPRS). The task order was awarded on 1 August 2019, however as a result of a protest, a stop work order was issued on 19 August 2019. The maximum time before the work is restarted is 100 days after the protest was filed (100 days after 9 August 2019). Once the task order is restarted, the IPRS will be due in 30 days, and must be reviewed and approved by CMS before it is implemented. During the stop work order period, CMS will continue to build the Collaborative Advanced Analytics & Data Sharing (CAADS™) platform which will provide an end-to-end solution for predictive

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									analytics in government healthcare. This tool will permit CMS's contractor to target claims from hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy.
CMS	OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	399-906-11-02-05257	Analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services	Concur	2020	In progress	CMS concurs with the recommendation. QIOs are currently conducting initial patient status reviews of short stays in acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay hospital claims.
CMS	OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	399-906-13-02-05258	Explore ways of protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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CMS	OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	399-906-11-02-05256	Identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy	Concur	2020	In progress	Here are the details of the IPRS: a. At least annually the BFCC-QIO will develop a IPRS that identifies risks to the Medicare Trust Fund and describes the selection strategy for providers and services that address risks associated with improper payment. The IPRS addresses both provider- and service-specific vulnerabilities and includes a prioritization of the problems based on data analysis findings and the availability of resources. b. The first IPRS should be submitted within 30 days of task order award and subsequent reports will be submitted annually. The CMS COR in consultation with the CMS SME, must approve the IPRS prior to implementation. The BFCC-QIO shall analyze and gather data from a variety of sources for this purpose. Examples may include but, are not limited to: Comprehensive Error Rate Testing (CERT)? Medicare Claims Auditor-identified problems Comparative billing reports (CBRs) Office of Inspector General (OIG) or Government Accountability Office (GAO) reports or MedPAC reports Data analysis on a specific benefit, diagnostic/procedure code, or place of service. This analysis

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									shall include an identification of the specific cause of improper payments Evaluation of utilization or probes: c. The IPRS will contain the following elements at a minimum: • Identified medical review (MR) prioritized problems • Data analysis for each prioritized problem • All review activities, provider outreach & education (POE), and other improper payment interventions focused on the prioritized problems. BFCC-QIO shall develop and implement a change package that spreads best practices among the provider and stakeholder community. • Measurable and achievable improvement goals for each prioritized problem • Evaluation methodology for the planned goals and improper payment interventions • Quality assurance activities The task order was awarded on 1 August 2019, however as a result of a protest, a stop work order was issued on 19 August 2019. The maximum time before the work is restarted is 100 days after the protest was filed (100 days after 9 August 2019). Once the task order is restarted, the IPRS will be due in 30 days, and must be reviewed and approved by CMS

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									before it is implemented. During the stop work order period, CMS will continue to build the ' Collaborative Advanced Analytics & Data Sharing (CAADS™) platform which will provide an end-to-end solution for predictive analytics in government healthcare. This tool will permit CMS' contractor to identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy. Year 2020 is the target date of completion.

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CMS	GAO-17-28	Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs	12/22/2016	1	To achieve a better understanding of the effect of certain PCS services on beneficiaries and a more consistent administration of policies and procedures across PCS programs, we recommend the Acting Administrator of CMS collect and analyze states' required information on the impact of the Participant-Directed Option and Community First Choice programs on the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice programs.	Concur	2021	In progress	CMS began work on CFC data collection, but this work was interrupted by COVID. We were also developing a plan for 1915(j), which was also interrupted.

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CMS	GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports	2/8/2017	1	To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS require all states to collect and report on progress towards achieving MLTSS program goals, such as whether the program enhances the provision of community-based care.	Concur	2021	In progress	June 2020: In 2017-2018, CMS analyzed the managed care regulations to ascertain if there were ways to achieve a better balance between appropriate federal oversight and state flexibility, while also maintaining critical beneficiary protections, ensuring fiscal integrity, and improving the quality of care for Medicaid and CHIP beneficiaries. This review process included convening a working group with the National Association of Medicaid Directors (NAMD), reviewing correspondence from states, and utilizing the technical expertise of consultants. This review process culminated in the November 14, 2018 proposed rule. A final rule is expected in the Summer of 2020. During this review, no MLTSS provisions were identified for revision.GAO Update Form attachedJune 2020: In 2017-2018, CMS analyzed the managed care regulations to ascertain if there were ways to achieve a better balance between appropriate federal oversight and state flexibility, while also maintaining critical beneficiary protections, ensuring fiscal integrity, and improving the quality of care for

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									Medicaid and CHIP beneficiaries. This review process included convening a working group with the National Association of Medicaid Directors (NAMD), reviewing correspondence from states, and utilizing the technical expertise of consultants. This review process culminated in the November 14, 2018 proposed rule. A final rule is expected in the Summer of 2020. During this review, no MLTSS provisions were identified for revision.
CMS	GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports	2/8/2017	3	To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS provide states with guidance that includes minimum standards for encounter data validation procedures.	Concur	2020	In progress	DMCP published the State Toolkit for Validating Medicaid Managed Care Encounter Data on 12/19/2019. It can be found at https://www.medicaid.gov/medicaid/managed-care/guidance/encounter-data/index.html. We recommend closing this recommendation.

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CMS	GAO-17-169	Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services	2/13/2017	4	To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of and spending on Medicaid personal care services, CMS should develop plans for analyzing and using personal care services data for program management and oversight.	Concur	2021	Awaiting Disposition	49 states and DC have taken advantage of this option for at least a portion of impacted authorities. In October 2019, CMCS established a state attestation process for states to demonstrate compliance with EVV requirements and provided guidance on this process. The attestation is required for states not requesting the GFE, therefore implementing EVV on January 1, 2020. TN completed the attestation for all PCS authorities; FL completed the attestation for PCS authorized under section 1905(a).
CMS	GAO-17-169	Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services	2/13/2017	3	To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of and spending on Medicaid personal care services, CMS should better ensure that personal care services data collected from states through T-MSIS and MBES comply with CMS reporting requirements.	Concur	2020	In progress	CMS previously provided information on the steps it is now taking to ensure that Personal Care Services (PCS) claims data meet reporting requirements. Please provide an update to the planned actions communicated to us last year.The recommendation also covers expenditure reporting in MBES. We reported in GAO-17-169 on instances in which states were incorrectly reporting PCS expenditures on the CMS-64, including reporting spending under the wrong authority or not separately reporting PCS expenditures using the designated feeder forms. Please describe any data validation steps, or other

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									actions CMS has taken to ensure that states are meeting these requirements when reporting their PCS expenditures in MBES.
CMS	GAO-17-312	Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending	5/3/2017	1	To improve consistency in CMS oversight of federal spending under section 1115 demonstrations, the Secretary of Health and Human Services should require the Administrator of CMS to develop and document standard operating procedures for monitoring spending under demonstrations that (1) require setting reporting requirements for states that provide CMS the data elements needed for CMS to assess compliance with demonstration spending limits; (2) require consistent enforcement of states' compliance with financial reporting requirements; and (3) require consistent tracking of the amount of unspent funds under	Concur	2020	In progress	MS has completed development of the standardized budget neutrality tool. CMS completed onboarding of the budget neutrality tool with all 1115 states in August 2019. All states with approved 1115s complete the budget neutrality tool as part of their PMDA monitoring submissions.

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					demonstration spending limits.				
CMS	A-05-15-00020	Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices	5/17/2017	332-915-13-1	We recommend that CMS seek legislation to eliminate the lump-sum payment option for all PMDs. If such legislation had been in place during CYs 2011 through 2014, Medicare could have saved at least an additional $10,245,539.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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CMS	A-05-14-00047	Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements	6/7/2017	307-009-01-2	We recommend that CMS recover $2,344,680 in overpayments made to Eligible Professionals after they switched programs.	Concur	2020	In Progress	Actions to recover the remaining balance will continue in conformance with CMS' collection process.
CMS	GAO-17-551	Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses	6/30/2017	1	To ensure that the HVBP program accomplishes its goal to balance quality and efficiency and to ensure that it minimizes the payment of bonuses to hospitals with lower quality scores, the Administrator of CMS should revise the formula for the calculation of hospitals' total performance score or take other actions so that the efficiency score does not have a disproportionate effect on the total performance score.	Concur	2020	Awaiting Disposition	• GAO reviewed CMS's response to our recommendation and determine that the recommendation will remain OPEN. • In our review of the HVBP program, we found that CMS's calculation of total performance scores and practice of proportional redistribution resulted in some hospitals with lower quality scores receiving bonuses. • This could jeopardize the HVBP program's goal of balancing quality and efficiency in the program. While CMS did take some steps to evaluate the formulas, no changes were ultimately made. As a result,

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									the underlying problem in the calculation of the TPS still exists, making it difficult for the HVBP program to meet its goal.
CMS	GAO-17-551	Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses	6/30/2017	2	To ensure that the HVBP program accomplishes its goal to balance quality and efficiency and to ensure that it minimizes the payment of bonuses to hospitals with lower quality scores, the Administrator of CMS should revise the practice of proportional redistribution used to correct for missing domain scores so that it no longer facilitates the awarding of bonuses to hospitals with lower quality scores.	Concur	2020	Awaiting Disposition	• GAO reviewed CMS's response to our recommendation and determine that the recommendation will remain OPEN. • In our review of the HVBP program, we found that CMS's calculation of total performance scores and practice of proportional redistribution resulted in some hospitals with lower quality scores receiving bonuses. • This could jeopardize the HVBP program's goal of balancing quality and efficiency in the program. While CMS did take some steps to evaluate the formulas, no changes were ultimately made. As a result, the underlying problem in the calculation of the TPS still exists, making it difficult for the HVBP program to meet its goal.

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CMS	GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	1	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to annually report improper payment estimates and error rates for the advance PTC program.	Concur	2021	In progress	CMS is in the process of developing an improper payment measurement for the advance premium tax credit (PTC). The development of the measurement methodologies will be a multi-year process which consists of the development of measurement policies, procedures, and tools. It also includes extensive pilot testing to ensure an accurate and efficient improper payment estimate, as well as, acquisition activities for procurement of improper payment measurement contractors
CMS	GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	2	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, and until annual reporting of improper payment estimates and error rates for the advance PTC program is performed, the Secretary of Health and Human Services should direct the Administrator of CMS to disclose significant matters relating to the Improper Payments Information Act (IPIA) estimation, compliance, and reporting objectives for the	Concur	2021	In progress	CMS continue to update its annual AFRs on the status of the measurement program development until the improper payment estimate is reported.

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					advance PTC program in the agency financial report, including CMS's progress and timeline for expediting the achievement of those objectives and the basis for any delays in meeting IPIA requirements.				
CMS	GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	3	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to design and implement procedures for verifying the identities of phone and mail applicants to reasonably assure that ineligible individuals are not enrolled in qualified health	Concur	2020	In progress	CMS is continuing to explore alternatives for assessing risk and ensuring integrity of applicant information that is provided to the program and ways to ensure personal information provided by a consumer is accurate through a variety of means. After this analysis phase, CMS will assess resource requirements, cost and operational implications for potential implementation approaches.

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					plans in the marketplaces or provided advance PTC.				
CMS	GAO-17-600	Medicare: CMS Should Evaluate Providing Coverage for Disposable Medical Devices That Could Substitute for Durable Medical Equipment	7/17/2017	1	The Administrator of CMS should evaluate the possible costs and savings of using disposable devices that could potentially substitute for DME, including options for benefit categories and payment methodologies that could be used to cover these substitutes, and, if appropriate, seek legislative authority to cover these devices.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
CMS	OEI-09-14-00020	Challenges Appear to Limit States' Use of Medicaid	9/5/2017	399-915-11-02-05447	CMS should provide additional technical assistance to help Medicaid agencies fully utilize Medicaid payment	Concur	2020	In progress	CMS continues to provide technical assistance to state Medicaid agencies on the use of the payment suspension tool and will follow-up with Medicaid agencies when appropriate to determine if

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		Payment Suspensions			suspensions as a program integrity tool				additional technical assistance is needed. CMS will be using its focused State Program Integrity Reviews to better inform which States should be engaged for more directed technical support. CMS will continue to review reported data on payment suspensions
CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	3	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that marketplace IT self-sustainability risk assessments are based on fully defined measurable terms, a clear categorization process, and a defined response to high risks.	Concur	NA	Awaiting Disposition	CMS partially-concurs with GAO's recommendation. As part of the Enterprise Life Cycle framework, state exchanges submitted Performance Measurement Plans during the system planning and design phases. HHS will continue to review IT metrics for state exchanges in the implementation phase as those states work to automate aspects of their systems. For states with systems in the operations and maintenance phase, each exchange is accountable for managing vendor and contractor performance regarding the reporting of IT metrics, under federal and state law. HHS works with states on the continuous improvement of their management and operations through an array of technical assistance activities and implementation of oversight and accountability measures, while taking into consideration the

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									burden to states and variations in state system reporting capabilities.
CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	4	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that states develop, update, and follow performance measurement plans that allow the states to continuously identify and assess the most important IT metrics for their state marketplaces.	Non-Concur	NA	Awaiting Disposition	CMS non-concurs with GAO's recommendation. As part of the Enterprise Life Cycle framework, HHS conducts an annual Open Enrollment Readiness Review, similar to operational analysis reviews, prior to each Open Enrollment period. The Open Enrollment Readiness Review is used to assess key performance indicators of the systems' readiness for open enrollment, as well as to assess whether each State Exchange is making progress on previously identified action items, while also working to implement new requirements.

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CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	5	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to conduct operational analysis reviews and systematically monitor the performance of states' marketplace IT systems using key performance indicators.	Non-Concur	NA	Awaiting Disposition	CMS also partially concurred with our sixth recommendation that CMS ensure that metrics collected from the states to monitor marketplaces' operational performance link to performance goals and include baselines and targets to monitor progress. HHS did not specifically identify which aspects of our recommendation it concurred with and did not concur with; however, the department stated that, while it requests performance measures from the state marketplaces, once the marketplaces are operational, states are responsible for monitoring their own performance measures. HHS also stated that it will continue to review IT metrics of state marketplaces in the implementation phase of their systems, but emphasized the burden on states and variations in state system reporting capabilities. However, as we noted in our report, CMS did not ensure that the metrics it is collecting from the states are linked to performance goals as suggested by best practices. Without this linkage, the agency may continue to be limited in its ability to monitor whether the state systems are performing efficiently and

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									effectively. Additionally, CMS may miss the opportunity to refine its current IT metrics collection to better balance its need for visibility into states' performance without unnecessarily burdening states.
CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	6	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that metrics collected from states to monitor marketplaces' operational performance link to performance goals and include baselines and targets to monitor progress.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation, no planned actions

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CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	1	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that state-based marketplace annual sustainability plans, to the extent possible, have complete 5-year budget forecasts.	Non-Concur	NA	Awaiting Disposition	CMS non-concurs with GAO's recommendation. HHS is committed to assisting state exchanges in their sustainability efforts. As part of these efforts, HHS assesses exchange self-sustainability risk, which includes asking exchanges to submit annual two-year budget forecasts. While in the past HHS has asked states for five-year budget forecasts, HHS engages in a collaborative process to collect timely, accurate, and relevant data on sustainability, while taking into consideration both the significant burden to states and the variations in states' budget cycles. HHS is working to streamline and simplify this data collection effort as part of the annual sustainability plan.
CMS	GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	2	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that all state-based marketplaces provide required annual financial audit reports which are in accordance with generally accepted government auditing standards.	Concur	2020	In progress	Per the ACA, a state operating a State-based Exchange must ensure that it is self-sustaining beginning on January 1, 2015 when the grant funding was no longer available. As a result, CMS focused its oversight efforts on assessing an Exchange's self-sustainability through a broad range of factors, including revenue source, issuer landscape, remaining grant funding, and staffing.

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CMS	GAO-17-632	Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs	9/13/2017	1	To improve CMS's oversight of states' MLTSS programs, the Administrator of CMS should take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.	Concur	2021	In progress	CMS is working with our contractor to create a paper-based version of this guidance (42 CFR 438.66(e) program report). By August 2020, we expect to conduct targeted state engagement on sections of the paper-based guidance to inform final development of the program report based on state feedback. We expect this paper-based tool to be released in final form by July 2021.
CMS	A-09-16-01002	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and	9/25/2017	212-919-10-3	To improve its procedures for SMART reviews, we recommend that CMS require marketplaces to submit additional data elements related to (1) average length of time to resolve inconsistencies, (2) number of unresolved inconsistencies, and (3) number of applicants for whom the marketplace received an FTR response code from the IRS and who were determined eligible for insurance affordability programs.	Non-Concur	NA	Awaiting Disposition	CMS position remains the same. CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

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		Insurance Affordability Programs							
CMS	A-09-16-01002	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs	9/25/2017	212-908-13-1	To improve its oversight of State marketplaces, we recommend that CMS set firm deadlines for marketplaces to fully develop system functionality for verifying applicants' eligibility and resolving inconsistencies, assess potential enforcement mechanisms that would ensure that marketplaces meet those deadlines, and, if such mechanisms are identified, seek legislative authority to establish them.	Concur	2021	In progress	The State Marketplace and Insurance Programs Group (SMIPG) continues to work with State-based Exchanges (SBEs) on submission of the Quarterly Metrics. CMS made changes to the Quarterly Metrics template in October 2017, and implemented those changes with SBEs in April 2018. SBEs have experienced resource constraints in building full reporting functionality for the Quarterly Metrics, but continue to work toward that goal. Per informal guidance from CMS, SBEs have prioritized efforts to ensure all Open Enrollment (OE) Weekly and Monthly data elements are submitted, as required. These metrics provide the most critical insight into an SBE's ability to conduct eligibility and enrollment during OE. CMS continues to

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									address Quarterly Metrics completion through technical assistance to SBEs and will submit evidence to support a recommendation for closure no later than December 2021, and considers this finding to remain in OPEN status until such time.
CMS	A-09-16-01002	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs	9/25/2017	212-919-10-2	To improve its procedures for SMART reviews, we recommend that CMS continue to work with marketplaces to develop the reporting capability to ensure that all required data elements in the Quarterly Metrics Reports are submitted.	Concur	2021	In progress	SMIPG continues to work with SBEs for submission of the Quarterly Metrics. Per recommendation 1 above, we made changes to the Quarterly Metrics template which was approved through the PRA in October 2017, and implemented with SBEs for PY 2018. We received the first submission from the SBEs in April 2018. The SBEs have reported resource constraints in building full reporting functionality for the Quarterly Metrics.

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CMS	OEI-03-13-00630	Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPICs and PSCs	9/27/2017	399-915-11-02-05439	To increase the likelihood of overpayments being recovered, CMS should implement the surety bond requirement for home health providers and consider the feasibility of implementing surety bonds for other providers based on their level of risk	TBD	2020	In progress	CMS is currently evaluating how to effectively implement a surety bond requirement while avoiding undue provider burden. The CMS concurs that implementing a surety bond requirement for HHAs may help reduce potential program vulnerabilities. CMS is currently evaluating its options in implementing this requirement.The surety bond rule would be a significant rule and thus subject to the Executive Order "Reducing Regulation and Controlling Regulatory Costs" issued by the President on January 30, 2017. Any further actions regarding a surety bond rule would be undertaken in that context. Actions to address this recommendation are still in progress.
CMS	OEI-03-13-00630	Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified	9/27/2017	399-915-11-02-05436	CMS should identify strategies to increase MACs' collection of ZPIC- and UPIC-referred overpayments	Concur	2020	In progress	CMS working to submit closure notice.

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		by ZPICs and PSCs							
CMS	A-01-15-00504	Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely-Failed Devices	9/28/2017	212-900-12-1	We recommend that CMS continue to work with the Accredited Standards Committee X12 to ensure that the DI is included on the next version of claim forms.	Concur	2020	In progress	CMS working with the X12 to ensure that the DI is included on the next version of claim transaction. the 837I Institutional claims version 7030 is currently being worked on. New transaction version is still out for public review. New transaction is pending going out for second public review.
CMS	A-01-15-00504	Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled	9/28/2017	212-900-12-2	We recommend that CMS require hospitals to use condition codes 49 or 50 on claims for reporting a device replacement procedure for all procedures that resulted from a recall or premature failure, regardless of whether the device was provided at no cost or with a credit of 50 percent or more.	Concur	2020	In progress	CMS working to submit closure notice.

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		and Prematurely-Failed Devices							
CMS	GAO-18-15	Prescription Opioids: Medicare Needs to Expand Oversight Efforts to Reduce the Risk of Harm	11/6/2017	3	The Administrator of CMS should require plan sponsors to report to CMS on investigations and other actions taken related to providers who prescribe high amounts of opioids.	Non-concur	NA	Awaiting Disposition	CMS did not concur with our recommendation that the agency establish numeric enrollment targets for healthcare.gov, to ensure that it can monitor its performance with respect to its objectives. Specifically, HHS noted that there are numerous external factors that can affect a consumer's decision to enroll in exchange coverage that are outside of the control of HHS, including the state of the economy and employment rates. HHS stated that it does not believe that enrollment targets are relevant to assess the performance of a successful open enrollment period related to the consumer experience. Instead, it believes a more informative performance metric would be to measure whether everyone who utilized healthcare.gov, who qualified for coverage, and who desired to purchase coverage, was able to make a plan selection. We continue to believe that the development of

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									numeric enrollment targets is important for effective monitoring of the program and management of its resources. Without establishing numeric enrollment targets for upcoming open enrollment periods, HHS's ability to evaluate its performance and make informed decisions about how it should deploy its resources is limited. We also believe that these targets could help the agency meet its program objectives of stabilizing the market and of increasing the mix of younger and healthier consumers purchasing plans through the individual market. Furthermore, HHS has previously demonstrated the ability to develop meaningful enrollment targets using available data. For example, in prior years, HHS developed numeric enrollment targets based on a range of factors, including the number of exchange enrollees, number of uninsured individuals, and changes in access to employer-sponsored insurance, Medicaid, and other public sources of coverage. In addition, the agency set numeric enrollment targets for regional markets that took these and other factors into account. Once these targets were established, HHS

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									officials were able to use them to monitor progress throughout the open enrollment period and revise its efforts as needed.

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CMS	A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program	11/15/2017	310-912-10-2	We recommend that CMS monitor supplier licensure requirements by implementing a system to identify and address potential unlicensed suppliers.	Concur	2021	In Progress	CMS is taking steps to ensure that suppliers have applicable licenses for furnishing durable medical equipment, prosthetics, orthotics, and supplies. The Medicare contractor validates supplier licenses at the time of bidding for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program. CMS is pursuing an additional contractor to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process. Further, the review of the providers identified by OIG as unlicensed has been completed. CMS found each of the 13 identified suppliers to be appropriately licensed in accordance with policies and procedures governing the competitive bid process. We have updated the chart from OIG to include CMS findings on each supplier. To complette implementation, CMS will procure and award a contract under the PEOG-IDIQ to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process.

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CMS	A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program	11/15/2017	310-912-10-1	The OIG recommends that CMS ensure that suppliers have applicable licenses for the specific competitions in which they are submitting a bid by continuing to work with State licensing boards, as recommended in our previous report.	Concur	2021	In Progress	CMS is taking steps to ensure that suppliers have applicable licenses for furnishing durable medical equipment, prosthetics, orthotics, and supplies. The Medicare contractor validates supplier licenses at the time of bidding for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program. CMS is pursuing an additional contractor to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process. Further, the review of the providers identified by OIG as unlicensed has been completed. CMS found each of the 13 identified suppliers to be appropriately licensed in accordance with policies and procedures governing the competitive bid process. We have updated the chart from OIG to include CMS findings on each supplier. To complette implementation, CMS will procure and award a contract under the PEOG-IDIQ to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process.

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CMS	OEI-12-17-00260	Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries	11/21/2017	399-915-13-02-05455	CMS should seek a legislative change that would provide the agency flexibility to determine when noncovered versions of a drug should be included in Part B payment amount calculations	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework	12/5/2017	2	The Administrator of CMS should conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk profiles and plans for regularly updating the assessments and profiles.	Concur	2020	In progress	CMS is currently conducting fraud risk assessments on various CMS programs utilizing an Enterprise Program Risk Management approach that incorporates the tenets of the GAO Fraud Risk Framework. This approach enables CMS to proactively identify potential and existing vulnerabilities in CMS programs and identify measurable, strategic solutions to mitigate these risks on a regular basis. Examples of programs under review include the Medicare Diabetes Prevention

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									program, the Quality Payment Program, home health requests for anticipated payment, and opioid treatment programs.
CMS	GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework	12/5/2017	3	The Administrator of CMS should, using the results of the fraud risk assessments for Medicare and Medicaid, create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for monitoring and evaluation.	Concur	2021	In progress	CMS is currently conducting fraud risk assessments on various Medicare related programs utilizing an Enterprise Program Risk Management approach which incorporates the tenets of the GAO Fraud Risk Framework. This approach enables CMS to examine existing vulnerabilities, identify measurable strategic solutions to reduce program risk as well as utilizing proactive approaches to reviewing new programs to reduce risk and impact to both the beneficiaries and the trust funds. Some of these programs under review include the Medicare Diabetes Prevention program, the Quality Payment Program, and CPAP machines. The Medicare Diabetes Prevention Program anti-fraud strategy is currently being developed.

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CMS	GAO-18-179	Medicaid Assisted Living Services:Improved Federal Oversight of Beneficiary Health and Welfare is Needed	1/5/2018	2	The Administrator of CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred.	Concur	2021	In progress	CMS has continued state site visits that allow for assessing administrative processes and future support needs.
CMS	GAO-18-179	Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed	1/5/2018	1	The Administrator of CMS should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community-based services (HCBS) waivers are required to report on their annual reports.	Concur	2020	In progress	A series of 3 national trainings on the results of the Incident Management Survey are scheduled for the Summer of 2020. This training includes common incident types across states. CMS will also issue training on promising practices identified by the Health and Welfare Special Review Team in the first nine states visited by 9/30/2020. DEHPG has also convened a Health and Welfare working group to look at common reporting measures. The COVID-19 response has delayed some of this work with states in the first half of calendar 2020, resulting in the December target date for completion of the reporting measures.

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CMS	GAO-18-179	Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed	1/5/2018	3	The Administrator of CMS should ensure that all states submit annual reports for HCBS waivers on time as required.	Concur	2020	In progress	A series of 3 national trainings on the results of the Incident Management Survey are scheduled for the Summer of 2020. CMS will also issue training on promising practices identified by the Health and Welfare Special Review Team in the first nine states visited by 9/30/2020.
CMS	GAO-18-70	Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight	1/8/2018	1	The Administrator of CMS, in partnership with the states, should take additional steps to expedite the use of T-MSIS data for program oversight. Such steps should include, but are not limited to, efforts to (1) obtain complete information from all states on unreported T-MSISdata elements and their plans to report applicable data elements; (2) identify and share information across states on known T-MSIS data limitations to improve data comparability; and (3) implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an	Concur	2020	In progress	HHS concurred with this recommendation. In March 2018, HHS stated that it developed a database on data quality findings, which could be used to identify solutions for common problems across states, and has begun to develop a data quality scorecard for T-MSIS users, which aggregates data quality findings in a user-friendly tool. HHS stated that it will (1) continue to work to obtain complete T-MSIS information from all states; (2) take additional steps to share information across states on T-MSIS data limitations; and (3) implement ways for states to collaborate regarding T-MSIS.

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					ongoing basis to improve the completeness, comparability, and utility of T-MSIS data.				
CMS	GAO-18-70	Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight	1/8/2018	2	The Administrator of CMS should articulate a specific plan and associated time frames for using T-MSIS data for oversight.	Concur	2020	In progress	Enrollment on the Exchanges remained steady in both 2018 and 2019. Specifically, year-end enrollment in 2018 exceeded that of 2017. In 2019, enrollment is virtually even with previous years, with a very slight decline in the FFE due principally to a shift from FFE enrollment to Medicaid enrollment that resulted from the recent Medicaid expansion in Virginia.

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CMS	GAO-18-103	Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services	1/16/2018	1	The Administrator of CMS should ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments.	Concur	2020	In progress	HHS already has a regulatory structure in place to protect against potential conflicts of interest on the part of entities responsible for determining eligibility for home and community based services and the development of person-centered service plans. To address conflict of interest concerns, states are required per 42 CFR 441.301(c)(l)(vi), 42 CFR 447.555(c)(5) and 42 CFR 441.555(c)(5), to separate entities engaged in person-centered service plan development from service delivery functions in order to address the potential conflict of interest concerns. In addition, Medicaid regulations at 42 CFR 431.10 require the responsibility for home and community based service eligibility to rest with the individual state's Medicaid agency. As such, states are required to evaluate an applicant's need for waiver services and make the final determination of eligibility.
CMS	OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for	1/16/2018	399-915-11-02-05481	CMS should establish and monitor MA encounter data performance thresholds related to MAO's submission of records with complete and valid data	Concur	2021	In progress	CMS has already begun developing thresholds for monitoring, which includes encounter data system review and updates, technical assistance and guidance to plans, analysis for monitoring and

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		Program Oversight, But Improvements Are Needed							compliance, and development and implementation of a compliance plan (including performance thresholds) designed to validate Medicare Advantage encounter data. The framework for the encounter data compliance plan was described in the 2018 Call Letter.
CMS	OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	399-915-11-02-05480	CMS should track MAOs' response to reject edits	Non-Concur	NA	In progress	CMS does not concur with this recommendation. Modifying our systems, as well as requiring that Medicare Advantage Organizations modify each of their own systems, to track rejected records and tie resubmissions to rejected records is administratively burdensome both to build and maintain, and would redirect limited resources away from regular submissions, which could ultimately reduce submission completeness. CMS's compliance plan takes a higher level approach of first prioritizing overall completeness and volume of data. CMS is developing completeness thresholds for Medicare Advantage encounter data and believes this approach is more comprehensive, more transparent, and less burdensome on both CMS and Medicare Advantage Organizations. Given the burden on

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									plans and the likelihood that plans would not be able to get all their data in if we required these data, CMS would need to weigh the administrative burden on plans to submit these specific data elements versus intended use for PI purposes.
CMS	OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	399-915-11-02-05476	CMS should provide targeted oversight of MAOs that submitted a higher percentage of encounter records with potential errors	Concur	2021	In progress	CMS already reaches out to Medicare Advantage Organizations to discuss frequently occurring edits and errors, as well as issuing quarterly report cards to plans, conducting on-site visits, holding monthly user group calls, and responding to inquiries. CMS also reaches out to plans through our technical assistance contract, who conducts outreach with submitters when issues arise. Furthermore, CMS recently released guidance regarding best practices that plans can implement to help with the encounter data submission process. CMS will review the list of MAOs that submitted a higher percentage of the encounter records with potential errors identified in OIGs review and consider how to

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									incorporate this information into our already extensive oversight activities.
CMS	OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	399-915-11-02-05478	CMS should require MAOs to submit ordering and referring provider identifiers for applicable records	Non-Concur	2021	Awaiting Disposition	This recommendation was closed in FY 2021
CMS	OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	399-915-11-02-05479	CMS should ensure that MAOs submit rendering provider identifiers for applicable records	Non-Concur	2021	In progress	CMS does not concur with this recommendation. CMS seeks to balance administrative burden on entities subject to reporting requirements. Because Medicare Advantage Organizations do not always require the ordering, operating, or facility National Provider Identifiers on their provider claims or encounter data, the Medicare Advantage Organizations often do not collect this information on their claims and therefore do not have this data

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									available to report. However, CMS will explore whether ordering and referring provider identifiers are necessary for program integrity purposes and will consider requiring their inclusion in the future.
CMS	A-09-16-02034	Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests	2/14/2018	322-916-01-1	We recommend that CMS direct the Medicare contractors to recover the $66,309,751 in identified improper payments.	Concur	2020	In progress	SMRC to generate more recent claims data and perform medical review.

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CMS	A-09-16-02034	Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests	2/14/2018	322-916-02-1	We recommend that CMS strengthen its system edits to prevent improper payments for specimen validity tests and instruct the Medicare contractors to educate providers on properly billing for specimen validity and urine drug tests, which could result in savings of an estimated $12,146,760 over a 5-year period.	Concur	2020	In progress	CMS concurs with this recommendation. CMS will examine the possibility of additional system edits to prevent improper payments for specimen validity tests, while protecting beneficiary access to care and reducing provider burden. CMS will also work with contractors to provide national education to providers on properly billing for urine drug tests. Examination is continuing about the feasibility of implementing FPS2 edits with the goal of determining whether implementation of such edits is possible without increasing provider burden or reducing access to care for beneficiaries with these conditions. If such edits are possible, CMS will work with contractors to provide national education to providers on properly billing for urine drug tests. Based on conversations with the NCCI team (October 2017), there will be no changes or new codes/edits developed on the NCCI side; the NCCI edits that are currently in place are appropriate.

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CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	2/14/2018	322-919-10-1	We recommend that CMS require the Medicare contractors to implement nation-wide prepayment edits to deny payments for emergency ambulance transports to destinations not covered by Medicare.	Concur	2020	In progress	CMS working on closure submission.
CMS	GAO-18-220	Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies	2/20/2018	2	The Administrator of CMS should issue written criteria for when CMS will allow limited evaluation of a demonstration or a portion of a demonstration, including defining conditions, such as what it means for a demonstration to be longstanding or noncomplex, as applicable.	Concur	2020	In progress	Still current as of November 2019.As previously indicated to the GAO, CMS has developed and is applying limited evaluation requirements through STCs for family planning demonstrations (that do not include new policies that have not been tested) and cross state coverage for former Medicaid recipients that aged out of foster care. We need more experience with the reports we receive under these requirements before finalizing our criteria. We are also

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		and Procedures							considering the specific definitions of high level tentative criteria that include: long standing demonstration, non-controversial, and clear evaluation findings that support the efficacy of the tested policy. For example, we are considering if research on similar policy outside of the 1115 demonstrations could satisfy the criteria for clear evaluation findings. Taken together, CMS expects to issue in late 2020 written criteria for when limited evaluation would apply to 1115 demonstrations.
CMS	A-05-16-00059	Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits	3/8/2018	322-919-10-1	We recommended that CMS assuming the OIG recommendation requiring the use of condition codes 49 and 50 is implemented, instruct its Medicare contractors to implement a post-payment process to follow up with any hospital that submits a claim for certain cardiac device replacement procedures (see Appendix C) with condition code 49 or 50 but no value code FD to determine whether an adjustment claim should be submitted.	Non-Concur	NA	Awaiting Disposition	CMS continues to non concur and supporting documents were submitted.

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CMS	A-05-16-00059	Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits	3/8/2018	223-905-12-1	We recommended CMS consider studying alternatives to implementing edits in order to eliminate the current Medicare requirements for reporting device credits, for instance, by reducing IPPS and OPPS payments for device-intensive procedures.	Concur	2021	In Progress	Working internally with the leadership to finalize course of action.
CMS	A-05-14-00041	Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements	3/14/2018	322-919-10-1	We recommended that CMS establish mechanisms to better monitor the appropriateness of outpatient physical therapy claims.	Concur	2021	In Progress	CMS will instruct the SMRC to review outpatient physical therapy claims, incorporating these reviews into our statutorily mandated MACRA reviews. As of 2020, guidance is still under development. The Exchange is now an established channel for individuals seeking insurance. CCIIO has continually assessed the way we do outreach about the Exchanges based on what has been most effective, and concluded that as the Exchange has grown in visibility and become more familiar to Americans seeking health insurance over the years, the need for federally funded Navigators has diminished. Our 2018 FOA reflects this fact.

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CMS	A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements	4/5/2018	303-904-10-1	We recommend that CMS take the following actions, which we estimated could have saved approximately $3,699,848 for calendar years 2014 and 2015: work with Medicare contractors to implement all telehealth claims edits listed in the Manual	Concur	2020	Awaiting Disposition	The CR for revisions to the Telehealth Billing Requirements for Distant Site Services has been issued and was effective 10/1/18. CMS requested OIG closure 2019.
CMS	A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements	4/5/2018	303-009-02-1	We recommend that CMS take the following actions, which we estimate could have saved approximately $3,699,848 for calendar years 2014 and 2015: conduct periodic postpayment reviews to disallow payments for errors for which telehealth claim edits cannot be implemented (for example, unallowable originating sites or unallowable means of communication).	Concur	2020	In Progress	CMS submitting OCD for OIG closure consideration. As part of the Comprehensive Error Rate Testing Program, which CMS uses to calculate the annual improper payment rate in the Medicare Fee-For- Service program, CMS reviews a sample of telehealth claims. As part of this process, medical review professionals perform complex medical review of documentation submitted to support the claim to determine whether the claim was paid properly under Medicare coverage, coding, and billing rules.
CMS	A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare	4/5/2018	303-909-10-1	We recommend that CMS take the following actions, which we estimate could have saved approximately $3,699,848 for calendar years 2014 and 2015: offer education and training sessions to practitioners on	Concur	2020	In progress	The Centers for Medicare & Medicaid Services (CMS) released educational information through our MLN Connects® newsletter and posted information to our Provider Compliance webpage (see the Fast Facts section) to respond to OIG recommendations related to

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		Requirements			Medicare telehealth requirements and related resources.				Medicare improperly making payments for some telehealth claims associated with services that did not meet Medicare requirements.
CMS	GAO-18-269	Federal Health Insurance Exchange: CMS Needs to Ensure Complete, Accurate Data on Terminations of Coverage for Nonpayment of Premiums	4/9/2018	1	The Administrator of CMS should ensure that CMS has complete data on terminations of enrollee coverage for nonpayment of premiums by requiring issuers to report these data.	Concur	2022	In progress	For the past several years, CMS has been implementing a process to ensure enrollment data contains termination reasons to identify enrollees whose coverage is terminated for nonpayment of premiums and other reasons. Termination reasons will help protect the integrity of the Exchanges by supporting oversight and audit of the grace period by indicating enrollees whose coverage was terminated for non-payment and therefore may not have paid some of their premium during the grace period. However, due to the COVID-19 pandemic and QHP issuers' need to focus on flexibilities relating to QHP coverage and collection of premium payments during this time, CMS has slightly delayed the final steps of this implementation.

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CMS	GAO-18-269	Federal Health Insurance Exchange: CMS Needs to Ensure Complete, Accurate Data on Terminations of Coverage for Nonpayment of Premiums	4/9/2018	2	The Administrator of CMS should provide a transparent process for issuers and CMS to systematically reconcile discrepancies in their data on terminations of enrollee coverage for nonpayment of premiums.	Concur	2022	In progress	For the past several years, CMS has been implementing a process to ensure enrollment data contains termination reasons to identify enrollees whose coverage is terminated for nonpayment of premiums and other reasons. Termination reasons will help protect the integrity of the Exchanges by supporting oversight and audit of the grace period by indicating enrollees whose coverage was terminated for non-payment and therefore may not have paid some of their premium during the grace period. However, due to the COVID-19 pandemic and QHP issuers' need to focus on flexibilities relating to QHP coverage and collection of premium payments during this time, CMS has slightly delayed the final steps of this implementation.
CMS	GAO-18-341	Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending	5/21/2018	1	The Administrator of CMS should subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization.	Concur	2021	In progress	CMS will explore available options to subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization.

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CMS	GAO-18-341	Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending	5/21/2018	2	The Administrator of CMS should take steps, based on results from evaluations, to continue prior authorization. These steps could include: (1) resuming the paused home health services demonstration; (2) extending current demonstrations; or, (3) identifying new opportunities for expanding prior authorization to additional items and services with high unnecessary utilization and high improper payment rates.	Concur	2021	In progress	HHS will continue to evaluate the prior authorization programs and will take the GAO's findings and recommendations into account when determining appropriate next steps.

CMS	GAO-18-291	Medicaid: CMS Needs to Better Measure Program Risks in Managed Care	6/6/2018	1	The Administrator of CMS should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs; such an effort could include actions such as revising the PERM methodology or focusing additional audit resources on managed care.	Concur	2020	In progress	CMS will be focusing additional audit resources on Medicaid As evidenced by a July 2019 meeting at the Medicaid Integrity Institute (MII), CMS, CMS's Unified Program Integrity Contractors (UPIC's) and States all gathered to discuss coordination of managed care provider investigations and how to generate actionable outcomes. During the Symposium - which included 32 States, including representatives from DC and the Virgin Islands - the UPICs developed action plans for high risk investigative leads. CMS will be monitoring the progress of those plans going forward in time. The feedback CMS received was overwhelmingly positive and helped CMS to better understand existing challenges, prioritize next-step-investigative strategies. As a result of the feedback and recommendations received during the Symposium, CMS is evaluating several process improvements. CMS has begun to implement several of those improvements; for example, we are taking action to: implement a new concurrent vetting process to ensure a more efficient and streamlined vetting of leads with both state and federal law enforcement; evaluate the fraud referral process to ensure prompt notification to state partners. During the July 16 session that focused on managed care, the

									participants discussed a wide range of challenges with managed care audits and how CMS's UPIC's can be involved with those actions. The subjects included Medicaid managed care organization (MCO) contract language, encounter data, providers with multiple payers, calculating recoveries and federal financial participation, as well as provider appeals to States. We reminded the GAO that in reference to a previous report (GAO 17-277), CMS submitted documentation to describe the meetings that CMS conducted with our contractors and each of the states they would be working with on collaborative audits while the UPIC's were phased-in. We submitted this documentation to demonstrate that the Agency and our contractors were taking steps to clearly communicate with States about audits and potential challenges (CMS submitted a list of when the UPIC's and CMS met with each State to discuss audit planning and sample agendas from meetings with specific states). Currently, CMS has 120 Medicaid managed care network provider investigations in 9 states 33 open investigations of Medicaid MCO network providers in 7 different states. CMS initiated recently completed an audit of a Medicaid managed care plan in Hawaii, the second plan level audit that CMS has

									conducted. CMS is conducting audits of select states' managed care organization (MCO) financial reporting by reviewing compliance with Medical Loss Ratio (MLR) to make sure claims experience matches what plans have been reporting. CMS is currently conducting an audit in California to make sure the financial information submitted by the Medicaid managed care plans and used by the state to perform the MLR calculations is consistent with contractual obligations and matches each plan's internal data and accounting systems. The Medicaid Managed Care guidance is anticipated for release in Q3 of FY 2020.

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CMS	A-04-17-04056	Most Medicare Claims for Replacement Positive Airway Pressure Device Supplies Did Not Comply With Medicare Requirements	6/7/2018	299-919-02-1	We recommended that CMS work with Medicare contractors to establish periodic reviews of claims for replacement PAP device supplies and take remedial action for suppliers that the contractors find consistently bill claims that do not meet Medicare requirements, which could have saved Medicare an estimated $631,272,181 over a 2-year period.	Concur	2021	In progress	In September 2018 CMS authorized its Supplemental Medical Review Contractor (SMRC) to conduct data analysis on PAP claims to identify a sample of providers.
CMS	OEI-06-16-00380	CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities	6/26/2018	399-915-11-02-05600	CMS should assess the costs and benefits of improving oversight of no-payment bills submitted by SNFs	Concur	2021	Awaiting Disposition	CMS will evaluate ways to improve oversight of no-payment bills submitted by skilled nursing facilities including assessing whether it would be cost effective to implement a process similar to the one that OIG used for this review to identify noncovered stays for which skilled nursing facilities did not submit the required no-payment bills and provide targeted education regarding submission of no-payment bills to skilled nursing facilities found to have high numbers of missing bills.

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CMS	OEI-06-16-00380	CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities	6/26/2018	399-915-11-02-05599	CMS should improve oversight of place-of-service codes submitted by DME suppliers for DME provided during noncovered SNF stays	Concur	2021	Awaiting Disposition	CMS concurs with this recommendation. CMS will instruct the Medicare Contractors to review place-of-service codes submitted by durable medical equipment suppliers during noncovered skilled nursing facility stays. CMS will recover any inappropriate reimbursements associated with these claims consistent with agency policy and procedures and will provide targeted education to durable medical equipment suppliers that are found to be frequently submitting inaccurate place of service codes.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05624	CMS should work with States to identify and share best practices about payment retention policies and incentives to increase recoveries.	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS believes that, while states should ensure that there are effective reporting mechanisms in place, they have the flexibility to decide whether standardization would be beneficial for their managed care environment.

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CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-11-02-05620	CMS should establish measures to assess the MEDIC's effectiveness.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS recently established a preclusion list in Medicare Parts C and D of certain individuals and entities that are revoked from Medicare or have engaged in behavior for which CMS could have revoked the individual or entity if they had been enrolled in Medicare. Payment to prescribers or providers on CMS's preclusion list is prohibited. CMS believes that the most effective means of reducing the burden of the Medicare Part C and Part D enrollment requirement on prescribers and providers is to concentrate our efforts on preventing Medicare Part D coverage of prescriptions written by prescribers who pose an elevated risk to Medicare beneficiaries, and preventing Medicare Part C payment for items and services furnished by providers and suppliers who pose an elevated risk to Medicare beneficiaries.
CMS	A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency	7/11/2018	322-919-10-1	We recommend that CMS require the Medicare contractors to implement nation-wide prepayment edits to ensure that payments to providers for nonemergency ambulance	Concur	2021	In progress	CMS concurs with this recommendation. CMS is work to implement natioanl prepayment edits for non-emergency ambualnace transports regarding approved and inappropriate

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		Ambulance Transports to Destinations Not Covered by Medicare			transports comply with Federal requirements.				destinations. SMRC Project in progress.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05627	CMS should work with States to ensure that MCOs provide complete, accurate, and timely encounter data.	Concur	2021	In progress	The CMS' Center for Program Integrity (CPI) is working on a series of educational tool kits to help states identify potential managed care fraud. These will include information about managed care encounter data. CMS has also developed several sub-committees of technical advisory groups that meet to share best practices and emerging topics related to managed care fraud.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05622	CMS should work with States to increase MCO reporting of corrective actions taken against providers suspected of fraud or abuse to the State.	Concur	2020	In progress	CMS concurs with this recommendation. CMS will work with states to discuss increasing the scope of reporting that results in actionable information, in line with CMS's authority in the final rule.

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CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05621	CMS should work with States to improve MCO identification and referral of cases of suspected fraud or abuse.	Concur	2020	In progress	CMS concurs with this recommendation and will work with states to provide technical assistance and education to identify and share best practices to assist states in improving managed care organization identification and referral of cases of suspected fraud or abuse.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05625	CMS should work with States to improve coordination between MCOs and other State program integrity entities.	Concur	2020	In progress	CMS concurs with this recommendation and will work with states to share best practices about payment retention policies and incentives to obtain recoveries.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address	7/11/2018	399-915-11-02-05626	CMS should work with States to standardize reporting of referrals across all MCOs in the State.	Non-Concur	NA	In progress	CMS does not concur with this recommendation. State flexibility is an important feature of the Medicaid program and states design their programs to fit the unique needs of their populations. While some states choose to standardize managed care organization referrals across the state, CMS believes that, while

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		Fraud and Abuse							states should ensure that there are effective reporting mechanisms in place, they have the flexibility to decide whether standardization would be beneficial for their managed care environment.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05628	CMS should monitor encounter data and impose penalties on States for submitting inaccurate or incomplete encounter data.	Concur	2020	In progress	CMS will work with states to improve coordination between managed care organizations and other state program integrity entities through regularly scheduled outreach and training courses.
CMS	OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	399-915-11-02-05623	CMS should work with States to clarify the information MCOs are required to report regarding providers that are terminated or otherwise leave the MCO network.	Concur	2021	In progress	CMS concurs with this recommendation and will work with states to clarify the information managed care organizations are required to report regarding providers who are terminated or regarding providers that have had a change in circumstance that may affect the provider's ability to participate in the managed care program, in line with CMS's authority in the final rule.

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CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-13-02-05619	CMS should ensure that the MEDIC has the ability to require medical records from prescribers of Part D drugs not under contractwith plan sponsors, obtaining legislative authority, if necessary.	Concur	NA	In Progress	CMS has provided the MEDIC with access to centralized Part C encounter data for specific projects. CMS is continuing to work with the MEDIC to provide access to all Part C encounter data fields, but complete access faces barriers related to how plan sponsors populate encounter data fields, making it difficult to use effectively for program integrity purposes. CM and CPI are considering what is feasible at this time and will get back to the OIG NLT end of FY19 Q3 to determine if there is a path forward or we have to revise our management decision (i.e., non-concur).
CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-11-02-05618	CMS should clarify the MEDIC's authority to require records from pharmacies, pharmacy benefit managers, and other entities under contract with Part C and Part D plan sponsors.	Concur	2020	In Progress	CMS sent out a Technical Direction Letter (TDL) on October 26th, 2016 specifying to the NBI MEDIC that it can directly obtain documentation from First Tier, Downstream and Related Entities (FDRs) and non-contracted providers (TDL 2016-0006). The TDL noted that pursuant to 42 CFR §§ 422.504(i)(2)(i) and 423.505(i)(2)(i), HHS, the Comptroller General, or the NBI MEDIC as a designee shall audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including

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									medical records and documentation from FDRs and non-contracted providers associated with Medicare Advantage (MA) organizations or Part D Sponsors. CMS attempted to close this recommendation on the basis of the above TDL but the OIG Response Memo indicates that the OIG wants additional clarification. CMS is evaluating next steps in response to this recommendation.
CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-11-02-05616	CMS should provide the MEDIC centralized access to all Part C encounter data.	Concur	2020	In Progress	CMS has provided the MEDIC with access to centralized Part C encounter data for specific projects. CMS is continuing to work with the MEDIC to provide access to all Part C encounter data fields, but complete access faces barriers related to how plan sponsors populate encounter data fields, making it difficult to use effectively for program integrity purposes. CM and CPI are considering what is feasible at this time and will get back to the OIG NLT end of FY19 Q3 to determine if there is a path forward or we have to revise our management decision (i.e., non-concur).

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CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-12-02-05617	CMS should require that Part C and Part D providers and pharmacies enroll in Medicare.	Non-Concur	2020	Awaiting Disposition	CMS has provided the MEDIC with access to centralized Part C encounter data for specific projects. CMS is continuing to work with the MEDIC to provide access to all Part C encounter data fields, but complete access is likely not technically feasible at this time.
CMS	OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	399-915-12-02-05615	CMS should require plan sponsors to report Part C and Part D fraud and abuse incidents and the corrective actions taken to address them to a centralized system.	Concur	2020	In progress	CMS will work with plan sponsors to implement reporting requirements. The SUPPORT Act includes provisions which address requirements on Part D Plans to share "corrective action plans" with CMS. It also requires CMS to share information on certain actions the Agency has taken against opioid prescribers. CMS is considering the need for further regulations to achieve mandatory fraud and abuse reporting. Nonetheless, consistent with the SUPPORT Act, CMS intends to implement new reporting standards in time for the CY 2021 plan year.

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CMS	GAO-18-528	Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks	7/26/2018	2	The Administrator of CMS should eliminate impediments to collaborative audits in managed care conducted by audit contractors and states, by ensuring that managed care audits are conducted regardless of which entity--the state or the managed care organization--recoups any identified overpayments.	Concur	2020	In Progress	CMS believes that we have taken the necessary action, to the extent possible - to eliminate impediments to collaborative audits in managed care. As evidenced by a July 2019 meeting at the Medicaid Integrity Institute (MII), CMS, CMS's Unified Program Integrity Contractors (UPIC's) and States all gathered to discuss coordination of managed care provider investigations and how to generate actionable outcomes.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05644	CMS should implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation and will not take any further action.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program	7/30/2018	399-915-11-02-05647	CMS should adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care	Non-Concur	NA	Awaiting Disposition	CMS continues to not concur with OIG's recommendation. CMS has oversight authority over Medicare Part D plan sponsors. CMS has directed certain plan sponsors to conduct audits for payments made for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately.

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		Integrity: An OIG Portfolio							CMS will continue its efforts to work with plan sponsors to address this issue.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05638	CMS should develop other claims-based information and include it on Hospice Compare	Concur	2022	Awaiting Disposition	CMS did not move forward with implementing the Transition from Hospice Care claims-based measure that was presented to the MAP in December 2018. That measure did not receive support from the MAP. However, in December 2019, the MAP reviewed the following claims-based measure for the Hospice Quality Reporting Program: Hospice Visits in the Last Days of Life. This measure received a preliminary recommendation of conditional support for rulemaking pending NQF review and endorsement. The MAP also further recommended that the existing hospice visit measures be removed from the Hospice Quality Reporting Program if CMS moves forward with implementing the claims-based hospice visits measure. In addition, we are working on other claims based measures with one that should address live

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									discharges as part of a composite claims-based measure, called the Care Composite Measure, that we are planning for the CY 2020 MUC List and future public reporting.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05639	CMS should work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.	Concur	2019	Awaiting Disposition	CMS actions are complete. Hospice information is available on Medicare.gov as well as in numerous products including Medicare Hospice Benefits, Medicare and Hospice Benefits: Getting Started, Your Medicare Benefits, and the Medicare & You handbook. Individuals can order these products through our product ordering website, downloading on Medicare.gov, or calling 1-800-MEDICARE.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality	7/30/2018	399-915-11-02-05635	CMS should analyze claims data to inform the survey process.	Non-concur	NA	Awaiting Disposition	CMS does not concur with OIG's recommendation. Surveyors evaluate the care provided in hospice as compared to the care indicated and ordered. They do not determine the medical necessity of

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		Care and Program Integrity: An OIG Portfolio							the services provided and are not an extension of the audit process.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05640	CMS should ensure that a physician is involved in the decisions to start and continue general inpatient care	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05643	CMS should increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate	Concur	2021	In Progress	CMS concurs with OIG's recommendation. CMS will work to increase oversight of general inpatient care through postpayment review.

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CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-13-02-05637	CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance.	Concur	2021	In progress	CMS will consider this recommendation when developing requests for the President's Budget.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05641	CMS should analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.	Concur	2020	In progress	In June 2018 CMS tasked its Supplemental Medical Review Contractor (SMRC) complete data analysis on hospice claims to recommend a review methodology and identify a sample of providers. The SMRC developed a methodology and identified 143 billing providers with 1,973 claims in its final sample. In October 2018 CMS authorized the SMRC to complete medical review of the recommended sample size of 143 billing providers with 1,973 claims.

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CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05645	CMS should develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D	Non-Concur	2020	Awaiting Disposition	Target Date of Completion: 05/15/2022
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05649	CMS should modify the payments for hospice care in nursing facilities	Non-Concur	2020	Awaiting Disposition	CMS continues to non concur, position remains the same.
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity:	7/30/2018	399-915-11-02-05646	CMS should assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs	Non-Concur	2020	Awaiting Disposition	CMS continues to non concur, position remains the same.

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		An OIG Portfolio							
CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05648	CMS should include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies	Non-Concur	NA	In progress	CMS does not concur with OIG's recommendation. As mentioned above, CMS is statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination. In FY15, 40 percent of hospice surveys were performed by these organizations and could not be included on Hospice Compare. The information section on this issue would therefore be skewed, and users would be selecting hospices based on lack of information that favors hospices that use accrediting organizations. This does not accord with CMS' goals for providing useful information in a consumer-friendly manner. As stated above, CMS has made information from surveys performed by state agencies publicly available.

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CMS	OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	399-915-11-02-05642	CMS should take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns	Concur	2021	In progress	CMS concurs with OIG's recommendation. As stated above, CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern.
CMS	OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	399-915-11-02-05652	CMS should revise the definition of the device name data element so that the information reported in this field is required to be more specific	Concur	2022	In progress	CMS is working to strengthen validation processes to ensure that actual drug names are reported and are accurate. With respect to devices, a unique device identification system is necessary to validate reported device names, and CMS is exploring various options to incorporate this information.
CMS	OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	399-915-11-02-05653	CMS should ensure that valid national drug codes are reported for drugs.	Concur	2021	In progress	CMS concurs with this recommendation. A unique device identification system is necessary to validate reported device names, and CMS is actively exploring various options to incorporate this information.

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CMS	OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	399-915-11-02-05651	CMS should strengthen validation rules and revise data element definitions so that actual drug and device names must be reported	Concur	2022	In progress	CMS concurs with this recommendation. With respect to drug names, CMS is working to strengthen validation processes to ensure that actual drug names are reported and are accurate. With respect to devices, a unique device identification system is necessary to validate reported device names, and CMS is exploring various options to incorporate this information.
CMS	OEI-03-18-00120	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices	8/6/2018	399-915-11-02-05655	CMS should expand the price substitution policy to include additional drugs.	Non-concur	NA	Awaiting Disposition	CMS continues to non-concur with OIG's recommendation. CMS appreciates the OIG's study and looks forward to evaluating additional data related to the potential expansion of the price substitution policy and taking it into consideration when developing plans for future rulemaking in this area. As additional data becomes available and CMS continues to gain experience with this policy, CMS will consider further changes as necessary.CMS notes the current price substitution policy includes several safeguards finalized through rulemaking, including the requirement that the applicable threshold must be exceeded in two consecutive or three of four quarters. This safeguard is intended to identify situations where average

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									manufacturer price consistently exceeds average sales price rather than using a single quarter of pricing which may suggest one aberrant pricing quarter rather than a market trend. This also minimizes the potential risk of impacting access to medically necessary drugs. While CMS appreciates that OIG evaluated drugs exceeding the threshold from a single quarter for both 2015 and 2016, CMS maintains that more systematic data analysis beyond one quarter year over year is needed in order to evaluate trends and then further consider the recommendation.

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CMS	A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year	8/8/2018	337-009-01-1	We recommend that CMS work with Treasury and QHP issuers to collect improper financial assistance payments, which we estimate to be $434,398,168, for policies for which the payments were not authorized in accordance with Federal requirements	Concur	2021	In Progress	CMS partially concurs with this recommendation. CMS has developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments to issuers, which includes verification of premium payment for a sample of issuer records. These audits cover 49 percent of total FFE payments to issuers for 2014 and have found a net payment error rate of around 0.1 percent. We note that these payment audits conducted certain checks for consistency with FFE records on a sample of 100 percent of each of the selected issuer's enrollment records. For any errors identified in a sample of records, the issuer was required to identify all other cases of the same error across their records for purposes of quantifying overall impact. CMS considers this method of assessing total error more robust than extrapolation. CMS is adjusting financial assistance payments to issuers for any overpayments or underpayments found. It is also important to note that because 2014 was the first year of Exchange coverage, the FFE and

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									issuers faced technological challenges and often had to create multiple policies per individual/family, process enrollment or updates retroactively, and perform manual workarounds. CMS communicated with issuers through a number of channels about additional flexibilities in enforcing premium payment dates and threshold payment amounts in cases of very small amounts owed by the consumer, which could include a single payment date for the full premium or an initial payment date for a threshold amount of the premium with subsequent payment dates for the remaining amounts. Due to these first-year technical challenges and flexibilities, CMS accepted issuer attestation for effectuation of coverage dates, including for those consumers receiving APTC. We therefore disagree with the OIG's analysis regarding effective dates and financial assistance payments and do not plan to require issuers to return APTC payment for policies on which they provided coverage in 2014 while acting in good faith on the basis of CMS-provided flexibility.

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CMS	A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year	8/8/2018	337-905-17-1	We recommend that CMS work with Treasury and QHP issuers to resolve the potentially improper financial assistance payments, which we estimate to be $504,889,518, for policies for which there was no documentation provided to verify enrollees had paid their premiums	Concur	2021	In progress	CMS concurs with this recommendation. CMS has strengthened guidance to issuers on terminating coverage for failure to pay premiums through updates to the Enrollment Manual. Issuers are required to collect the first month's "binder" premium (or an amount within the premium payment threshold if the issuer utilizes such a threshold) to effectuate coverage, and observe a three consecutive month grace period before terminating coverage for those enrollees who are eligible for and have elected to receive the benefit of APTC. If an individual fails to pay their premium, the issuer terminates the individual for failure to pay a premium after the appropriate grace period and notifies the FFE. Adjustments to APTC are subsequently processed and made within 1-2 payment cycles from when the FFE is updated with the termination. CMS has developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments to issuers, including review of grace periods. CMS will continue to review its processes to ensure it has reliable and transparent data on

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									terminations of enrollee coverage for nonpayment of premiums in order to protect the integrity of the Exchanges.
CMS	A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year	8/8/2018	337-919-10-1	We recommend CMS clarify guidance for QHP issuers on Federal requirements for terminating an enrollee's coverage when the enrollee fails to pay his or her monthly premium.	Concur	2021	In progress	CMS concurred with this OIG recommendation. CMS has (and continues to) clarify guidance to QHP issuers relating to terminating coverage for failure to pay premium through updates to the Enrollment Manual8. CMS has also developed a coordinated, risk-based audit process to determine the accuracy and integrity of 2014 financial assistance payments to issuers, including review of grace periods. CMS continues to strengthen our processes to ensure we have reliable and transparent data on terminations of enrollee coverage for non-payment of premium in order to protect the integrity of the Exchanges. CMS continues to audit additional benefit years, and are currently working to

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									close out 2015 audits. Lastly, we have provided letters to issuers noting our program integrity framework and the potential to utilize CMPs starting in benefit year 2020. CMS with OIG recommendation. **Therefore, we consider this recommendation closed.**
CMS	GAO-18-565	Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance	8/23/2018	2	The Secretary of HHS should establish numeric enrollment targets for healthcare.gov, to ensure it can monitor its performance with respect to its objectives.	Non-Concur	NA	Awaiting Disposition	CMS maintains its non-concur position
CMS	GAO-18-565	Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment	8/23/2018	3	Should the agency continue to focus on enhancing the consumer experience as a goal for the program, the Secretary of HHS should assess other aspects of the consumer experience, such as those it previously identified as key, to ensure it	Non-Concur	NA	In progress	CMS non-concurs with this recommendation. CMS is committed both to providing a seamless enrollment experience for HealthCare.gov consumers and to putting taxpayer dollars for the Federally-facilitated Exchange (FFE) to their most cost effective use. CMS has previously assessed a range of aspects of the consumer

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		Performance			has quality information to achieve its goal.				experience, and has determined that the activities cited by GAO – namely, outreach and education events and the availability of in-person consumer assistance, such as that provided by navigators – did not lead to measurably different results in terms of numbers of consumers enrolling.
CMS	GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	3	The Administrator of CMS should revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk.	Concur	2020	Awaiting Disposition	CMS considers this recommendation closed not implemented. CMS considers the expansion population an area of high risk within the Medicaid program which is why we perform focused sampling on this population during the CMS-64 quarterly review process. The focused sampling (although a limited sample of claims due to time constraints to perform the review and limited resources), is designed so reviewers have the flexibility to sample small, medium, and large dollar fee-for-service claims, and managed care claims, as well as, various eligibility groups or specific populations or service categories.CMS has determined that, given current resources, our sampling methodology for reviewing Medicaid expansion expenditures is sufficient.

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CMS	GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	1	The Administrator of CMS should complete a comprehensive, national risk assessment and take steps, as needed, to assure that resources to oversee expenditures reported by states are adequate and allocated based on areas of highest risk.	Concur	2020	In progress	CMS response as part of the Duplication Mandate Report update: CMS is assessing risk, staff allocation, and capacity as part of a recent realignment across CMS' Medicaid and CHIP operations effort that took place on November 20, 2019. The purpose of the realignment is to and improve consistency so that financial operations are cohesive across the nation, regardless of location. The revised Center for Medicaid and CHIP organizational chart is located here: https://www.medicaid.gov/about-us/organization/cmcs-organizational-chart.pdf
CMS	GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	2	The Administrator of CMS should clarify in internal guidance when a variance analysis on expenditures with higher match rates is required.	Concur	2020	In progress	CMS response as part of the Duplication Mandate Report update: CMS is assessing risk, staff allocation, and capacity as part of a recent realignment across CMS' Medicaid and CHIP operations effort that took place on November 20, 2019. The purpose of the realignment is to and improve consistency so that financial operations are cohesive across the nation, regardless of location. The revised Center for Medicaid and CHIP organizational chart is located here: https://www.medicaid.gov/about-

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									us/organization/cmcs-organizational-chart.pdf
CMS	OEI-09-16-00410	Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials	9/25/2018	399-915-11-02-05737	CMS should provide beneficiaries with clear, easily accessible information about serious violations by MAOs	Concur	2019	Awaiting Disposition	CMS concurred with the third recommendation to provide beneficiaries with clear, easily accessible information about serious violations by MAOs. CMS noted that it is testing options to provide beneficiaries with clear, meaningful, and accessible information on MAO performance that will help them make the best decisions about their care.
CMS	OEI-09-16-00410	Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials	9/25/2018	399-915-11-02-05735	CMS should enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate	Concur	2019	Awaiting Disposition	CMS conducted interviews that focused on assessing: • Participants' understanding of and reactions to text related to sanctioned plans; • Participants' understanding of and reactions to an icon and explanatory text related to CMPs; Test results showed that adding this information was misleading and did not provide beneficiaries with accurate information on an MAO's current performance.

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CMS	A-01-15-00500	Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements	9/27/2018	079-919-10-1	We recommend that CMS educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop and share compliance best practices that may lead to improved internal controls.	Concur	2020	Awaiting Disposition	This recommendation was closed in FY 2021
CMS	A-01-15-00500	Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements	9/27/2018	212-915-11-1	We recommend that CMS reevaluate the IRF payment system, which could include: conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices, studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them, and considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a	Concur	2022	In progress	CMS continuously evaluates the inpatient rehabilitation facility payment system on an annual basis. Recommendation implementation in progress.

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					component of a unified post-acute-care PPS system.				
CMS	GAO-19-10	Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability	10/19/2018	1	The Administrator of CMS should provide states with more information on how to fulfill the requirement for independent encounter data audits, including information on the required audit scope and methodology and what should be described in the resulting report.	Concur	2020	In Progress	CMS published the updated encounter data toolkit in December 2019. It is available at the following link: https://www.medicaid.gov/medicaid/downloads/ed-validation-toolkit.pdf. CMS is developing a reporting template that contains specific sections for Encounter Data. This reporting template will satisfy the reporting requirements in 438.602(e) and 438.66(e).

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CMS	GAO-19-10	Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability	10/19/2018	3	The Administrator of CMS should provide states with information on the circumstances under which CMS would defer or disallow matching funds in response to noncompliant encounter data submissions.	Concur	2020	In Progress	CMS continues to work on multiple fronts to improve the quality of state-submitted T-MSIS data, while sharing data for program monitoring and oversight. To this end, CMS continues to work one-on-one with each state on a series of priority data quality issues. The vast majority of states have made strong progress on the T-MSIS Priority Items (TPIs). CMS reviews T-MSIS data submissions, including encounter data, as part of the T-MSIS state compliance process as referenced in CMS issued guidance (State Health Official (SHO) Letter 18-008 issued on August 10, 2018 and CMCS Informational Bulletin T-MSIS State Compliance issued on March 18, 2019), outlining T-MSIS data reporting requirements for state Medicaid and CHIP programs. CMS also sent all State Medicaid Directors a compliance letter in December 2019 indicating their states' enhanced systems funding is at risk if their state does not address their respective remaining priority data quality issues (these letters were state specific, and we are including AR's SMD letter regarding their 2019 compliance as an example). Furthermore, when

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									deficiencies are found in the T-MSIS data submissions, CMS will work extensively with a state to rectify incomplete, inaccurate or untimely encounter data submissions. CMS continues to monitor each state's monthly submissions to assure compliance with TPIs 1-12. In 2019, CMS used its "regulatory authority to be clear with states that CMS would withhold state information technology system funding if a state's T-MSIS data did not meet minimum thresholds." CMS believes that these actions implement the recommendation, and we recommend closure of this item. Documents to support these actions included below.
CMS	GAO-19-10	Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability	10/19/2018	2	The Administrator of CMS should provide states information on the required content of the annual assessment of encounter data reliability.	Concur	2020	In Progress	CMS is developing a reporting template that contains specific sections for Encounter Data. This reporting template will satisfy the reporting requirements in 438.602(e) and 438.66(e). CMCS is working with a contractor to come up with possible measures for all areas of the annual assessment outlined in 438.66. In 2019 we hope to engage the National Association of Medicaid Director's in discussion about

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									content and reporting of the elements.
CMS	A-02-17-01017	CMS Did Not Always Ensure Hospitals Complied With Medicare Reimbursement Requirements for Graduate Medical Education	11/1/2018	512-908-10-1	We recommend that CMS take steps to ensure that no resident is counted as more than one FTE. This could include implementing procedures to analyze MACs' IRIS data or requiring MACs to determine if residents claimed by hospitals in their jurisdiction were claimed as more than one FTE.	Concur	2021	In Progress	CMS concurs with the recommendation. The implementation of the new national Intern and Resident Information System will help ensure no resident is counted as more than one full-time equivalent. To achieve this, CMS is replacing the current Dbase IRIS database with an XML IRIS database. This will allow for better cross referencing of the IRIS data to the GME/IME FTEs reported on the Medicare cost reports. It would also allow for better identification of true duplicate FTEs in the IRIS database. The new IRIS XML format is pending with OMB for approval. Further, new steps are being added to the revised Uniform Desk Review (UDR) program performed by the MAC contractors which will require additonal review of FTE duplicates and overlaps, with expected implementation of the UDR in FY21.

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CMS	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	29	The Administrator of CMS should direct the Office of the CIO and other offices, as appropriate, to take steps to ensure that the actions taken to comply with OMB's common baseline for implementing FITARA on individual investments are adequately documented.	Concur	2020	In Progress	CMS concurs with GAO's recommendation. As GAO reported, CMS addressed many aspects of OMB's common baseline for implementing FITARA on individual investments reviewed. CMS has also made significant improvements to our IT governance process by implementing a Target Life Cycle framework for all new and existing IT efforts. The CIO now co-chairs the agencies' governance review board (GRB) which reviews / approves all IT-related inter-agency agreements (IAAs), requests for additional funds (mid-year funding adjustments), and the creation of all new life-cycle ids.
CMS	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	28	The Administrator of CMS should ensure that the Office of the CIO and other offices, as appropriate, develop and implement policies and procedures that document the CIO's role in reviewing IT resources that are to support major program objectives and significant increases and decreases in IT resources.	Concur	2019	In Progress	CMS concurs with GAO's recommendation. CMS will document the CIO's role in reviewing IT resources that support major program objectives and significant increases and decreases in IT resources. The CIO already reviews IT resources that support major program objectives and significant increases and decreases in IT resources when these occur. Of note, no increases or decreases in resources occurred for the CMS investments in the year GAO reviewed. The amount reported

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									through the Federal IT Dashboard included all funds requested for the FY17 budget process. Additional resources reviewed by the CIO, but not reported on the IT Dashboard, represent user fees. CMS will ensure these funds are captured in the Federal IT Dashboard moving forward.
CMS	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	27	The Administrator of CMS should ensure that the Office of the CIO and other offices, as appropriate, develop and implement policies and procedures that document the processes by which program leadership works with the CIO to plan an overall portfolio of IT resources.	Concur	2019	In Progress	CMS concurs with GAO's recommendation. As GAO reported, CMS documented the procedures by which program leadership was to work with the CMS CIO to plan IT resources for selected major and non-major investments through its IT investment review board. CMS will further clarify the process of reviewing non-major IT investments and how responsibilities are delegated and/or coordinated between the IT investment review board and other boards or workgroups that make recommendations up to the IT investment review board. In addition, CMS is considering implementing other processes for program budget briefings, by which program leadership works with the CIO to plan an overall portfolio of IT resources.

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CMS	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	26	The Administrator of CMS should ensure that the Office of the CIO and other offices, as appropriate, develop and implement policies and procedures that include the CIO in the planning and budgeting stages for all programs that are fully or partially supported with IT resources.	Concur	2020	In Progress	CMS concurs with GAO's recommendation. The CMS CIO is already involved in all IT budgeting decisions, major and non-major alike. As GAO reported, CMS's IT investment review board policies and procedures already require the CIO to review and approve major, high-risk, and mission critical IT investments. CMS will update its IT investment review board policies and procedures to more explicitly clarify the CIO's involvements in non-major IT investments.
CMS	A-03-16-00202	Although Hospital Tax Programs in Seven States Complied With Hold-Harmless Requirements, the Tax Burden on Hospitals Was Significantly Mitigated	11/18/2018	077-915-10-1	We recommend that CMS re-evaluate the effects of the health-care-related tax safe-harbor threshold and the associated 75/75 requirement to determine if modifications are needed, such as the reduction or elimination of the safe harbor threshold or adjusting the 75/75 requirement, and take appropriate action.	Concur	2020	In Progress	CMS is in the process of rule making and will continue to review all implications of health care related taxes.

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CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-913-10-1	We recommend that CMS rescind its own hold-harmless policy to use the wage data of a reclassified hospital to calculate the wage index of its original geographic area.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS believes that using data from the most hospitals to calculate the average wages for an area provides the most accurate and stable measure. Therefore, CMS believes that it is appropriate to include the salaries and hours of all hospitals in an area even if they are reclassifying to another area.
CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-310-10-1	We recommend that, if there is no movement toward comprehensive reform, CMS work with the MACs to develop a program of in-depth wage data audits at a limited number of hospitals each year, focusing on hospitals whose wage data has a high level of influence on the wage index of their area.	Concur	2023	In Progress	CMS concurs with this recommendation. CMS continuously evaluates the wage data audit process and will take the OIG's recommendation into account when determining appropriate next steps.
CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-900-13-1	We recommend that CMS seek legislative authority to penalize hospitals that submit inaccurate or incomplete wage data in the absence of misrepresentation or falsification.	Concur	2021	In Progress	The President's FY 2021 Budget includes a legislative proposal to create a statutory demonstration to test comprehensive wage index reform.

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CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-913-13-1	We recommend that we recommend that CMS and the Secretary revisit the plan to comprehensively reform the hospital wage index system, including the previously researched option of a commuting-based wage index.	Concur	2021	In Progress	CMS will review to see if the proposal is included in FY2022 President's Budget.
CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-913-13-2	We recommend that CMS seek legislation to repeal the law creating the rural floor wage index.	Concur	2022	In Progress	In the absence of authority under current law or legislative reform, CMS will consider whether to recommend this proposal for inclusion in the next President's budget.
CMS	A-01-17-00500	Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments	11/21/2018	399-913-13-3	We recommend that CMS seek legislation to repeal the hold-harmless provisions in the Act relating to the wage data of reclassifying hospitals, which would allow CMS to calculate each area wage index based on the wage data of hospitals that reclassify into the area and the wage data of hospitals geographically located in the area if they do not reclassify out.	Concur	2022	In Progress	In the absence of authority under current law or legislative reform, CMS will consider whether to recommend this proposal for inclusion in the next President's budget.

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CMS	A-07-16-06068	CMS's Enhanced Controls Did Not Always Prevent Terminated Drug Utilization in Medicare Part D	11/27/2018	302-900-10-1	We recommend that CMS continue to strengthen its internal controls to ensure that all PDE data for terminated drugs are rejected by working with FDA to verify the accuracy of drug termination dates, to include comparing the information on termination dates in its quarterly Medicaid drug rebate files with the information in the NSDE file, investigating discrepancies between the two data sources, and verifying termination dates with the drug manufacturers when discrepancies are identified.	Non-Concur	NA	Awaiting Disposition	CMS continues to non-concurs with the OIG's recommendation. CMS recognizes the importance of states' achieving full system functionality in order to verify applicant's eligibility and resolve inconsistencies, and CMS will continue to work with state exchanges in order to do so. However, CMS is statutorily limited in regards to enforcement mechanisms for state exchanges. CMS works with state exchanges on the continuous improvement of their management and operations through an array of technical assistance activities and implementation of oversight and accountability measures. CMS assists states within the parameters of its oversight authority to prioritize their organizational resources and to identify mitigation strategies.
CMS	A-09-17-03035	Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics	11/29/2018	322-347-10-1	We recommend that CMS direct the DME MACs to recommend that the suppliers refund to beneficiaries up to $8,702,539 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf	Concur	2020	In Progress	CMS concurs with this recommendation. CMS will recommend that the suppliers refund beneficiaries any deductible or coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

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		, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays							
CMS	A-09-17-03035	Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays	11/29/2018	322-347-10-2	We recommend that CMS direct the DME MACs to identify and recover any improper payments to suppliers after our audit period and recommend that those suppliers refund to beneficiaries any deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf	Concur	2019	In Progress	CMS concurs with this recommendation. CMS will work with the Durable Medical Equipment Medicare Administrative Contractors to identify and recover improper payments to suppliers after the audit period. CMS will recommend that tile suppliers refund beneficiaries any deductible or coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

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CMS	A-09-17-03035	Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays	11/29/2018	322-919-13-1	We recommend that CMS take all necessary actions, including seeking legislative authority, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A.	Concur	2021	In Progress	In the absence of authority under current law, CMS will consider whether to recommend this proposal for inclusion in the President's next budget.
CMS	A-09-17-03035	Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to	11/29/2018	322-347-01-1	Direct the Medicare contractors to recover the $34,014,796 in identified improper payments to suppliers in accordance with CMS's policies and procedures and recommend that the suppliers refund to beneficiaries up to $8,702,539 in deductile and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf	Concur	2020	In Progress	Due to the large volume of claims (228,974) associated with this audit, the DME MACs requested that VMS write a mass adjustment program to adjust these claims. However, before any claims can be selected for mass adjustment, each inpatient record for each claim had be reviewed to determine if coverage guidelines were met. The DME MACs discovered a significant volume of claim lines in which the date of service is equal to the date of discharge. In accordance with

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		Beneficiaries During Inpatient Stays							Medicare guidelines, DMEPOS can be covered under the Part B benefit for patients when the date of service is equal to the date of discharge. However, if a patient is discharged and readmitted or transferred to another facility, coverage is payable under the Part A benefit of Medicare.The development of the mass adjustment program and the review of the inpatient records impacted the release of the TDL and initiation of claim adjustments and overpayment recovery. CMS issued TDL-190311 which instructed the Medicare Administrative Contractors to issue demands and recover the $30,618,331 that represents the claims that were within the 4-year claim reopening period.
CMS	GAO-19-67	Medicare Laboratory Tests: Implementation of New Rates May Lead to Billions in Excess Payments	11/30/2018	1	The Administrator of CMS should take steps to collect all of the data from all laboratories that are required to report. If only partial data can be collected, CMS should estimate how incomplete data would affect Medicare payment rates and address any significant challenges to setting accurate Medicare rates.	Concur	2019	In Progress	CMS believe the response provided to GAO still stands: The requirements to phase-in payment rate reductions from the national limitation amounts were finalized after notice and comment rulemaking in the Medicare Clinical Diagnostic Laboratory Tests Payment System final rule (81 FR 41036) and codified in 42 C.F.R. § 414.507(d). Any changes to these requirements would need

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									to be implemented through rulemaking. No further action required from CMS.
CMS	GAO-19-67	Medicare Laboratory Tests: Implementation of New Rates May Lead to Billions in Excess Payments	11/30/2018	3	The Administrator of CMS should use bundled rates for panel tests, consistent with its practice prior to 2018, rather than paying for them individually; if necessary, the Administrator of CMS should seek legislative authority to do so.	TBD	2019	In Progress	CM/FFS/HAPG states: prior GAO response still applies and analysis is ongoing: Prior to implementation of the Protecting Access to Medicare Act of 2014, automated test panels without a current procedural terminology (CPT) code were paid at a bundled rate using a payment algorithm developed by HHS. However, section 216(a) of the Protecting Access to Medicare Act of 2014 established section 1834A of the Act, which generally requires that the Medicare payment rates for each clinical diagnostic laboratory test under the Clinical Laboratory Fee Schedule be an amount that is equal to the weighted median of the private payor rates for the test, based on the applicable information reported by applicable laboratories. Therefore, HHS discontinued the use of these automated test panel payment algorithms that bundled component CPT codes. HHS will

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									revisit this determination regarding our authority, and HHS is considering other approaches to payment for these tests consistent with section 1834A of the Social Security Act such as adding codes to the Clinical Laboratory Fee Schedule for this purpose.
CMS	GAO-19-67	Medicare Laboratory Tests: Implementation of New Rates May Lead to Billions in Excess Payments	11/30/2018	2	The Administrator of CMS should phase in payment-rate reductions that start from the actual payment rates Medicare paid prior to 2018 rather than the national limitation amounts. CMS should revise these rates as soon as practicable to prevent paying more than necessary.	Non-Concur	2019	In Progress	Analysis on this recommendation is still ongoing.

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CMS	A-07-18-04107	Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures	12/6/2018	303-000-10-1	We recommend that CMS instruct all State agencies to review, revise, develop, and implement policies and procedures to monitor the SDAC and SBHS programs in their States and thereby ensure that: claimed SDAC and SBHS costs comply with Federal requirements with respect to reasonableness, allowability, and supportability; State agencies obtain DCA approval for their cost allocation plans before submitting their RMTS methodologies to CMS for approval; RMTS methodologies comply with Federal requirements for statistical validity, reliability, and allowability and are always submitted to CMS for approval before being implemented; RMTS responses are properly coded and include documentation adequate to support activities performed that were reimbursable by Medicaid and to permit reproduction and verification of sample results; random moment	Concur	2020	In Progress	CMS is updating it's Administrative Claiming Guide to provide states with consistent national instructions for claiming FFP associated with administrative Medicaid services.

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					samples generated through RMTS reflect all of the time and activities performed by employees participating in SDAC and SBHS and do not reflect times when schools are not in session or times that are outside employee work hours.				

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CMS	A-07-18-04107	Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures	12/6/2018	303-919-10-1	We recommend that CMS either develop and promulgate formal guidance directing State agencies to maintain and retain adequate medical record documentation to validate the RMTS responses and support the SBHS costs claimed or consider no longer permitting States to use RMTS methodologies to allocate and claim SBHS costs.	Concur	2020	In Progress	CMS is updating it's Administrative Claiming Guide to provide states with consistent national instructions for claiming FFP associated with administrative Medicaid services.
CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments	12/7/2018	209-922-10-1	Verify that future overpayments are reported correctly on Line 10 of the CMS-64	Concur	2021	Awaiting Disposition	This process is ongoing in CMS reviews. We consider this recommendation closed.

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		Identified by OIG Audits							
CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits	12/7/2018	209-922-10-2	Require states to submit corrected CMS-64s to identify recovered overpayments on Line 10 when done incorrectly	Concur	2021	Awaiting Disposition	Update as part of CMS' oversight responsibility we verify states accurate report and require correction when necessary. We consider this recommendation closed.
CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion	12/7/2018	209-923-10-1	Continue to educate the States about their responsibility to report overpayments on the correct line of the CMS-64 to improve oversight of the reporting process	Concur	2020	Awaiting Disposition	CMS Considers all actions complete.

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		Dollars in Medicaid Overpayments Identified by OIG Audits							
CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits	12/7/2018	214-511-10-1	Recover the remaining $1,644,235,438 due the Federal Government from the current period	Concur	2020	In Progress	Update CMS has been working to resolve complex policy questions related to 29 of the 79 audits totaling $1,009,112,045 and has issued demand letters for $142,757,660 of the 29 audits. CMS issued or is in the process of issuing disallowances totaling $148,424,974, is working to resolve $216,278,846, and is still reviewing 32 audits totaling $315,321,181.

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CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits	12/7/2018	214-511-10-2	Recover the remaining $188,593,212 due the Federal Government from the prior period	Concur	2020	In Progress	Of the remaining 7 identified audits, CMS issued disallowances to collect overpayments or resolved findings related to the following 5 audits totaling $164,059,194:A-07-05-03071 - CMS issued a disallowance on July 24,2012.A-05-01-00102 - CMS issued a disallowance on July 27,2016.A-05-01-00099 - CMS issued a disallowance on Iuly 27,2016.A-07-06-04063 - CMS issued a disallowance on March 12,2019.A-02-07-01028- CMS resolved the finding. The state submitted additional documentation tosupport its claim. CMS is close to resolving the recommendations for the following 2 audits by disallowing any uncollected, sustained Medicaid overpayment amounts or by amending the audit clearance document to non-concur and setting aside any amounts found allowable:A-07-06-01029A-05-07-00076
CMS	A-05-17-00013	The Centers for Medicare & Medicaid Services Had Not Recovered	12/7/2018	299-935-10-1	Develop policies and procedures to improve the timeliness of recovering overpayments by setting guidelines for the amount of time CMS has to: (1) discuss with State officials regarding the audit findings, (2) obtain	Concur	2020	In Progress	There are currently policies and procedures established as identified in the audit recommendation, however CMS continues to work toward improving the timeliness of resolving audits.

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		More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits			documentation to substantiate the State's position, and (3) issue the disallowance letter to the State				
CMS	A-07-18-03228	Although the Centers for Medicare & Medicaid Services Has Made Progress, It Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	1/15/2019	214-909-10-1	We recommend that CMS promptly resolve the 140 outstanding audit recommendations that were past due as of September 30, 2016.	Concur	2020	In Progress	CMS is working to resolving the remaining recommendations in 2020.

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CMS	A-07-18-03228	Although the Centers for Medicare & Medicaid Services Has Made Progress, It Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	1/15/2019	214-920-10-1	We recommend that CMS continue to follow its policies and procedures related to the audit resolution process, and enhance them where possible, to ensure that all management decisions are issued within the required 6-month resolution period.	Concur	2019	In Progress	CMS will continue to assess and further refine its audit resolution process to ensure that recommendations are resolved within the required time period.
CMS	GAO-19-159	Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements	2/4/2019	1	CMS should take action to ensure South Dakota's Medicaid state plan provides coverage for abortions in cases of rape and in cases of incest, in addition to life endangerment, to comply with federal law, which currently requires such coverage.	Concur	2021	In progress	CMS is reviewing the best course of action for this recommendation.

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CMS	GAO-19-159	Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements	2/4/2019	2	CMS should determine the extent to which state Medicaid programs are in compliance with federal requirements regarding coverage of Mifeprex and take actions to ensure compliance, as appropriate	Concur	2021	In Progress	CMS is reviewing the best course of action for this recommendation.
CMS	GAO-19-159	Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements	2/4/2019	3	CMS should determine the extent to which state Medicaid programs are accurately reporting fee-for-service abortions on line 14 of the CMS-64 and take actions to ensure accuracy, as appropriate.	Concur	2020	In Progress	HHS is developing written instructions to reiterate abortion "fee for service" reporting to states.

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CMS	A-01-17-00506	Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements	2/6/2019	303-347-01-1	We recommend that CMS direct the Medicare contractors to notify the ambulance suppliers responsible for the remaining 57,906 nonsampled beneficiary days, with potential overpayments estimated at $19.9 million, so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60 day rule; and identify and track any returned overpayments as having been made in accordance with this recommendation.	Concur	2021	In Progress	The CMS issued TDL-190343, which instructed MACs to send provider notification letters to ambulance suppliers who had non-sampled claims for services subject to SNF consolidated billing requirements. The notification letters will provide instructions to the ambulance suppliers for investigating and returning self-identified overpayments. However, CMS did not instruct the MACs to send letters to all 1,984 suppliers because it would not be feasible. Instead, the MACs were instructed to send letters to 48 suppliers who the OIG identified were each responsible for billing more than $100,000 for services subject to SNF consolidated billing requirements. As mentioned in the R3 CAP, 14 suppliers' claims from R3 were added to R4 because those suppliers have claims for R4 as well. OFM and OIG met on 06/21/2019. OIG informed OFM that it claims associated with the 48 suppliers were “turned over to the OIG’s OCIG attorneys to explore the possibility of imposing civil monetary penalties.” OIG recommended that OFM turn the overpayments over to the RACs to

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									collect any overpayment that are within the 4-year reopening period. Instead, OFM turned the claims over to CPI. Some MACs have indicated that the OIG has contacted them to request they cease any notification/collection efforts related to some of the 48 suppliers. As of the last reporting cycle 6/30/20, $343,446 was collected.
CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing	2/7/2019	211-913-10-1	To help ensure the health and safety of nursing home residents, we recommend that CMS work with State agencies to address technical issues with the ASPEN system for maintaining supporting documentation.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 06/30/2021.CMS concurs with this recommendation. CMS continually reviews its systems for technical issues and addresses these issues as they arise. In addition, CMS will continue to

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		Home Residents							provide education and technical support to states on its systems. State agencies have designated staff who receive the Automated Survey Processing Environment (ASPEN) database training and information on system updates. CMS has established clear communication paths with state agencies for prompt handling of technical issues through ASPEN Technical Support and additional support available through experienced CMS ASPEN technical experts. In addition, CMS has worked with states identified as having ASPEN system issues to implement updated policies, procedures and training to ensure that appropriate supporting documentation is maintained in ASPEN.
CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved	2/7/2019	310-905-10-1	To help ensure the health and safety of nursing home residents, we recommend that CMS consider improving its forms related to the survey and certification process, such as the Forms CMS-2567, CMS-2567B, and CMS-1539, so that surveyors can explicitly indicate how a State agency verified correction of	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe.

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		To Help Ensure the Health and Safety of Nursing Home Residents			deficiencies and what evidence was reviewed				CMS concurs with this recommendation. CMS will review forms related to the survey and certification process, including Forms CMS-2567, CMS-2567B, and CMS-1539, and evaluate whether updates are needed. This review will also take into consideration current CMS efforts to reduce unnecessary provider burden and duplicative reporting requirements.
CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents	2/7/2019	310-909-10-1	To help ensure the health and safety of nursing home residents, we recommend that CMS reconsider its position on permitting State agencies to certify nursing homes' substantial compliance on the basis of correction plans without obtaining evidence of correction for less serious deficiencies (deficiencies with ratings D, E, and F without substandard quality of care).	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. CMS concurs with this recommendation. For less serious deficiencies where no actual harm was identified, CMS will review current guidance regarding the requirement to provide evidence of correction and determine if updates

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									are needed to help verify correction of the deficiency. This review will include a risk based assessment, taking into consideration current CMS efforts to reduce unnecessary provider burden and state agency workload to ensure adequate resources are available to prioritize remediation of more serious and repeat deficiencies.
CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents	2/7/2019	310-912-10-1	To help ensure the health and safety of nursing home residents, we recommend that CMS revise guidance to State agencies to provide specific information on how State agencies should verify and document their verification of nursing homes' correction of less serious deficiencies before certifying nursing homes' substantial compliance with Federal participation requirements.	Concur	2021	In Progress	CMS concurs with this recommendation. CMS will review the current guidance to states regarding the verification and documentation of correction of less serious deficiencies and discuss with states any areas needing additional clarification in determining the scope of changes needed. As part of this effort, CMS will take into consideration current CMS efforts to reduce unnecessary provider burden and state agency workload to ensure adequate resources are available to prioritize remediation of more serious and repeat deficiencies.

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CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents	2/7/2019	310-912-10-2	To help ensure the health and safety of nursing home residents, we recommend that CMS revise guidance to State agencies to clarify the type of supporting evidence of correction that should be provided by nursing homes with or in addition to correction plans.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. CMS concurs with this recommendation. As required in the Medicare State Operations Manual, the course of action for verifying provider compliance varies based on the seriousness of the noncompliance, ranging from reviewing a plan of correction and associated supporting documentation where needed to conducting an onsite revisit survey. If supporting documentation is required, examples of acceptable supporting documentation may include an invoice or receipt verifying purchases or repairs, and sign-in sheets verifying attendance of staff at in-services training. CMS will review guidance to state agencies and continue to educate

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									state agencies on the types of supporting evidence of correction where needed that should be provided with corrective action plans.
CMS	A-09-18-02000	CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents	2/7/2019	310-912-10-3	To help ensure the health and safety of nursing home residents, we recommend that CMS strengthen guidance to State agencies to clarify who must attest that a correction plan will be implemented by a nursing home.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. Target Date of Completion 06/30/2021. CMS concurs with this recommendation. CMS will clarify which nursing home officials may attest that a correction plan will be implemented. Currently, CMS

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									requires signature by the nursing home representative on the plan of correction. CMS will review our existing policies and guidance to ensure that a nursing home official with authority and responsibility for operations of the facility is attesting to the plan of correction and its implementation.
CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	2/14/2019	306-900-10-1	Require hospitals to provide a written notification to beneficiaries whose discharge plans include posthospital SNF care, clearly stating how many inpatient days of care the hospital provided and whether the 3-day rule for Medicare coverage of SNF stays has been met. If necessary, CMS should seek statutory authority to do so.	Non-Concur	NA	Awaiting Disposition	CMS continues to non concur with this recommendation. Hospitals already provide written notification and an oral explanation of that notification to beneficiaries who receive observation services as outpatients for more than 24 hours to inform beneficiaries of, among other things, how their status may affect eligibility for Medicare coverage of skilled nursing facility services. In addition, CMS encourages skilled nursing facilities to provide written notification to beneficiaries prior to providing care that Medicare never covers, including when the 3-day rule was not met using the voluntary Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage.

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CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	2/14/2019	306-900-10-2	Require SNFs to obtain from the hospital or beneficiary, at the time of admission, a copy of the hospital's written notification to the beneficiary and retain it in the beneficiary's medical record. (See our second recommendation.) If necessary, CMS should seek statutory authority to do so	Concur	2019	Awaiting Disposition	Recommendation closed and supporting documents submitted.
CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requireme	2/14/2019	306-900-10-4	Educate SNFs about their responsibility to submit accurate and valid claims for payment that are supported with documentation that clearly shows that the SNF services qualify for reimbursement.	Concur	2019	Awaiting Disposition	Recommendation closed and supporting documents submitted.

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		nt Was Not Met							
CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	2/14/2019	306-905-10-1	Educate hospitals about the importance of explicitly communicating the correct number of inpatient days to beneficiaries and whether the inpatient days qualify subsequent SNF care for Medicare reimbursement so that beneficiaries understand their potential financial liability related to SNF care.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS already requires skilled nursing facilities to provide written notification to beneficiaries prior to providing an item or service that may not be paid for by Medicare because it is not medically reasonable and necessary or it is custodial care, using the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage. In addition, CMS encourages skilled nursing facilities to provide written notice to beneficiaries prior to providing care that Medicare never covers, including when the 3-day rule was not met, using the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage. CMS recently released a revised Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage along with newly developed, concise and separate

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									instructions for form completion which included an example for use when the 3-day rule was not met and encouraged skilled nursing facilities to provide notice as a courtesy to the beneficiary and to forewarn them of impending financial obligation.
CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	2/14/2019	306-900-10-3	We made the following recommendation to CMS, which could have saved an estimated $84,202,593 during our audit period: Require SNFs to provide written notice to beneficiaries if Medicare is expected to deny payment for the SNF stay when the 3-day rule is not met. If necessary, CMS should seek statutory authority to do so.	Non-Concur	NA	Awaiting Disposition	CMS continues to non concur with this recommendation. As previosly stated, hospitals are required to provide beneficiaries who receive more than 24 hours of observation services written notification of their status and an oral explanation of that notification that includes, among other things, how their status may affect eligibility for Medicare coverage of skilled nursing facility services. Discharge planning requirements are set out in the hospital Conditions of Participation, which generally do not differentiate between patients based on source of payment. Therefore, CMS does not believe that it would be appropriate to include a requirement referencing Medicare coverage criteria for

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									skilled nursing facility care as part of the hospital discharge planning requirements.
CMS	A-05-16-00043	CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	2/14/2019	299-919-10-1	Ensure that when SNF claims are being processed for payment, the CWF qualifying inpatient hospital stay edit for SNF claims is enabled and operating properly to identify SNF claims ineligible for Medicare reimbursement.	Concur	2019	In Progress	CR 10280 (forwarded by email) submitted as documentation to close the recommendation.

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CMS	GAO-19-277	Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments	3/27/2019	1	The Administrator of CMS should institute a process to routinely assess, and take steps to ensure, as appropriate, that Medicare and Medicaid documentation requirements are necessary and effective at demonstrating compliance with coverage policies while appropriately addressing program risks.	Concur	2020	In Progress	As stated above, HHS uses a variety of sources to identify the root causes of improper payments and target corrective actions to reduce improper payments. HHS can encourage states to utilize findings from all sources when developing corrective actions to address identified root causes of improper payments. However, using data from other sources, such as state auditor and OIG findings, on state-specific program risks to adjust the PERM sampling approach could jeopardize the statistical validity of the PERM program. Under the PERM program in FY 2017, HHS subjected nearly 31,000 Medicaid FFS claims to medical reviews at a cost of nearly $8 million. Those costs did not include state costs, the federal share of state costs, or provider costs. As GAO notes in its report, estimating improper payments for specific service types within states with the same precision as the national estimate would require substantially expanding the number of medical reviews conducted and lead to an increase in PERM costs and burden on states and providers.

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CMS	GAO-19-277	Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments	3/27/2019	2	The Administrator of CMS should take steps to ensure that Medicaid medical reviews provide robust information about and result in corrective actions that effectively address the underlying causes of improper payments. Such steps could include adjusting the sampling approach to reflect state-specific program risks, and working with state Medicaid agencies to leverage other sources of information, such as state auditor and the Department of Health and Human Services' Office of the Inspector General findings.	Concur	2020	In Progress	HHS concurs with GAO's recommendation. Regarding current policy, HHS already provides guidance in the January 2018 PERM Manual to states to determine whether providers included in the PERM sample are under fraud investigation. Should states determine that PERM medical reviews could compromise an investigation, they may notify the PERM contractor and the contractor will end all contact with the provider. HHS will consider clarifying our policy to help ensure that such providers are not contacted in the first instance. HHS will explore additional actions it can take to minimize the potential for PERM medical reviews to compromise fraud investigations. 2020 CMS Update Rec. Closure Request
CMS	GAO-19-277	Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify	3/27/2019	3	The Administrator of CMS should take steps to minimize the potential for Payment Error Rate Measurement (PERM) medical reviews to compromise fraud investigations, such as by directing states to determine whether providers selected for PERM medical reviews	Concur	2020	In Progress	HHS considers this recommendation closed – implemented. In addition to the actions outlined under Recommendation 3, HHS PERM has removed errors related to missing documentation for fraudulent providers from the Corrective Action Plans (CAPs) that states are required to complete.

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		Improper Payments			are also under fraud investigation and to assess whether such reviews could compromise investigations.				
CMS	GAO-19-277	Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments	3/27/2019	4	The Administrator of CMS should address disincentives for state Medicaid agencies to notify the PERM contractor of providers under fraud investigation. This could include educating state officials about the benefits of reporting providers under fraud investigation, and taking actions such as revising how claims from providers under fraud investigation are accounted for in state-specific FFS improper payment rates, or the need for corrective actions in such cases.	Concur	2020	Awaiting Disposition	CMS considers this recommendation closed – implemented. In addition to the actions outlined under Recommendation 3, HHS PERM has removed errors related to missing documentation for fraudulent providers from the Corrective Action Plans (CAPs) that states are required to complete.

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CMS	GAO-19-313R	Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations that Persisted in Oregon for At Least 15 Years	4/15/2019	1	CMS should evaluate state survey agency processes in all states to ensure all state survey agencies are meeting federal requirements that state survey agencies are responsible for investigating complaints and facility-reported incidents alleging abuse in nursing homes, and that the results of those investigations are being shared with CMS.	Concur	2021	In Progress	Guidance is under development. CMS concurs with GAO's recommendation. CMS Regional Offices will review state policies and procedures to confirm that they are using appropriate personnel to investigate nursing home complaints and facility-reported incidents in accordance with the federal guidelines provided in the State Operations Manual and sharing the results of those investigations with HHS. HHS officials in some regions have already met with states to evaluate their state survey agency processes for investigating complaints and confirmed these policies and procedures as presented by the states align with federal requirements.
CMS	GAO-19-313R	Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigati	4/15/2019	2	CMS should identify options for capturing information from Oregon's APS investigations of complaints and facility-reported incidents of abuse and incorporate this information into oversight of Oregon nursing homes.	Concur	2021	In Progress	Guidance is under development.

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		ons that Persisted in Oregon for At Least 15 Years							
CMS	OEI-07-16-00160	National Background Check Program for Long Term Care Providers: Assessment of State Programs Concluded Between 2013 and 2016	4/22/2019	399-915-11-02-05815	CMS should take appropriate action to encourage participating States to obtain necessary authorities to fully implement Program requirements	Concur	2024	In Progress	CMS Project Officer (PO) and CMS contractor (CNA) will conduct a milestone review of each active grantee State either annually. This is normally only done when a State is closing out their final grant period. On a case by case or as appropriate the use of deficiency notices such as: Program Assistance Letter (PAL), initial formal acknowledgement by CMS (PO) that there are identified areas of performance concern that need to addressed to meet specific milestones that are deemed to be within the State NBCP control; and a Corrective Action Letter (CAL) from CMS (PO) which is a formal warning notice directing the State NBCP on specific steps that need to be taken to avoid either potential loss of grant funds and/or removal from the grant program.

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									OAGM has the capacity (authority) to freeze NBCP grant funds based on a grantee State's performance or concern of misappropriation of grant funds. We recommend that OIG coordinate with OAGM regarding the specifics of their authority to take funding actions against grantee States. The CMS PO can provide information about a State's performance issues to OAGM in order for that office to determine what funding action/s would be appropriate. Ongoing - CMS will continue to work closely with the participating states and continue to support the recommendation to take appropriate action to encourage participating states to obtain necessary authorities to fully implement program requirements. The grant end date for the last three States awarded in the program is June 2021. However, if the no cost extensions are requested and approved, grant end dates could be extended until June 2024.

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CMS	A-06-18-04002	Medicaid Could Save Hundreds of Millions by Excluding Authorized Generic Drug Transactions to Secondary Manufacturers from Brand Name Drugs' Average Manufacturer Price Calculations	4/29/2019	212-915-13-1	We recommend that CMS seek legislative change to exclude authorized generic drug transactions to secondary manufacturers from the AMP calculation of the brand name drug. This change may increase manufacturer Medicaid rebate obligations by hundreds of millions each year.	Concur	2022	In Progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
CMS	OEI-03-17-00120	One Percent of Drugs With Medicaid Reimbursement Were Not FDA-Approved	5/3/2019	399-915-10-02-05837	CMS should work with States to ensure that they prevent inappropriate reimbursement for drugs that are not FDA-approved and do not meet the criteria for an exception	Concur	2020	In Progress	Draft guidance is in review. Delays due to COVID.

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CMS	OEI-03-17-00120	One Percent of Drugs With Medicaid Reimbursement Were Not FDA-Approved	5/3/2019	399-916-01-02-05835	CMS should work with States to recoup any potentially inappropriate Federal reimbursement for drugs that CMS determines were not FDA-approved and did not meet the criteria for an exception	Concur	2020	In Progress	Draft guidance is in review. Delays due to COVID.
CMS	A-05-19-00005	Four States Did Not Comply With Federal Waiver and State Requirements in Overseeing Adult Day Care Centers and Foster Care Homes	5/16/2019	079-919-10-1	We recommend that CMS work with all States to review current training the States provide to centers and homes.	Concur	2021	In Progress	CMS has continued state site visits that allow for assessing training programs and future support needs. CMS has also developed a virtual on-site visit protocol in response to COVID-19. As of 6/30/2020, no state has utilized the virtual approach. CMS continues gathering data from additional states in preparation for virtual visits in FFY 2021.
CMS	A-05-19-00005	Four States Did Not Comply With Federal Waiver and State Requirements in	5/16/2019	079-919-10-2	We recommend that CMS assist all States to ensure the health and safety of vulnerable adults by offering technical assistance to look at possible templates for administrative records in centers, homes, and other HCBS settings.	Concur	2021	In Progress	CMS has continued state site visits that allow for assessing administrative processes and future support needs.

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		Overseeing Adult Day Care Centers and Foster Care Homes							
CMS	A-05-19-00005	Four States Did Not Comply With Federal Waiver and State Requirements in Overseeing Adult Day Care Centers and Foster Care Homes	5/16/2019	099-919-10-1	We recommend that CMS work with the States reviewed to ensure that the instances of noncompliance with health and safety and administrative requirements identified in this report are corrected.	Concur	2020	In Progress	CMS worked with the states that were reviewed by OIG to develop Corrective Action Plans that address the recommendations and resolve the instances of noncompliance with health and welfare. CMS and the states meet regularly to track progress and identify any needed TA.
CMS	A-05-19-00005	Four States Did Not Comply With Federal Waiver and State Requirements in Overseeing	5/16/2019	099-919-10-2	We recommend that CMS assist all States to ensure the health and safety of vulnerable adults by offering technical assistance to look at staffing models in centers, homes, and other HCBS settings.	Concur	2021	In Progress	CMS continued on-site visits in states and has developed a virtual on-site visit protocol in response to COVID-19. As of 6/30/2020, no state has utilized the virtual approach. CMS continues gathering data from additional states in preparation for virtual visits in FFY 2021.

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		Adult Day Care Centers and Foster Care Homes							
CMS	GAO-19-315	Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency	5/17/2019	1	The Administrator of CMS should develop and communicate a policy that defines when changes to a pending section 1115 demonstration application are considered major and should prompt a new review of the application against the transparency requirements applicable to the pending application.	Concur	NA	In Progress	GAO spoke with CMS officials in January about GAO-19-315, rec 1. As discussed then, while GAO understands CMS's position that they plan no action in response to GAO's recommendation, they are keeping the recommendation open. When GAO met with CMS January, it was clear that, while CMS originally concurred with this recommendation, this is no longer the case, though CMS said that was an "unofficial" position.
CMS	GAO-19-315	Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency	5/17/2019	2	The Administrator of CMS should develop and communicate a policy whereby applications for section 1115 demonstration amendments that may have significant impact are subject to transparency requirements comparable to those for new demonstrations and extensions.	Concur	2021	In Progress	CMS will develop "substantial change" criteria for amendments, that will similarly apply to extensions, which carefully considers the wide breadth of state requests and the varied impact on beneficiaries. CMS intends to develop draft guidance in 2020 announcing implementation of this policy; however, due to COVID priorities, CMS may be delayed on the release of this guidance and it may not occur until early 2021.

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									HHS concurs with this recommendation. HHS has already implemented processes to help improve the transparency of section 1115 amendment applications . HHS will review the implementation of these process enhancements and develop additional policy and associated processes, as needed, to enhance the transparency relating to applications for section 1115 demonstration amendments that propose substantial changes to existing demonstrations.
CMS	A-01-17-00513	CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	6/7/2019	299-919-10-1	We recommend that CMS compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. While CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect, CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. Based on suggestions in OIG's early alert on this topic, CMS is exploring

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									claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this information may be useful in efforts to address instances of potential abuse and neglect.
CMS	A-01-17-00513	CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	6/7/2019	299-919-10-2	We recommend that CMS use the complete list of diagnosis codes to conduct periodic data extracts of all Medicare claims containing at least one of the codes indicating either potential abuse or neglect of adult and child Medicare beneficiaries.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. While CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect, CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. As mentioned above, claims review may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered. However, based on suggestions in OIG's early alert on this topic, CMS is exploring claims

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									data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this may be useful in efforts to address instances of potential abuse and neglect.
CMS	A-01-17-00513	CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	6/7/2019	299-919-10-3	We recommend that CMS inform States that the extracted Medicare claims data are available to help the States ensure compliance with their mandatory reporting laws.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect and will continue to work with states to support their efforts in addressing instances of potential abuse and neglect. CMS regulations require all facilities and their practitioners comply with the mandatory reporting laws for abuse and neglect applicable to their state, including compliance with timeliness requirements. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-

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									sensitive nature of instances of potential abuse and neglect. As mentioned above, claims review may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered. However, based on suggestions in OIG's early alert on this topic, CMS is exploring claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this may be useful in efforts to address instances of potential abuse and neglect.
CMS	A-01-16-00509	Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	6/7/2019	079-920-10-1	We recommend that CMS take the following actions to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported: work with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe.

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CMS	A-01-16-00509	Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	6/7/2019	212-919-10-1	We recommend that CMS require the Survey Agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe.
CMS	A-01-16-00509	Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	6/7/2019	212-919-10-2	We recommend that CMS monitor the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe.
CMS	A-01-16-00509	Incidents of Potential Abuse and Neglect at Skilled	6/7/2019	212-925-10-1	We recommend that CMS clarify guidance to clearly define and provide examples of incidents of potential abuse or neglect.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the

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		Nursing Facilities Were Not Always Reported and Investigated							pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe.

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CMS	A-01-17-00513	CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	6/7/2019	043-915-10-1	We recommend that CMS assess the sufficiency of existing Federal requirements, such as CoPs and section 1150B of the Act, to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate.	Concur	2021	In Progress	CMS is actively working to provide clarity in reporting requirements related to abuse and neglect in sub-regulatory guidance and educational products. Outside the 1150B reporting requirements associated with the requirements for Long Term Care Facilities, CMS relies on existing reporting requirements in the Conditions of Participation (COPs) or Conditions for Coverage (CFCs) for individual provider or supplier types. These are complimented by requirements at the State levels for both providers, suppliers, and individuals for mandatory reporting in accordance with State laws. CMS has drafted survey guidance to clarify actions surveyors should take for all providers and suppliers if required reporting has not occurred or cannot not be verified. These changes are currently under review within CMS and pending final clearance. Additionally, CMS has drafted interpretive guidance for hospice to better clarify the relationship between these requirements and expectations for reporting. CMS has already begun educational outreach to providers to

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									better clarify expectations in this area. On January 30th, 2020, CMS highlighted the release of a Medicare Learning Network fact sheet on abuse and neglect in hospice. This fact sheet identifies hospice responsibilities related to patient rights, provides examples of abuse and neglect, includes requirements and responsibilities for reporting abuse and neglect, as well as hyperlinks to resources related to abuse & neglect and associated reporting mechanisms. This fact sheet was disseminated via the weekly MLN Connects newsletter which highlights different issues facing the Agency. This newsletter has over 1 million subscribers, including over 200 associations, who reach more than 5 million members. The fact sheet can be found at: https://www.cms.gov/outreach-and-educationmedicare-learning-network-mlnmlnproductsmln-publications/2020-01-1 CMS remains committed to strengthening survey guidance to clarify actions surveyors should take for all providers and suppliers related to reporting of abuse and neglect if it has not occurred or

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									cannot be verified. Due to the 2019 Novel Coronavirus pandemic, agency resources have shifted in the interim to focus on this response and the review for these changes have been delayed until further notice.

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CMS	A-04-17-07069	Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements	6/7/2019	303-347-01-1	We recommend that CMS instruct the MACs to recover the portion of the $56,668 in identified net overpayments that are within the 4-year reopening period.	Non-Concur	NA	In Progress	CMS is currently working OIG on an acceptable resolution to recommendation implementation and CMS management decision.
CMS	A-04-17-07069	Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements	6/7/2019	303-347-10-1	We recommend that CMS instruct the MACs to notify the 117 providers associated with 147 claims (83 beneficiaries with 150 corresponding lines of service) with potential overpayments of $56,668 so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.	Non-Concur	NA	In Progress	CMS is currently working OIG on an acceptable resolution to recommendation implementation and CMS management decision.

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CMS	GAO-19-288	Data Protection: Federal Agencies Need to Strengthen Online Identity Verification Processes	6/14/2019	1	The Administrator of the Centers for Medicare and Medicaid Services should develop a plan with time frames and milestones to discontinue knowledge-based verification, such as by using Login.gov or other alternative verification techniques.	Non-Concur	NA	Awaiting Disposition	CMS non-concurs with this recommendation. CMS is committed both to providing a seamless enrollment experience for HealthCare.gov consumers and to putting taxpayer dollars for the Federally-facilitated Exchange (FFE) to their most cost effective use. CMS has previously assessed a range of aspects of the consumer experience, and has determined that the activities cited by GAO – namely, outreach and education events and the availability of in-person consumer assistance, such as that provided by navigators – did not lead to measurably different results in terms of numbers of consumers enrolling.
CMS	OEI-02-17-00020	Hospice Deficiencies Pose Risks to Medicare Beneficiaries	7/3/2019	399-915-11-02-05897	Include on Hospice Compare the survey reports from State agencies	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. While CMS is supportive of increased transparency of hospice survey findings, publicly reporting survey reports only from state agencies may be misleading to consumers when researching hospice options. CMS is currently statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations with the exception of home health agencies and information that relates to a CMS

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									enforcement determination. In FY15, approximately 40 percent of hospice surveys were performed by these organizations and could not be publicly disclosed. CMS is exploring ways to increase transparency of hospice quality in a useful, consumer-friendly manner.
CMS	OEI-02-17-00020	Hospice Deficiencies Pose Risks to Medicare Beneficiaries	7/3/2019	399-915-11-02-05900	Increase oversight of hospices with a history of serious deficiencies	Concur	2020	In Progress	CMS is referring the OIG's list of hospices with serious systemic deficiencies to the appropriate CMS Regional Offices and State Survey Agencies for complaint surveys and will take appropriate enforcement action based on any findings of non-compliance. We received the data file on these early December and the team was working on the analysis. However, we have since determined the script that used to pull the data did not capture the parameters we intended so we are going in to the system and manually pulling the data to confirm accuracy. This has changed the results significantly so we need more time to re-do the analysis and write up. Normally, we would be able to turn it around faster but that is a challenge with all the COVID work we are doing.

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CMS	OEI-02-17-00020	Hospice Deficiencies Pose Risks to Medicare Beneficiaries	7/3/2019	399-915-11-02-05899	Educate hospices about common deficiencies and those that pose particular risks to beneficiaries	Concur	2020	In Progress	On August 27, 2020 the Centers for Medicare & Medicaid Services (CMS) released educational information through our MLN Connects® newsletter and posted information to our Provider Compliance webpage (see the Fast Facts section) to meet the recommendation to educate hospices on common deficiencies in hospice care that pose risk to Medicare beneficiaries.Our MLN Connects weekly newsletter highlights different issues facing the Agency. We have over 1 million subscribers (over 400K direct subscribers and over 700K who subscribe through the Medicare Administrative Contractors (MACs)) and over 200 associations, who reach more than 5 million members.Supporting Documentation:As noted above, CMS released the information below in the newsletter and posted it on the Provider Compliance webpage on CMS.gov.Creating an Effective Hospice Plan of CareIn a recent report the Office of Inspector General (OIG) determined that CMS should educate hospices about common deficiencies that pose risks to beneficiaries. We developed

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									Creating an Effective Hospice Plan of Care Fact Sheet in response to this recommendation. Additional resources:Hospice Final RuleMLN Matters Number: SE20011Quality, Certification and Oversight Reports (QCOR) database: Contains various surveyreports and data reporting elements for surveys conducted by State Agency (SA); includescomplaint survey information from both hospice Accrediting Organizations (AO) and StateSurvey Agencies (SA)Quality, Safety & Education Portal (QSEP) for certified provider/supplier basic surveyoron-demand trainingsState Operations Manual Appendix M – Guidance to Surveyors: Hospice
CMS	OEI-02-17-00020	Hospice Deficiencies Pose Risks to Medicare Beneficiaries	7/3/2019	399-915-11-02-05895	Expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices	Concur	2022	In Progress	CMS concurs with this recommendation. CMS will work to enhance reporting of the current information about hospice deficiencies that accrediting organizations report to CMS and use it to strengthen oversight of hospices. The transition to iQIES is ongoing and the timeframe to implement changes in the reporting of deficiency data for deemed hospice is targeted for 2022. CMS is aware

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									of the issue and necessary changes that need to be made during the transition and will take the necessary steps to remedy this concern at that time. CMS recommends focusing the agency response on the intent of the OIG recommendation, comprehensive analysis of deemed and non-deemed hospice deficiency data, while acknowledging the impact of additional AO requirements reporting to ASSURE.

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CMS	OEI-02-17-00021	Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm	7/3/2019	399-915-11-02-05919	CMS should improve and make user-friendly the process for beneficiaries and caregivers to make complaints	Non-Concur	2021	In Progress	1. CMS is continuing the process of developing guidance to provide clarity on the complaint reporting process. This work is ongoing as part of a larger revision to hospice guidance in the State Operations Manual (SOM). Target date for completion is May 30, 2021. 2. & 3. CMS has reviewed complaint reporting guidelines in the Medicare Hospice Handbook and has updated information to assist beneficiaries in making quality of care complaints. This information provides three choices for filing complaints, these include Quality Improvement Organizations (QIOs), online through Medicare.gov, and via telephone to 1-800 Medicare. All three processes provide the ability to transfer complaints to the respective CMS location office for investigation when appropriate. CMS continues to work internally to assess the steps involved in each of these processes to make these more user-friendly. Target date for completion is May 30, 2021. CMS intends to add a hyperlink to the Hospice Compare website to assist beneficiaries in making

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									complaints. This was due to be published in Summer 2020 but has been delayed due to agency initiatives related to the COVID-19 Public Health Emergency. The new target date is May 30, 2021. CMS has also published a Medicare Learning Network (MLN) fact sheet on abuse and neglect in hospice which also provides clarity in complaint reporting for beneficiaries and hospices. This information was released in February 2020. For example, we will review the information contained in our existing educational materials, such as the Hospice Handbook , to see if it should be updated to be more user-friendly.
CMS	OEI-02-17-00021	Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiari	7/3/2019	399-915-11-02-05917	CMS should strengthen guidance for surveyors to report crimes to local law enforcement	Concur	2019	In Progress	CMS has revised Appendix Q of the Medicare SOM to include language regarding the referral of crimes to law enforcement. This additional language has been issued to reinforce the expectation that all crimes and suspected crimes are referred to law enforcement.

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		es From Harm							
CMS	OEI-02-17-00021	Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm	7/3/2019	399-915-11-02-05915	CMS should strengthen requirements for hospices to report abuse, neglect, and other harm	Concur	2020	In Progress	These changes are part of a comprehensive revision to the hospice survey process that is currently underway and is targeted to be released in late 2020. CMS plans to add new interpretive guidance for hospices to aid in the reporting of abuse, neglect and other harm. This new guidance will assist in identification of abuse, neglect, and harm as well as expectations for reporting under existing state licensure and mandatory reporting requirements. CMS will also update this information in the Hospice Basic online training course. Target Date if Completion: 12/31/2020

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CMS	OEI-02-17-00021	Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm	7/3/2019	399-915-11-02-05918	CMS should monitor surveyors' use of immediate jeopardy citation	Concur	2021	In Progress	CMS will conduct annual data analysis on immediate jeopardy citations in hospice and trend these findings and over time. Additionally, CMS will also conduct an annual quality assurance study selecting a random sample of hospice citations to determine if citations were cited at the appropriate level, including the determination of immediate jeopardy. CMS will utilize this information to assess the need for further guidance or training related to appropriate citation of deficiencies. CMS will provide a report of the analysis 90-days after the end of the period ending December 31 each year. CMS will consider this recommendation to be closed after three reporting periods. CMS will provide this information on an annual basis with the first reporting occurring in 2020.
CMS	OEI-05-18-00070	Problems Remain for Ensuring That All High Risk Medicaid Providers Undergo	7/10/2019	399-915-11-02-05936	CMS should amend its guidance so that States cannot forgo conducting criminal background checks on high risk providers applying for Medicaid that have already enrolled in	Non-Concur	NA	Awaiting Disposition	CMS does not concur with OIG's recommendation. CMS permits states to forgo conducting criminal background checks on providers that Medicare has already enrolled in the "high" risk category. In addition, CMS intends to procure a contractor to perform provider

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		Criminal Background Checks			Medicare unless Medicare has conducted the checks.				enrollment fingerprint-based criminal background checks for all Medicare and Medicaid providers. CMS anticipates conducting fingerprint-based criminal background checks on all remaining providers after we procure the new contract. We believe this is the most effective and least burdensome approach to ensure that providers with many locations are screened appropriately.
CMS	OEI-05-18-00070	Problems Remain for Ensuring That All High Risk Medicaid Providers Undergo Criminal Background Checks	7/10/2019	399-915-11-02-05937	CMS should compare high risk Medicaid providers' self reported ownership information to Medicare's provider ownership information to help States identify discrepancies.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with OIG's recommendation. Many states collect provider ownership information in paper format. It would place an extreme burden on states to share this data with CMS. It would also place burden on CMS to collect these paper records and match them against Medicare provider ownership information. For states that collect this information in an electronic format, CMS offers a data matching service that can identify discrepancies between a state Medicaid agency's ownership information and the information Medicare has on file. CMS then takes steps to make sure Medicare providers are disclosing information in compliance with Medicare's requirements or

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									recommends follow-up actions by the state. CMS will request that states with electronic provider ownership information take advantage of this resource. As stated above, states with paper or electronic provider ownership information may use the Medicare enrollment system, the Provider Enrollment Chain and Ownership System, to verify that the information they receive from providers matches the information Medicare has on file. CMS has encouraged states to report any discrepancies they identify through this process to CMS so that we can take appropriate follow-up action.
CMS	OEI-05-18-00070	Problems Remain for Ensuring That All High Risk Medicaid Providers Undergo Criminal Background Checks	7/10/2019	399-915-11-02-05935	CMS should ensure that all States fully implement fingerprint based criminal background checks for high risk Medicaid providers.	Concur	2020	In Progress	CMS concurs with OIG's recommendation. CMS has provided extensive technical assistance and guidance to states to help them implement fingerprint-based criminal background checks for "high" risk Medicaid providers. As a result of these efforts, most states have implemented the fingerprint-based criminal background check requirement. CMS is working with the remainder of states to complete implementation.

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CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-11-02-05979	Identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health	Concur	2020	Awaiting Disposition	CMS continues to explore ways to integrate the SNF 3-day waiver as well as test other innovative payment waivers in new and existing models. For example the SNF 3-day waiver is being incorporated into the recent Direct Contracting Model and Kidney Care Choices Model. In addition, the CMMI ACO Learning System has held peer to peer learning activities to share experiences and lessons learned from implementing the waiver. These include the following recent sessions: MSSP ACO Learning System Webinar: ACO Approaches to Implementing the SNF 3-Day Rule Waiver (November 19, 2019); Region III ACO In-Person Learning Collaborative (November 22, 2019); and a case study: Southwestern Health Resources Accountable Care Network's SNF 3-Day Rule Waiver: Approach to Communication and Implementation. (Disseminated to SSP ACOs and publicly in November 2019) There have been several lessons learned from these sessions related

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									to use of this waiver in the SSP program (see below for an overview). CMS is taking these lessons learned into consideration as we implement this waiver for new models. In addition to SSP, the SNF 3-day waiver is also utilized by many ACOs in the Next Generation ACO model. Anecdotally, ACOs have reported that their use of the waiver is limited by the need for substantial clinical practice changes to identify and admit patients appropriate and eligible for the waiver. For instance, clinicians have had to develop new protocols to identify patients who can safely be admitted to skilled nursing facilities without first receiving three or more days of inpatient care. Clinicians also have had to explain the waiver opportunity to patients and their caregivers in order to receive their consent, support selection of a SNF, and allay concerns around Medicare coverage of a SNF stay without a prior three-day inpatient stay. Clinicians also have had to locate an available SNF bed from among NGACO ACO-selected facilities participating in the waiver.

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CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-11-02-05975	Review the impact of programmatic changes on ACOs' ability to promote value-based care	Concur	2019	In Progress	We routinely review annual quality and financial performance results, as well as quarterly expenditure and utilization results used to forecast performance, as part of our program operations and monitoring activities. New ACOs launched under Pathways to Success policies for a July 1, 2019 and January 1, 2020 start date nearly doubled the number of ACOs under performance based risk which have shown to produce higher net program savings historically than one sided ACOs. Currently, we are completing 2019 financial reconciliation which includes the first 6 months of experience under the Pathways to Success policies. The results will be shared with ACOs this Fall along with the posting of Public Use Files on data.cms.gov. The first full year of performance data for 2020 under Pathways to Success will not be available until August 2021. CMS is analyzing the 2019 data to assess the early impact of the Pathways to Success policies and plans to analyze the 2020 financial results when available in 2021 to further understand the impact by October 2021.

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CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-11-02-05977	Adopt outcome-based measures and better align measures across programs	Concur	2021	In Progress	The Core Quality Measures Collaborative (CQMC) ACO workgroup will continue to meet and make updates to the first version of the core set, while taking into consideration updates to the Meaningful Measures initiative. Target Date of Completion for this recommendation is 9/13/21 (end of Option Year 2 of the CQMC work).
CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-11-02-05981	Prioritize ACO referrals of potential fraud, waste, and abuse	Concur	2020	In Progress	CMS concurs with this recommendation. CMS is committed to ensuring program integrity through expeditious review and prioritization of referrals of potential fraud, waste, and abuse from all sources, including ACOs. CMS will ensure that referrals from ACOs are provided a heightened level of attention commensurate with the quality of these referrals. Criteria for review will continue to include factors such as the degree for potential fraud and potential harm to beneficiaries. When an ACO, ACO participant, or ACO provider/supplier identifies and reports aberrant billing patterns or suspected fraud, the Shared

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									Savings Program staff refers such activity to CMS's Center for Program Integrity (CPI). CMS will continue to ensure that ACO referrals of suspected fraud, waste, and abuse, like all referrals, are reviewed to determine whether the referral is actionable. In addition, CMS will continue to refer cases of suspected fraud to OIG.

CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-11-02-05980	Identify and share information about strategies that encourage patients to share behavioral health data	Concur	2020	In Progress	The Shared Savings Program has collaborated with the CMMI ACO Learning System for over eight years to provide resources and a forum for ACO peer-to-peer learning about topics of most relevance to the ACOs. ACOs identified 4 topics of highest interest: Patient Engagement, Care Coordination, Provider Engagement, and Data Use. Within the context of these four priority topics, many sub-topics were discussed, including behavioral health and social determinants of health. The following are key takeaways related to social determinants of health from recent in person learning collaboratives and case studies. UCSF Health ACO (Fall IPLC, October 2019): UCSF Health ACO, a Track 1+ ACO, lowered care management costs by using patient navigators as health coaches to address social determinants of health. They also use the care management team as the “eyes and ears” for providers outside the office setting (e.g., the team anticipates and addresses patients’ needs and links them to community resources to avoid unnecessary emergency department (ED) visits). Cape Fear Valley ACO (Fall IPLC, October 2019): Cape Fear Valley, a Track 1 ACO, worked with social workers and mental health counselors to build

									partnerships with community organizations to improve referrals to community-based services. Aurora ACO (Fall IPLC, November 2019): Aurora, a Basic Level E ACO in the Pathways to Success program, started screening for social determinants of health using NowPow, an application that facilitates referrals to community partners. Imperium Health (Fall IPLC, November 2019): Imperium Health oversees both Track 1 and Basic Level B ACOs. During a break-out session, ACO attendees at this fall IPLC shared that the ACO uses an application to engage patients around non-clinical needs when they present to the ED. Patients receive a cell phone link to complete a questionnaire related to their social determinants of health, which also includes information about relevant resources in their area to support self-management. Community Healthcare Partners (CHP) (Fall IPLC, November 2019): CHP, a Track 1+ ACO, is working to implement more sophisticated screening and evaluation tools for addressing transportation needs. Connected Care of Southeastern Massachusetts ACO (Fall IPLC, December 2019): This ACO, a Level E ACO in the Pathways to Success program, found that addressing the social determinants of its patients' health has helped

									reduce inpatient admissions. Part of its reduction strategy involves efficiently connecting patients to outpatient services through engaged service providers. Keystone ACO (Case Study, Disseminated to SSP ACOs in October 2019): Keystone ACO, a Track 1+ ACO, implemented a care navigator program to identify and close both clinical and non-clinical gaps in care. Under the program, the ACO identifies patients who might have complex needs through predictive analytics and provider referrals and then has a community health assistant (CHA) visit the person's home to conduct a needs assessment. Needs assessments explore both clinical and non-clinical needs (e.g., food security, financial constraints). Based on the assessments, the CHA develops a care plan for the provider's review and also helps to connect the patient to community resources. Buena Vida Y Salud ACO (Shared Learning Webinar, August 13, 2020): During this webinar, this Track 1 ACOs described their social determinants of health initiatives. Buena Vida Y Salud ACO discussed efforts to reduce unnecessary ED utilization by addressing beneficiaries' social needs. Working with primary care practices, the ACO began the "Senior Buddies" program to reduce loneliness by pairing

									vulnerable seniors with volunteers to provide social support. Mission Health Partners ACO (Shared Learning Webinar, August 13, 2020): The Track 1 ACO presented on their interprofessional care coordination initiative that includes a team consisting of psychiatry, medical, nursing, and social work representatives. This team identifies beneficiaries' clinical and social needs in order to connect them to the ACO's "Pathways Hub" initiative to receive social support from community partners, such as securing food and medications, accessing legal assistance, and procuring medical equipment. Additionally, we note that ACOs and their providers and suppliers along with the beneficiaries they serve are part of the Medicare FFS program and also benefit from the following ways that CMS is working to improve and encourage behavioral health integration for all Medicare beneficiaries, including those assigned to ACOs:

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CMS	OEI-02-15-00451	ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	7/19/2019	399-915-12-02-05978	Assess and share information about ACOs' use of the 3-day waiver and apply these results when making changes to the Shared Savings Program or other programs	Concur	2020	In Progress	CMS concurs with this recommendation. CMS is committed to ensuring program integrity through expeditious review and prioritization of referrals of potential fraud, waste, and abuse from all sources, including ACOs. CMS will ensure that referrals from ACOs are provided a heightened level of attention commensurate with the quality of these referrals. Criteria for review will continue to include factors such as the degree for potential fraud and potential harm to beneficiaries. When an ACO, ACO participant, or ACO provider/supplier identifies and reports aberrant billing patterns or suspected fraud, the Shared Savings Program staff refers such activity to CMS's Center for Program Integrity (CPI). CMS will continue to ensure that ACO referrals of suspected fraud, waste, and abuse, like all referrals, are reviewed to determine whether the referral is actionable. In addition, CMS will continue to refer cases of suspected fraud to OIG.

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CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	1	The administrator of CMS should require that abuse and perpetrator type be submitted by state survey agencies in CMS's databases for deficiency, complaint, and facility-reported incident data, and that CMS systematically assess trends in these data.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.
CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	2	The administrator of CMS should develop and disseminate guidance—including a standardized form—to all state survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.

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CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	3	The administrator of CMS should require state survey agencies to immediately refer complaints and surveys to law enforcement (and, when applicable, to Medicaid Fraud Control Units (MFCU)) if they have a reasonable suspicion that a crime against a resident has occurred when the complaint is received.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.
CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	4	The administrator of CMS should conduct oversight of state survey agencies to ensure referrals of complaints, surveys, and substantiated incidents with reasonable suspicion of a crime are referred to law enforcement (and, when applicable, to MFCUs) in a timely fashion.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.

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CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	5	The administrator of CMS should develop guidance for state survey agencies clarifying that allegations verified by evidence should be substantiated and reported to law enforcement and state registries in cases where citing a federal deficiency may not be appropriate.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.
CMS	GAO-19-433	Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse	7/23/2019	6	The administrator of CMS should provide guidance on what information should be contained in the referral of abuse allegations to law enforcement.	Concur	2021	In Progress	Due to the 2019 Novel Coronavirus pandemic, much of the regulatory work that was being undertaken by the division of nursing homes has had to slow down due to shifting priorities in responding to the pandemic. As you are aware, nursing home residents are extremely vulnerable to COVID-19 and we are focused on ensuring that Medicare certified facilities are providing quality care and keeping residents safe. The Target date of response will be submitted 06-01-2021.

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CMS	GAO-19-483	Federal Rulemaking: Selected Agencies Should Clearly Communicate Practices Associated With Identity Information in the Public Comment Process	7/26/2019	2	The Administrator of Centers for Medicare & Medicaid Services (CMS) should create and implement a policy for standard posting requirements regarding comments and their identity information, particularly for duplicate comments, and should clearly communicate this policy to the public on the CMS website.	Concur	2020	Awaiting Disposition	We have updated our boilerplate documents that solicit public comments, as reflected on page 3 in the SUPPLEMENTARY INFORMATION section of the attached proposed rule boilerplate. The language on page 3 is consistent in what we have included on the CMS website regarding our standard posting requirements that GAO requested that we add. See language below. This language will appear in all of our published Federal Register documents that solicit comments.

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CMS	GAO-19-601	Medicaid Payment: CMS Has Not Overseen States' Implementation of Changes to Third-Party Liability	8/9/2019	1	The Administrator of CMS should ensure the agency's Medicaid third-party liability guidance is consistent with federal law related to the requirement for states to apply cost avoidance procedures to claims for labor, delivery, and postpartum care services, the requirement for states to make payments without regard to potential third-party liability for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days, and state flexibility to make payments without regard to potential third-party liability for pediatric services provided to child support enforcement beneficiaries.	Concur	2020	Awaiting Disposition	HS considers this recommendation implemented and therefore closed – no further action necessary. In November of 2019 CMS issue an Informational Bulletin providing technical assistance to States - https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419.pdf On June 19, 2020, CMS, via the OFR, published NPFM 2484-P revising Third Party Liability requirements - https://www.federalregister.gov/documents/2020/06/19/2020-12970/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and.
CMS	GAO-19-601	Medicaid Payment: CMS Has Not Overseen States' Implementation of	8/9/2019	2	The Administrator of CMS should determine the extent to which state Medicaid programs are meeting federal third-party liability requirements and take actions to ensure compliance as appropriate. Such actions	Concur	2020	Awaiting Disposition	Official regulation published in OFR 2482-P.

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		Changes to Third-Party Liability			can include ensuring that state plans reflect the law.				
CMS	OEI-07-17-00170	Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Followup Care	8/13/2019	399-915-11-02-05999	CMS should collaborate with partners to develop strategies for improving rates of followup care for children treated for ADHD.	Concur	2020	In Progress	The initial partner call was held in February 2020. CMS will hold a follow-up call with those partners and will include CDC's National Center on Birth Defects and Developmental Disabilities as OIG specifically requested in their response to CMS' stated actions.
CMS	OEI-07-17-00170	Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Followup Care	8/13/2019	399-915-11-02-06000	CMS should provide technical assistance to States to implement strategies for improving rates of followup care for children treated for ADHD.	Concur	2020	In Progress	Using the Quality Technical Advisory Group, CMS will share with states the activities identified by HHS partners in response to recommendation 1.

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CMS	OEI-07-17-00170	Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Followup Care	8/13/2019	399-915-11-02-06001	CMS should analyze the effectiveness of strategies for improving rates of followup care for children treated for ADHD.	Concur	2023	In Progress	CMS will conduct an analysis of reporting on this core set measure in response to the information shared with states. Because of the cycle of core set reporting, FY 2022 data is the first year this analysis will be available.
CMS	OEI-05-18-00480	National Review of Opioid Prescribing in Medicaid Is Not Yet Possible	8/15/2019	399-915-11-02-06002	CMS should work to ensure that individual beneficiaries can be uniquely identified at a national level using T-MSIS.	Concur	2021	In Progress	Guidance issued regarding new record segment in the T-MSIS Eligible file to enable linking of the various identifiers within a state associated with a beneficiary over the course of his/her involvement with the Medicaid/CHIP programs. Completed June 2020. States have until December 31, 2020 to comply.Guidance to states, published at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/99011

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CMS	OEI-05-18-00480	National Review of Opioid Prescribing in Medicaid Is Not Yet Possible	8/15/2019	399-915-11-02-06003	CMS should ensure the correct submission of prescriber NPIs.	Concur	2021	In Progress	Technical Assistance efforts to improve state reporting of the prescribing provider NPI number, and other T-MSIS measures, are ongoing. The next set of TPIs for measures will be identified in Fall 2020. As of June 2020 FMD There are currently 7 states that have data quality items related to completeness of the prescribing provider NPI number. Three of the states (FL, ME, and RI) are not reporting the prescribing provider NPI. New Hampshire is missing the prescribing provider NPI on approximately 21% of records. Three other states are missing the provider NPI number on 6%, 4%, and 6% respectively. This last group of states' measure statistics (DE, MA, MT) fall under the 10% threshold used when this analysis was originally performed. State Performance against data quality measures is tracked within the T-MSIS Data Quality Tool (DQT) which is accessible via https://portal.cms.gov . The data quality measures are also available on the landing page of the DQT. The DQT can only be accessed with an appropriate CMS EIDM role.

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CMS	A-06-17-08004	Medicare Part D Is Still Paying Millions for Drugs Already Paid for Under the Part A Hospice Benefit	8/22/2019	399-906-02-1	CMS must do more to avoid paying twice for the same drugs. As we have previously recommended, CMS should work directly with hospices to ensure that they are providing drugs covered under the hospice benefit. In addition, we recommend that CMS should develop and execute a strategy to ensure that Part D does not pay for drugs that should be covered by the Part A hospice benefit, which would save at least an estimated $160.8 million a year in Part D total cost, with potentially much higher annual savings associated with the drugs that hospices said they were not responsible for providing. This should include working with Part D sponsors and seeking whatever authorities are necessary to develop proper controls.	Concur	2019	In Progress	While CMS agrees with the importance to avoid duplicate payments to Medicare Part D drug plan sponsors and hospices, we maintain that CMS's current efforts will address the issue and help ensure there is no disruption in beneficiary access. As such, CMS will continue to engage in meaningful activities to reduce duplicate payment in this area, such as ensuring hospice providers are proactively educating beneficiaries on covered services and items (including drugs) and Part D drug plan sponsors are appropriately applying prior authorization criteria and coordinating with hospice providers on drug coverage issues.

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CMS	A-09-18-03030	Medicare Incorrectly Paid Providers for Emergency Ambulance Transports From Hospitals to Skilled Nursing Facilities	9/11/2019	322-916-02-1	We recommend that the Centers for Medicare & Medicaid Services develop a fraud prevention model specific to emergency ambulance transports from hospitals to skilled nursing facilities to help ensure that payments for these ambulance transports comply with Federal requirements, which could have saved an estimated $849,170 during our audit period and $119,548 in calendar year 2018.	Concur	2020	In Progress	CMS concurs with this recommendation. CMS will develop a fraud prevention model specific to emergency ambulance transports from hospitals to skilled nursing facilities to help ensure that payments for these ambulance transports comply with federal requirements.
CMS	OEI-02-17-00490	Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care	9/12/2019	399-915-11-02-06035	CMS should identify States that have limited availability of behavioral health services and develop strategies and share information to ensure that Medicaid managed care enrollees have timely access to these services.	Concur	2020	In Progress	DEHPG worked with a contractor to complete a secret shopper initiative of six states on the availability of BH providers (August 2019), which resulted in a Recommendations Memo. DEHPG worked with a contractor to host 3 Behavior Health Access Forums with the intention of hosting at least one more before the end of the summer (2020). Each of these forums addressed a topic identified during the secret shopper initiative and was detailed in the Recommendations Memo. These forums allow states with BH access issues to interact with states that have identified/operationalized

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									fixes for BH access issues. When the forums are complete, the DEHPG will work with the contractor to create and publish a BH Access Toolkit with an expected publication date of 12/2020. DEHPG worked with a contractor to complete a secret shopper initiative of six states on the availability of BH providers (August 2019), which resulted in a Recommendations Memo. DEHPG worked with a contractor to host 3 Behavior Health Access Forums with the intention of hosting at least one more before the end of the summer (2020). Each of these forums addressed a topic identified during the secret shopper initiative and was detailed in the Recommendations Memo. These forums allow states with BH access issues to interact with states that have identified/operationalized fixes for BH access issues. When the forums are complete, the DEHPG will work with the contractor to create and publish a BH Access Toolkit with an expected publication date of 12/2020.

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CMS	GAO-19-481	Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings	9/16/2019	1	The Administrator of CMS should work with states and relevant federal agencies to collect accurate and complete data on blood lead screening for Medicaid beneficiaries in order to ensure that CMS is able to monitor state compliance with its blood lead screening policy, and assist states with planning improvements to address states' compliance as needed.	Concur	2021	Awaiting Disposition	Beginning with FY 2020 reporting, states will have the option to have CMS populate the Form CMS-416 using T-MSIS data. T-MSIS will provide more complete blood lead screening data and will improve CMS and states ability to assess gaps.
CMS	GAO-19-481	Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings	9/16/2019	2	The Administrator of CMS should regularly assess the appropriateness of performance measures and targets for the EPSDT benefit, and take any necessary actions to ensure their relevance and use, including adding, changing, or removing measures, or targets, and regularly communicating performance measures, or targets, and regularly communicating performance measures and targets to states.	Non-Concur	NA	Awaiting Disposition	CMS Non-concurs with the recommendations. SOA submitted June 2020

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CMS	GAO-19-481	Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings	9/16/2019	3	The Administrator of CMS should conduct regular evaluations of state performance by comparing states' performance measurement data with CMS's EPSDT targets to identify gaps in states' performance and areas for improvement.	Non-Concur	NA	Awaiting Disposition	CMS Non-concurs with the recommendations. SOA submitted June 2020
CMS	GAO-19-481	Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings	9/16/2019	4	The Administrator of CMS should assist states with planning needed improvements, including providing focused assistance, to resolve gaps in states' performance in meeting CMS's EPSDT targets.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS acknowledges the issue but notes that there are significant obstacles to developing a reliable control for active treatment. CMS will implement a program to prior authorization medical review of certain services provided by chiropractors as required by the Medicare Access and CHIP Reauthorization Act (MACRA). CMS believes this program will help to address the concerns OIG identifies in this recommendation.

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CMS	GAO-19-481	Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings	9/16/2019	6	The Administrator of CMS should develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the Child Core Set to improve EPSDT oversight and streamline state reporting.	Concur	2021	Awaiting Disposition	As noted in our comments to the draft report, not all of the measures on the Child Core Set can be calculated using administrative data from T-MSIS. That said, HHS has taken concrete steps towards addressing the parts of this recommendation that we consider feasible and considers this recommendation open. • HHS is currently exploring the feasibility of extracting Core Set data for selected Child Core Set measures using T-MSIS data to reduce the administrative burden on states. • HHS is conducting a pilot with five Child Core Set measures using the 2018 T-MSIS Analytic Files (TAF). The initial five measures in the pilot include only the Child Core Set measures that can be reliably measured using a single year of administrative claims data. • Upon completion of this pilot, HHS plans to engage state stakeholders in a robust review process to validate the data by comparing it against the data for the same measures states reported to CMS. HHS will also solicit state feedback on utilizing T-MSIS data for state level reporting of Core Set measures rather than the current state generated/submitted data

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									method. • Results will then be used to determine the timeline for generating the remaining Child Core Set data through T-MSIS that can be generated using administration data.
CMS	OEI-09-16-00411	Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs	9/18/2019	399-915-11-02-06066	CMS should take action to reduce inappropriate pharmacy rejections.	Concur	2019	In Progress	CMS has monitored inappropriate pharmacy rejects and has finalized the CMP methodology. This is publicly posted on the CMS website. CMS considers actions complete.

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CMS	OEI-09-16-00411	Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs	9/18/2019	399-915-11-02-06067	CMS should take action to reduce inappropriate coverage denials.	Concur	2021	In Progress	At this stage we're just continuing to look at the reporting requirements data. CMS concurs with this recommendation. CMS has already taken several steps to ensure sponsors receive assistance on this issue. CMS also conducts program audits that measure a sponsoring organization's compliance with Medicare program requirements, including the requirements related to a beneficiary's access to covered medical services and prescription drugs. Going forward, CMS will analyze annual performance data from plan sponsors and determine how to best provide additional oversight to prevent unnecessary coverage denials.

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CMS	OEI-09-16-00411	Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs	9/18/2019	399-915-11-02-06065	CMS should take additional steps to improve electronic communication between Part D sponsors and prescribers to reduce avoidable pharmacy rejections and coverage denials.	Concur	2021	In Progress	CMS concurs with this recommendation. CMS is engaging in efforts to improve electronic communication through the implementation of electronic standards, such as electronic prior authorization, and by improving the formulary and benefit standard, which could help reduce avoidable pharmacy rejections and denials by providing a faster and more precise way to transfer information. CMS has required sponsors to implement an RTBT capable of integrating with at least one prescriber's e-prescribing or electronic health record by January 1, 2021. Once this requirement goes into effect, and to the extent it is not replaced by a subsequent requirement, CMS will examine plan sponsors' implementation of electronic RTBT. As noted above, CMS has required sponsors to implement an RTBT capable of integrating with at least one prescriber's e-prescribing or electronic health record by January 1, 2021. Once this requirement goes into effect, and to the extent it is not replaced by a subsequent requirement, CMS will examine

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									plan sponsors' implementation of electronic RTBT.
CMS	OEI-09-16-00411	Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs	9/18/2019	399-915-11-02-06068	CMS should provide beneficiaries with clear, easily accessible information about sponsor performance problems, including those relate to inappropriate pharmacy rejections and coverage denials.	Concur	2019	In Progress	CMS concurs with this recommendation. CMS is currently gathering feedback from beneficiaries and plan quality improvement staff that will help CMS understand what information consumers expect and/or would like to see on Medicare Plan Finder (MPF) to help them make informed choices. After reviewing the feedback, CMS will consider how best to include it on MPF.
CMS	OEI-12-17-00130	Reasonable Assumptions in Manufacturer	9/18/2019	399-915-11-02-06064	CMS should implement a system to share responses to manufacturer inquiries for technical assistance	Concur	2020	In Progress	CMS and OIG met in July 2020 on possible resolution. Awaiting OIG feedback.

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		Reporting of AMPs and Best Prices							
CMS	OEI-12-17-00130	Reasonable Assumptions in Manufacturer Reporting of AMPs and Best Prices	9/18/2019	399-915-11-02-06063	CMS should assess the costs and benefits of implementing a targeted process to review certain assumptions	Concur	2020	In Progress	CMS and OIG met in July 2020 on possible resolution; however, OIG has not accepted CMS' actions on this recommendation.
CMS	OEI-12-17-00130	Reasonable Assumptions in Manufacturer Reporting of AMPs and Best Prices	9/18/2019	399-915-11-02-06062	CMS should issue guidance related to the areas identified in the report, specifically value based purchasing arrangements	Concur	2020	In Progress	Posted to federal register. OIG stated when CMS actions are complete it will consider the recommendation implemented.
CMS	GAO-19-628	Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurem	9/19/2019	1	The Administrator of CMS should, to the extent feasible, maintain more complete information on both the total amount of funding allocated for quality measurement activities and the extent to which this funding supports each of its quality	Concur	2022	In Progress	CMS is migrating to a consolidated budget system to better plan and manage resources. As part of the migration, CMS has reviewed existing tracking mechanisms to better align to programmatic activities. As of this update, CMS is currently validating and collecting budget data based on the new structure with full

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		ent Activities Promote Its Objectives			measurement strategic objectives.				implementation scheduled for the beginning of fiscal year 2021. Once the data is validated, CMS will link the standardized tracking elements to quality strategic plan providing programmatic offices with improved budgetary decision making tools.
CMS	GAO-19-628	Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives	9/19/2019	2	The Administrator of CMS should develop and implement procedures to systematically assess the measures it is considering developing, using, or removing in terms of their impact on achieving CMS's strategic objectives and document its compliance with those procedures.	Concur	2020	In Progress	CMS intends to review and update the Measure Management System Blueprint to incorporate changes in the regulatory environment and in healthcare quality measurement science and to meet the evolving needs of measure developers and in the context of CMS' quality measurement strategic objectives. CMS is actively refining the Meaningful Measures framework to better align with Agency strategic initiatives specifically for quality measurement and to improve the quality of care through tracking measurable outcomes and impact. Anticipated and evolving stakeholder feedback will be incorporated in both the Blueprint and the Meaningful Measures framework to help inform how measure decisions impact the achievement of strategic objectives. CMS is also developing and actively testing a tool, the Quality Measure Index, to provide a

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									standard and transparent methodology to assess individual measures and to have an improved, systematic way to assess measures in a more quantitative manner and based on dimensions that include CMS quality measurement strategic objectives.
CMS	GAO-19-628	Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives	9/19/2019	3	The Administrator of CMS should develop and use a set of performance indicators to evaluate the agency's progress towards achieving its quality measurement strategic objectives.	Concur	2020	In Progress	CMS is actively refining the Meaningful Measures framework to better align with Agency strategic initiatives specifically for quality measurement and to improve the quality of care through tracking measurable outcomes and impact. CMS intends to obtain comment and feedback on any potential updates to the Meaningful Measures framework which will continue to guide the development and use of performance indicators to evaluate progress towards CMS' quality measurement strategic objectives.

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CMS, DAB, OMHA, ASFR	GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	3	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, OMHA, or DAB to modify the various Medicare appeals data systems to collect consistent data across systems, including appeal categories and appeal decisions across MAS and MODACTS	Concur	2020	Awaiting Disposition	To the extent possible, CMS is continually working to standardize appeals data and reporting. CMS deployed CR 747 to modify the MAS system to standardize appeal categories between Levels 1 through 3. The appeals category list was updated and went into effect during release 16.11 (November 2016). Additionally, CMS collaborated with OMHA to provide the MAS appeal categories for Levels 1 and 2 to incorporate into the current design of ECAPE to enhance consistency of data. Continued progress is being made towards Part B and DME MAS data consistency with the implementation the Data Collection Pilot (DCP), set to go live by the end of August 2020. However, this recommendation will remain open until MAS is fully implemented across all MACs.

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CMS, DAB, OMHA, ASFR	GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	2	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, OMHA, or DAB to modify the various Medicare appeals data systems to capture the amount, or an estimate, of Medicare allowed charges at stake in appeals in Medicare Appeals System (MAS) and Medicare Operations Division Automated Case Tracking System (MODACTS).	Concur	2019	Awaiting Disposition	OMHA had proposed a change in the basis for determining the amount in controversy in a NPRM issued in June 2016. This change would have resulted in the reporting of the allowed amount for certain denied claims at Level 3 of the appeals process. However, this provision was removed after HHS conducted further analysis and determined that the costs of the proposal outweighed the benefits. OMHA issued the final rule in January 2017. While this discussion had resurfaced in 2019, it was again determined that implementation of this recommendation would be an overly budensome/complicated/expensive initiative for CMS, which would have a minimal impact on appeals to OMHA. CMS again insisted this recommendation be closed at that time (July 2019).

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CMS, ONC,	GAO-14-207	Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care	3/6/2014	2	To ensure that CMS and ONC can effectively monitor the effect of the EHR programs and progress made toward goals, the Secretary of Health and Human Services should direct the agencies to develop performance measures to assess outcomes of the EHR programs--including any effects on health care quality, efficiency, and patient safety and other health care reform efforts that are intended to work toward similar outcomes.	Concur	2020	Awaiting Disposition	Data submission will occur from January through March of 2020…We analyze the data received in the Fall of 2020. Target Date of Completion: 12/31/2020
CMS, ONC,	GAO-14-207	Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care	3/6/2014	3	To ensure that CMS and ONC can effectively monitor the effect of the EHR programs and progress made toward goals, the Secretary of Health and Human Services should direct the agencies to use the information these performance measures provide to make program adjustments, as appropriate, to better achieve program goals.	Concur	2020	Awaiting Disposition	Data submission will occur from January through March of 2020…We analyze the data received in the Fall of 2020. Target Date of Completion: 12/31/2020

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CMS, ONC,	GAO-17-5	Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures	10/13/2016	1	To make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, the Secretary of HHS should direct CMS and the Office of the National Coordinator for Health Information Technology to prioritize their development of electronic quality measures and associated standardized data elements on the specific quality measures needed for the core measure sets that CMS and private payers have agreed to use.	Concur	2020	Awaiting Disposition	CMS completed an analysis to determine which of the remaining 53 Core Quality Measures Collaborative Core Measure Sets are feasible to develop as eCQMs. CMS found that 8 measures are highly feasible to retool as an eCQM; 8 measures are moderately feasible (that is, most data are expected to be collected in an EHR); 15 measures have low feasibility for retooling (that is, one or more critical data elements is not captured in EHR systems or technically not likely to be feasible to express in QDM standards); and 22 measures have an unknown feasibility for retooling as an eCQM because the existence of certain structured data fields within the specified setting was unknown. To understand feasibility of those 22 measure, CMS would need to do a formal feasibility assessment to assess whether data elements are captured in structured fields in EHRs.

CMS, ONC,	GAO-17-184	Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings	2/27/2017	2	To improve efforts to promote EHR use and electronic exchange of health information in post-acute care settings, the Secretary of Health and Human Services should direct CMS and ONC to comprehensively plan for how to achieve the department's goal related to the use of EHRs and electronic information exchange in post-acute care settings. This planning may include, for example, identifying specific actions related to post-acute care settings and identifying and considering external factors.	Concur	2020	Awaiting Disposition	ONC noted the following in its latest open recommendation update. In 2015, ONC published a federal strategic plan to advance the adoption and interoperability of HIT, including in post-acute care (PAC) settings: Federal Health IT Strategic Plan 2015 – 2020 (the Plan). Contributors to the Plan included representatives from across the federal government, including CMS. The Plan: (1) addresses the federal HIT strategy for all health care industry segments that are health information exchange partners, including long-term care and post-acute; (2) explains how the federal government is working to achieve the mission of 'improving the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most'; (3) applies broadly to stakeholders across the care continuum, including PAC providers, and aims to modernize the U.S. HIT infrastructure so individuals, providers, and communities can use it to help achieve health and wellness goals; (4) includes goals, objectives, and strategies intended to drive the actions needed to improve HIT adoption and PAC interoperability; and, (5) states "long-term and post-acute care plays an integral role in helping to keep individuals healthy and have

									numerous situations that necessitate collaboration and sharing of information with the greater health community." ONC has also taken actions to advance HIT adoption and interoperability for PAC providers through outreach/collaboration, supports for HIT adoption, and standards/initiatives specific to PAC.ONC believes it has addressed the recommendations made in the GAO report that are within ONC's authority and considers the recommendation fully implemented. In August 2019 CMS submitted the Data Element Library response to GAO. It is our understanding that ONC will provide a response regarding the State Medicaid matching funds and additional responses related to their efforts.The program area is hopeful that this closes out both recommendations of this audit for CMS. IMPLEMENTATION UPDATE 9/30/2020:ONC continues to take actions in response to and to close out GAO's recommendation, including: (1) releasing the draft 2020-2025 Federal Health It Strategic Plan in January 2020; (2) hosting a series of webinars on the ONC Cures Act Final Rule; (3) developing informational materials to support providers, clinicians, patients and health IT developers; (4) reaching out to PAC stakeholders on policy

									and technical advancements at a number of conferences. ONC also anticipates work to advance FHIR APIs and their use in PAC will improve interoperable standards implementation and workflow challenges in PAC settings as these standards are developed and tested in collaboration with the PAC industry. ONC believes we have addressed the recommendations made in the GAO report that are within ONC's authority and considers the recommendations fully implemented.

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CMS, DAB, OMHA, ASFR	GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	1	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, Office of Medicare Hearings and Appeals (OMHA), or Departmental Appeals Board (DAB) to modify the various Medicare appeals data systems to collect information on the reasons for appeal decisions at Level 3.	Concur	2020	Awaiting Disposition	OMHA recommends closure on this recommendation. In the July 2017 interim release of the Electronic Case Adjudication and Processing Environment (ECAPE) system, OMHA added a "Reason for Disposition" data field for most dispositions issued by an adjudicator. Because the "Reason for Disposition" data field limits the number of reasons that can be selected, OMHA added more categories in later releases. As of November 2019, ECAPE has been implemented in all of OMHA's field offices and its satellite office. Information on the reasons for Level 3 appeal decisions can currently be reported within ECAPE. DAB recently added new data fields and case categories to its case management system to capture more detail about pending cases, including the reasons for ALJ dismissals at level 3. In addition, DAB continues to work towards developing system interoperability with ECAPE. Once baseline interoperability is established, DAB will work with OMHA to explore the feasibility of incorporating level 3 "Reason for Disposition" data into its new system.

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FDA	OEI-05-07-00730	The Food and Drug Administration's Oversight of Clinical Investigators' Financial Information	1/1/2009	399-902-11-06-00927	FDA should require that sponsors submit financial information for clinical investigators as part of the pretrial application process	Non-Concur	NA	Awaiting Disposition	FDA believes that clinical investigator financial disclosures are being appropriately identified and managed during the study planning process and that additional disclosure to and review by FDA at that time is not needed and would not be an efficient use of FDA resources
FDA	GAO-10-246	Food Safety: FDA Should Strengthen Its Oversight of Food Ingredients Determined to Be Generally Recognized as Safe (GRAS)	2/3/2010	2	To better ensure FDA's oversight of the safety of GRAS substances, the Commissioner of FDA should develop a strategy to minimize the potential for conflicts of interest in companies' GRAS determinations, including taking steps such as issuing guidance for companies on conflict of interest and requiring information in GRAS notices regarding expert panelists' independence.	Concur	NA	In progress	On November 16, 2017, FDA published a notification of availability for the draft guidance "Best Practices for Convening a GRAS Panel: Guidance for Industry," with a request for comments on the draft guidance by May 15, 2018. The draft guidance represents FDA's current thinking on strategies to minimize the potential for conflicts of interest in companies' GRAS determinations, including assessing potential GRAS panel members for conflicts of interest. As of July 2020, FDA had not yet finalized the guidance.
FDA	OEI-02-08-00080	FDA Inspections of Domestic Food Facilities	4/1/2010	399-908-13-06-01691	FDA should consider seeking statutory authority to impose civil penalties through administrative proceedings against facilities that do not voluntarily	Concur	NA	Awaiting Disposition	The Food Safety Modernization Act (FSMA), P.L. 111-353 failed to include civil monetary penalties. Given the continued lack of congressional support for civil penalties linked to the failure to

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					comply with statutory and regulatory requirements.				register, FDA does not plan to pursue this further.
FDA	OEI-01-08-00510	Challenges to FDA's Ability To Monitor and Inspect Foreign Clinical Trials	6/1/2010	399-507-11-06-01707	FDA should require standardized electronic clinical trial data and create an internal database	Concur	2022	In Progress	FDA anticipates its final guidance related to this recommendation will enter clearance in FY2020. Specifically, in February 2018, FDA published draft industry guidance entitled Standardized Format for Electronic Submission of NDA and BLA Content for the Planning and Conduct of Bioresearch Monitoring (BIMO) Inspections for CDER Submissions to support inspection planning and conduct. Since then, Version 2.0 of the BIMO Conformance Guide containing technical specifications (that accompanied the draft guidance) entered the Center for Drug Evaluation and Research clearance process. Revisions to the draft guidance itself are underway.

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FDA	GAO-10-960	FDA Administration: Overseas Offices Have Taken Steps to Help Ensure Import Safety, but More Long-Term Planning Is Needed	9/30/2010	1	To help ensure that FDA's overseas offices are able to fully meet their mission of helping to ensure the safety of imported products, the Commissioner of FDA should ensure, as it completes its strategic planning process for the overseas offices, that it develops a set of performance goals and measures that can be used to demonstrate overseas office contributions to long-term outcomes related to the regulation of imported products and that overseas office activities are coordinated with the centers and Office of Regulatory Affairs (ORA).	Concur	NA	In progress	In June and July 2018, FDA reported on its recent efforts to assess the effectiveness of the foreign offices' contributions to drug-safety related outcomes. Among other things, FDA developed new performance measures for these offices along with a monitoring and evaluation plan and conducted an assessment of the foreign offices to help set their objectives and ensure the right balance of personnel, skillsets, and resources. In August 2020, FDA indicated that because of a reorganization and strategic planning effort for its Office of Global Policy and Strategy, it was still revising and updating its measures and its approach to evaluating impact in 2020 to align with a five-year strategic plan completed in March 2020.

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FDA	GAO-12-346	Information Technology: FDA Needs to Fully Implement Key Management Practices to Lessen Modernization Risks	3/15/2012	2	To help ensure the success of FDA's modernization efforts, the Commissioner of FDA should direct the CIO to, in completing the assessment of Mission Accomplishments and Regulatory Compliance Services (MARCS), develop an integrated master schedule (IMS) that (1) identifies which legacy systems will be replaced and when; (2) identifies all current and future tasks to be performed by contractors and FDA; and (3) defines and incorporates information reflecting resources and critical dependencies.	Concur	NA	In progress	In September 2020, FDA identified legacy services, components and systems that have been decommissioned and indicated that key modernization efforts are progressing, including replacement of key components of the ORA legacy applications. FDA recommended that, because the MARCS Program was discontinued, this recommendation be closed.
FDA	OEI-01-11-00210	Dietary Supplements: Structure/Function Claims Fail To Meet Federal Requirements	10/2/2012	399-915-13-06-03071	FDA should seek explicit statutory authority to review substantiation for structure/function claims to determine whether claims are truthful and not misleading	Non-Concur	NA	Awaiting Disposition	FDA is not currently seeking explicit statutory authority to review substantiation for structure/function claims beyond its existing authorities. As noted in the report, under section 403(r)(6) of the Federal Food, Drug, and Cosmetic Act (the FD&C Act), a manufacturer must have substantiation that a structure/function claim used in the labeling of a supplement is truthful and not misleading, and must notify FDA of the claim no later than 30

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									days after the first marketing of the supplement with the claim. FDA can request that manufacturers voluntarily submit substantiation for structure/function claims, and has done so in the past, but these requests are not always granted. FDA also has a right to review and inspect a firm's substantiation records as part of our general records inspection authority, should we have concerns about a particular structure/function claim. In addition, FDA collaborates with and supports Federal Trade Commission efforts to enforce the substantiation requirements.
FDA	OEI-01-11-00211	Dietary Supplements: Companies May Be Difficult To Locate in an Emergency	10/2/2012	399-915-13-06-03075	FDA should seek statutory authority to impose civil monetary penalties on companies that do not comply with registration requirements	Non-Concur	NA	Awaiting Disposition	The Food Safety Modernization Act (FSMA), P.L. 111-353 failed to include civil monetary penalties. Given the continued lack of congressional support for civil penalties linked to the failure to register, FDA does not plan to pursue this further.
FDA	OEI-04-11-00510	FDA Lacks Comprehensive Data To Determine Whether Risk	2/12/2013	399-904-13-06-03257	Seek legislative authority to enforce FDA assessment plans.	Concur	NA	Awaiting Disposition	FDA has considered this recommendation further and does not wish to pursue such a legislative change at this time. FDA is concerned that legislation describing the requirements for REMS assessments could have the unintended consequence of

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		Evaluation and Mitigation Strategies Improve Drug Safety							constraining its authority over the types of information it can seek in assessments.
FDA	OEI-04-11-00510	FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation Strategies Improve Drug Safety	2/12/2013	331-900-10-06-03253	Identify REMS that are not meeting their goals and take appropriate actions to protect the public health.	Concur	2022	In progress	FDA reviews every REMS assessment to determine whether a specific REMS is meeting its goal. Further, FDA can require REMS program modifications if a REMS assessment reveals that the REMS program is not meeting its goals. FDA published two draft guidances, which are designed to help with the design and reporting of REMS programs. Specifically, these documents were created to improve the quality of data collected about whether particular REMS programs are meeting their goals.
FDA	OEI-04-11-00510	FDA Lacks Comprehensive Data To Determine Whether Risk Evaluation and Mitigation	2/12/2013	399-915-10-06-03258	Ensure that assessment reviews are timely.	Concur	2021	In progress	On December 18, 2019, FDA published the REMS Assessment Manual of Policies and Procedures, delineating the timeframes, responsibilities of specific offices at the Center for Drug Eenforcement and Research, and the detailed steps for conducting reviews of REMS assessments. These policies and procedures expand FDA's goal of reviewing

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		Strategies Improve Drug Safety							REMS assessments to 180 days, which include time to initiate and complete the review, discuss the review findings with the REMS Assessment Review Team, and communicate the conclusion of the review to applicants. The revisions to FDA's policies and procedures make it more likely that FDA will complete their reviews of REMS assessments within the specified timeframe.
FDA	GAO-14-194	Drug Shortages: Threat to Public Health Persists, Despite Actions to Help Maintain Product Availability	2/10/2014	2	To enhance its oversight of drug shortages, particularly as the agency fine-tunes the manner in which it gathers data on shortages and transitions from its database to a more robust system, the Commissioner of FDA should conduct periodic analyses using the existing drug shortages database (and, eventually, the new drug shortages information system) to routinely and systematically assess drug shortage information, and use this information proactively to identify risk factors for potential drug shortages early, thereby potentially helping FDA to recognize trends, clarify	Concur	NA	In progress	In September 2018, FDA was using its drug shortage data system, the "Shortage Tracker," to summarize information reported by manufacturers as the reasons for existing shortages. FDA was developing a model that would factor in drug shortage data, warning signs identified through social media, and other factors to help identify early indicators that may predict future shortages. In July 2019, FDA could conduct periodic analyses of the causes of drug shortages. In an August 2020 written response to GAO, FDA reported that it was undertaking modeling efforts to explore the feasibility of predicting future drug shortages using machine learning approaches. FDA plans to complete the initial modeling by fall 2020, at

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					causes, and resolve problems before drugs go into short supply.				which time it would identify next steps.
FDA	GAO-15-38	Food Safety: FDA and USDA Should Strengthen Pesticide Residue Monitoring Programs and Further Disclose Monitoring Limitations	11/6/2014	1	To better inform users of the annual monitoring report about the frequency and scope of pesticide tolerance violations, the Secretary of Health and Human Services should direct the Commissioner of FDA to disclose in the agency's annual pesticide monitoring program report which pesticides with EPA-established tolerances the agency did not test for in its pesticide monitoring program and the potential	Concur	NA	Awaiting Disposition	In February 2020, FDA suggested to GAO that the recommendation should be closed as not implemented. FDA has previously said that it remained concerned that the disclosure of pesticides for which FDA does not test would enable users to more easily circumvent the pesticide monitoring program, which could jeopardize public health and, at a minimum, would undermine FDA's law enforcement efforts. In addition, FDA discloses in its annual reports all pesticides tested for within the reports' annual scope as required by the Pesticide

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					effect of not testing for those pesticides.				Monitoring Improvements Act of 1988. FDA's annual reports also clarify that not all pesticides for which EPA has established tolerances were analyzed. FDA said that the Pesticide Monitoring Improvements Act of 1988 does not specifically direct the agency to report information on untested pesticides with EPA-established tolerances.
FDA	GAO-15-183	Food Safety: Additional Actions Needed to Help FDA's Foreign Offices Ensure Safety of Imported Food	2/27/2015	1	To help ensure the safety of food imported into the United States, the Commissioner of Food and Drugs should complete an analysis to determine the annual number of foreign food inspections that is sufficient to ensure comparable safety of imported and domestic food. If the inspection numbers from that evaluation are different from the inspection targets mandated in FSMA, FDA should report the results to Congress and recommend appropriate legislative changes.	Concur	NA	Awaiting Disposition	On March 25, 2020, FDA officials met with GAO staff to discuss the status of the recommendation. FDA officials said that they cannot meet the number of foreign inspections required under FSMA due to capacity constraints, and FDA's current strategy for the safety of imported food relies on a "cumulative oversight" approach involving multiple programs (including the Third-Party Certification Program, the Foreign Supplier Verification Program, the Voluntary Qualified Importer Program, and systems recognition), in addition to foreign inspections. FDA officials said that it could be a number of years before these programs are fully implemented and that FDA will provide GAO with more specific status updates

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									on the implementation and monitoring of each of these programs in future responses to this recommendation. Because FDA is still implementing their cumulative oversight approach and has not reported the number of foreign inspections required to ensure imported food safety, the recommendation remains open.
FDA	GAO-15-671	Drug Compounding for Animals: FDA Could Improve Oversight with Better Information and Guidance	9/28/2015	2	To help ensure that FDA has relevant and timely information to support management decisions, including the critical information necessary to ensure the safety and effectiveness of drugs compounded for animals, the Secretary of Health and Human Services should direct the Commissioner of the FDA to develop policy or guidance for agency staff that specifies circumstances under which FDA will or will not enforce compounding regulations for animals and clearly define key terms.	Concur	NA	In progress	In November 2019, FDA released for public comment its new Draft Guidance for Industry #256 - Compounding Animal Drugs from Bulk Drug Substances. The draft guidance describes FDA's policy regarding the compounding of animal drugs from bulk drug substances including the conditions under which FDA does not intend to take enforcement action for violations of the Federal Food, Drug, and Cosmetic Act's requirements for approval, adequate directions for use, and current Good Manufacturing Practices. In August 2020, FDA indicated that, in response to numerous requests from external stakeholders, the comment period on the draft guidance has been extended to October 2020. Once

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									the comments have been reviewed, FDA anticipates finalizing the guidance by the end of calendar year 2021.
FDA	GAO-15-671	Drug Compounding for Animals: FDA Could Improve Oversight with Better Information and Guidance	9/28/2015	3	To help ensure that FDA has relevant and timely information to support management decisions, including the critical information necessary to ensure the safety and effectiveness of drugs compounded for animals, the Secretary of Health and Human Services should direct the Commissioner of the FDA to consistently document the bases for FDA's decisions about how or whether it followed up on warning letters, adverse event reports, and complaints about drug compounding for animals.	Concur	NA	In progress	In July 2019, FDA reported to GAO that when the Draft Guidance for Industry #256 was issued that calendar year, FDA intended to develop a risk-based compliance program to address compounding of animal drugs from bulk drug substances. As part of that compliance program, FDA intends to consistently document the basis for its decisions about what actions are taken--for example, warning letters, adverse event reports, and complaints. As of August 2020, a working group has been formed to develop a risk-based compliance strategy, which will include a process for documenting the basis for FDA's decisions about how or whether it followed up on warning letters, adverse event reports, and

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									complaints about drug compounding for animals. FDA anticipates implementing this strategy simultaneously with the finalization of Guidance for Industry #256, which is anticipated to occur at the end of calendar year 2021.
FDA	GAO-16-79	Critical Infrastructure Protection: Sector-Specific Agencies Need to Better Measure Cybersecurity Progress	11/19/2015	4	To better monitor and provide a basis for improving the effectiveness of cybersecurity risk mitigation activities, informed by the sectors' updated plans and in collaboration with sector stakeholders, the Secretaries of Agriculture and Health and Human Services (as co-SSAs) should direct responsible officials to develop performance metrics to provide data and determine how to overcome challenges to monitoring the food and agriculture sector's cybersecurity progress.	Concur	NA	In progress	The Department of Health and Human Services (HHS), as the co-sector specific agency for the food and agriculture sector, with the Department of Agriculture (USDA) continues to implement cybersecurity-related activities for the sector. In particular, through the sector coordination council, they routinely share best practices and informational bulletins from the Department of Homeland Security on cybersecurity with sector stakeholders via the Homeland Security Information Network. In addition, at semi-annual council meetings, they have hosted roundtable discussions of cybersecurity challenges and best practices. No evidence of performance metrics to track and

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									report on the SSAs' activities or the sector's cybersecurity progress has been provided.
FDA	GAO-16-182	Information Technology: FDA Has Taken Steps to Address Challenges but Needs a Comprehensive Strategic Plan	12/17/2015	2	To help ensure that FDA's IT strategic planning activities are successful in supporting the agency's mission, goals, and objectives, the Commissioner of FDA should require the CIO to implement the plan to ensure that expected outcomes of the agency's key IT initiatives are achieved.	Concur	NA	In progress	In September 2019, the FDA Principal Deputy Commissioner and Acting CIO published the FDA's Technology Modernization Action Plan (https://www.fda.gov/media/130883/download). The TMAP describes the actions FDA is taking to modernize IT to advance FDA's public health mission. Additionally, OIMT has defined the five key priority areas that encapsulate the TMAP: (1) User Experience, (2) Financial Management, (3) Cloud Forward, (4) Process Improvements, and (5) People and Culture. Each of the priority areas is led by an OIMT senior leader and supported by a multi-discipline work group. OIMT defined key performance

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									indicators and targets to monitor the performance of the priority areas. Beginning in FY21, quarterly performance reports will be presented to the OIMT Leadership Council.
FDA	GAO-16-192	Drug Safety: FDA Expedites Many Applications, But Data for Postapproval Oversight Need Improvement	1/14/2016	2	To improve the data on tracked safety issues and postmarket studies that are needed for required reporting and for systematic oversight of postmarket drug safety, the Secretary of HHS should direct the Commissioner of FDA to work with stakeholders within FDA to identify additional improvements that could be made to FDA's current database or future information technology investments to capture information in a form that can be easily and systematically used by staff for oversight purposes.	Concur	NA	In Progress	FDA has made changes intended to improve its process for overseeing tracked safety issues, but as of August 2020, FDA was still working on changes to its process for postmarket study data. For tracked safety issues, FDA held a one-day workshop to solicit input from staff on changes to its tracked safety issue process and collect user requirements for a new IT system to support tracking safety issues. In April 2020, FDA finalized new policies and procedures and implemented a new IT system for tracking safety issues. The new IT system allows anyone within FDA's Center for Drug Evaluation and Research to enter new safety signals and has integrated product and adverse event dictionaries. FDA stated that integrating standardized data will support consistent regulatory decisions and improve the quality

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									of analysis. For postmarket studies, FDA has indicated that it intends to formally assess the IT needs of users as part of the planned transfer of postmarket data to its new informatics platform. As of August 2020, FDA anticipated creating a project team to address specific concerns related to postmarket study data by the end of calendar year 2020 or the beginning of calendar year 2021.
FDA	GAO-16-432	Medical Product Oversight: FDA Needs More Strategic Planning to Guide its Scientific Initiatives	6/15/2016	1	In order to improve FDA's strategic planning for regulatory science efforts, we recommend the Secretary of Health and Human Services direct the Commissioner of FDA to develop and document measurable goals, such as targets and time frames, for its regulatory science efforts so it can consistently assess and report on the agency's progress in regulatory science efforts.	Concur	NA	In progress	In September 2018, FDA reportedto GAO the actions of committees developed by each of the centers to oversee their regulatory science activities. In July 2019, FDA indicated that it was revisiting its strategic regulatory science priorities as part of its cyclical strategic planning process, and the centers and various offices have taken steps to address the recommendation. In an August 2020 written response, FDA reported that a committee had undertaken a review its 2011 regulatory science strategic plan that will result in the issuance of an accountability framework--an internal document outlining the type of information that FDA centers and offices will provide to

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									the agency's Chief Scientist to demonstrate progress made in addressing relevant focus areas of regulatory science. FDA reported that its goal was to complete this work by the end of December 2020.
FDA	GAO-16-432	Medical Product Oversight: FDA Needs More Strategic Planning to Guide its Scientific Initiatives	6/15/2016	2	In order to improve FDA's strategic planning for regulatory science efforts, we recommend the Secretary of Health and Human Services direct the Commissioner of FDA to systematically track funding of regulatory science projects across each of its priority areas.	Concur	NA	In progress	In September 2018 and July 2019, FDA described actions taken by each center to better track its regulatory science funding. However, FDA still needed to complete these activities and document that funds are systematically tracked across each of the priority areas. In an August 2020 written response, the agency reported that there continue to be efforts to improve tracking of funds for regulatory science projects in priority areas. Specifically, it described the development of an accountability framework--an internal document outlining the type of information that FDA centers and offices will provide to the agency's Chief Scientist to demonstrate progress made in addressing relevant focus areas of regulatory science. As part of the internal accountability framework, it will track regulatory science

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									projects. FDA reported that its goal was to complete this work by the end of December 2020.
FDA	GAO-16-500	FDA: Comprehensive Strategic Planning Needed to Enhance Coordination Between Medical Product Centers	6/15/2016	1	To ensure that FDA can effectively coordinate and integrate its medical product centers' programs and emerging issues, the Secretary of Health and Human Services should direct the Commissioner of FDA to engage in a strategic planning process to identify challenges that cut across the medical product centers and document how it will achieve measurable goals and objectives in these areas.	Concur	NA	In progress	FDA concurred with the recommendation and in September 2016 and January 2018 described steps it had taken toward strategic planning for its medical product centers. However, in June 2020, FDA informed GAO that there had been several senior leadership changes and its agency-wide strategic planning process was paused to focus on the covid-19 pandemic response. Officials also noted that FDA continues to address existing strategic priorities.

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FDA	OEI-01-14-00390	FDA is Issuing More Postmarketing Requirements, but Challenges with Oversight Persist	7/20/2016	399-915-11-06-05000	FDA should build capacity in DAARTS to support PMR oversight	Concur	2021	In Progress	FDA reports that it is transitioning from DARRTS to a new informatics system with enhanced workflow and content management capabilities, and is testing the IT system to determine whether it meets CDER's needs. CDER anticipates that the project team for PMRs and PMCs will be established by the end of the second quarter of calendar year 2021. FDA also reports that it continues to work with its stakeholders to improve its tracking of PMRs and PMCs and the accuracy of its data. Finally, FDA reports that it expanded PMR and PMC program staff's ability to edit DARRTS data so that they can correct inaccuracies and added personnel to manage daily quality checks and timely entry of PMR and PMC data. FDA reports that it is transitioning from DARRTS to a new informatics system with enhanced workflow and content management capabilities, and is testing the IT system to determine whether it meets CDER's needs. CDER anticipates that the project team for PMRs and PMCs will be established by the end of the second quarter of calendar year 2021. FDA also reports that it

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									continues to work with its stakeholders to improve its tracking of PMRs and PMCs and the accuracy of its data. Finally, FDA reports that it expanded PMR and PMC program staff's ability to edit DARRTS data so that they can correct inaccuracies and added personnel to manage daily quality checks and timely entry of PMR and PMC data.
FDA	OEI-01-14-00390	FDA is Issuing More Postmarketing Requirements, but Challenges with Oversight Persist	7/20/2016	399-915-11-06-04999	FDA should provide a standardized form for ASRs, ensure that they are complete, and require sponsors to submit them electronically	Concur	NA	In Progress	FDA reports that it developed two electronically fillable forms for postmarket requirements and commitments (PMR/PMC) submissions and ASRs (FDA Forms 3988 and 3989). The forms are pending clearance by the Office of Management and Budget. Additionally, FDA developed draft guidance for industry Annual Status Report Information and Other Submissions for Postmarketing Requirements and Commitments: Using Forms FDA 3988 and 3989, which is in the final stage of Center for Drug Evaluation and Research (CDER) clearance and is expected to be available in the second quarter of calendar year

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									2020. FDA has taken steps to standardize these forms and require sponsors to submit them electronically.
FDA	GAO-17-143	Drug Safety: FDA Has Improved Its Foreign Drug Inspection Program, but Needs to Assess the Effectiveness and Staffing of Its Foreign Offices	1/17/2017	1	To help ensure that FDA's foreign offices are able to fully meet their mission of helping to ensure the safety of imported products, as the agency continues to test performance measures and evaluate its Office of International Programs (OIP) strategic workforce plan, the Commissioner of FDA should assess the effectiveness of the foreign offices' contributions by systematically tracking information to measure whether the offices' activities specifically contribute to drug safety-related outcomes, such as inspections, import alerts, and warning letters.	Concur	NA	In progress	In June and July 2018, FDA reported on its recent efforts to assess the effectiveness of the foreign offices' contributions to drug-safety related outcomes. These efforts include the development of new performance measures for these offices along with a monitoring and evaluation plan; strengthened communications and collaboration between the foreign offices and FDA program centers and its Office of Regulatory Affairs; and an assessment of the foreign offices to help set their objectives and ensure the right balance of personnel, skillsets, and resources. However, FDA still had to develop intermediate outcomes to link with final outcomes. In an August 2020 written response, the agency reported that because of a reorganization and strategic planning effort for its Office of Global Policy and Strategy, it was still revising and updating its

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									measures and its approach to evaluating impact in 2020 to align with a five-year strategic plan completed in March 2020.
FDA	GAO-17-189	Antibiotics: FDA Has Encouraged Development, but Needs to Clarify the Role of Draft Guidance and Develop Qualified Infectious Disease Product Guidance	3/2/2017	2	In order for drug sponsors to benefit from FDA's revised guidance on antibiotic development and take full advantage of the QIDP designation, FDA should develop and make available written guidance on the QIDP designation that includes information about the process a drug sponsor must undertake to request the fast track designation and how the agency is applying the market exclusivity incentive.	Concur	NA	In progress	FDA issued draft guidance (a document of frequently asked questions) in January of 2018 that describes the QIDP designation. This document is in draft form and has not yet been finalized. As of August 2020, FDA is working to finalize this guidance this year.

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FDA	GAO-17-192	Antibiotic Resistance: More Information Needed to Oversee Use of Medically Important Drugs in Food Animals	3/16/2017	3	The Secretary of Health and Human Services should direct the Commissioner of FDA to develop performance measures and targets for actions to manage the use of antibiotics such as revising the veterinary feed directive and developing guidance documents on judicious use.	Non-Concur	NA	In progress	In October 2019, FDA announced the availability of performance measures that track the progress of the Center of Veterinary Medicine's (CVM) Five-Year Plan for Supporting Antimicrobial Stewardship in Veterinary Settings. This information is part of FDA-TRACK, a tool that promotes transparency and monitors certain FDA programs through performance measures and projects. CVM's five-year plan is organized under three goals: 1. Align antimicrobial drug product use with the principles of antimicrobial stewardship 2. Foster stewardship of antimicrobials in veterinary settings 3. Enhance monitoring of antimicrobial resistance and antimicrobial drug use in animals To date, FDA has provided information for key projects within goals one and three of CVM's five-year plan. • Key projects for goal one include: bringing all dosage forms of medically important antimicrobial drugs approved for use in animals under veterinary oversight, ensuring that medically important antimicrobial drugs used in the feed or drinking water of food-

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									producing animals have a defined duration of use and updating the list of medically important antimicrobials. • Key projects for goal three include: antimicrobial use in animals and antimicrobial resistance in animals. Key projects and performance measures for goal two of CVM's five-year plan are under development. Once complete, information on goal two will be available in FDA-TRACK. Information in FDA-TRACK will be updated on a semi-annual basis for each project.

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FDA	GAO-17-192	Antibiotic Resistance: More Information Needed to Oversee Use of Medically Important Drugs in Food Animals	3/16/2017	2	The Secretary of Health and Human Services should direct the Commissioner of FDA to establish steps to increase veterinary oversight of medically important antibiotics administered in routes other than feed and water, such as injections and tablets.	Non-Concur	NA	In progress	In September 2018 FDA released a broad, five-year plan outlining the activities and important steps it intends to take to support stewardship of medically important antimicrobials in veterinary settings. As part of that plan, in September 2019, FDA's CVM released draft guidance for industry (GFI) #263 to explain the recommended process for voluntarily bringing remaining approved animal drugs containing antimicrobials of human medical importance (i.e., medically important) under the oversight of licensed veterinarians by changing the approved marketing status from over-the-counter (OTC) to prescription (Rx). This draft GFI provides the framework, including proposed timelines, for transitioning from OTC to Rx marketing status for all approved medically important antimicrobial drugs that are not yet subject to veterinary oversight. In conjunction with issuing this draft strategy, CVM published a list of affected new animal drug applications. Accompanying the publication of draft GFI #263 was the opportunity for the public to submit comments to FDA on the

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									process for voluntarily bringing the remaining approved animal drugs containing antimicrobials of human medical importance under veterinary oversight. FDA offered a 90-day opportunity for stakeholders to provide such feedback, which ultimately resulted in the receipt of over 7,000 comments. FDA has since reviewed the comments and has begun the process to finalize GFI #263 by end of December 2020.
FDA	GAO-17-192	Antibiotic Resistance: More Information Needed to Oversee Use of Medically Important Drugs in Food Animals	3/16/2017	1	The Secretary of Health and Human Services should direct the Commissioner of FDA to develop a process, which may include time frames, to establish appropriate durations of use on labels of all medically important antibiotics used in food animals.	Non-Concur	NA	In progress	Since the time of its last update in 2019, FDA has awarded two $250,000 grants to fund research projects in fiscal year (FY) 2019 aimed to help target and define durations of use for certain medically important antimicrobial drugs approved for use in the feed of food-producing animals. These research projects will generate publicly available data, which can be used by sponsors of affected approved animal drug applications to update product dosage regimens and better target when and for how long a drug may be used. In January 2020, FDA expanded its FY 2019 funding opportunity and announced a new FY 2020 funding

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									opportunity and Request for Applications (RFA) for studies that can generate data to help establish more targeted durations of use for certain medically important antimicrobial drugs approved for use in the feed of food-producing animals. In September 2018, FDA announced its five-year action plan for supporting antimicrobial stewardship in veterinary settings. As part of the five-year action plan, FDA continues its efforts to establish appropriately targeted durations of use for medically important antimicrobial drugs used in the feed or water of food-producing animals. To that end, FDA planned to publish a draft strategy, including deadlines, for how sponsors could submit applications to revise the approved conditions of use of affected new animal drugs later in 2020.
FDA	GAO-17-445	Emerging Infectious Diseases: Actions Needed to Address the Challenges of Respondin	5/23/2017	2	The Secretary of Health and Human Services should direct the Commissioner of the Food and Drug Administration to require manufacturers to list the identity of comparator assays on their diagnostic test labels.	Concur	NA	Awaiting Disposition	In August 2020, FDA reported to GAO that this task has been completed.

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		g to Zika Virus Disease Outbreaks							
FDA	OEI-05-14-00640	Drug Supply Chain Security: Wholesalers Exchange Most Tracing Information	9/12/2017	399-915-11-06-05445	FDA provide technical assistance regarding exempt products	Concur	2022	In Progress	In response to this recommendation, FDA notes it conducts ongoing outreach and education at professional and trade association meetings on what drugs are excluded from the definition of a product (defined under section 581(13) of the FD&C Act). FDA also notes that it responds to individual questions about which products are exempted or excluded from section 582 requirements. FDA has three draft guidances related to product waivers, exceptions, and exemptions.
FDA	OEI-02-14-00420	Challenges Remain in FDA's Inspections of Domestic Food Facilities	9/25/2017	399-915-11-06-05443	FDA should conduct timely follow-up inspections to ensure that significant inspection violations are corrected.	Concur	2022	In Progress	FDA has prioritized follow-up activities after regulatory action as a performance measure indicator. FDA implemented IT system changes through the development of an internal dynamic visual dashboard which displays the percentage of inspections with significant violations. In addition to the visual dashboard, FDA has developed and implemented internal customized reports that track whether OAI follow-up

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									inspections are conducted within 6 months and provide field managers with information in advance to plan accordingly. FDA reports continued efforts to evaluate these new tools to ensure their effectiveness in supporting timely inspection follow-up activities, as well as continued efforts to evaluate its current regulatory case assessment processes to increase operational efficiencies.
FDA	OEI-02-14-00420	Challenges Remain in FDA's Inspections of Domestic Food Facilities	9/25/2017	399-915-11-06-05442	FDA should improve the timeliness of FDA's actions, including warning letters, so that facilities do not continue to operate under harmful conditions.	Concur	2022	In Progress	FDA reported prioritizing follow-up activities after regulatory action as a performance measure indicator, and has developed and implemented internal custom reports to track OAI follow-up inspections conducted within 6 months that provide field managers information to plan accordingly. FDA continues to evaluate these new tools to ensure their effectiveness in supporting timely inspection follow-up activities. In addition, FDA continues to evaluate its current regulatory case assessment processes to increase operational efficiencies. FDA anticipates these changes will facilitate more effective management of compliance and enforcement work, such as the timeliness of warning letters for

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									violations of regulatory significance.
FDA	GAO-17-443	Imported Seafood Safety: FDA and USDA Could Strengthen Efforts to Prevent Unsafe Drug Residues	10/2/2017	1	The Commissioner of FDA should pursue formal agreements with countries exporting seafood to the United States that commit these countries to test for drugs of concern to FDA and the corresponding maximum residue levels (MRLs) that FDA established for these drugs.	Concur	NA	In Progress	FDA is working on a plan to explore the viability of reaching cooperative arrangements with foreign regulatory bodies concerning imported aqua-cultured seafood. In exploring such arrangements, FDAwill seek to explore a means by which the agency can leverage foreign regulatory bodies' seafood safety programs to provide additional oversight for seafood destined for the United States; such arrangements would be negotiated depending on countries' specific situations.

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FDA	GAO-17-443	Imported Seafood Safety: FDA and USDA Could Strengthen Efforts to Prevent Unsafe Drug Residues	10/2/2017	4	The Commissioner of FDA should coordinate and communicate with FSIS in developing drug residue testing methods and corresponding maximum residue levels for imported seafood that may also be applicable to imported catfish.	Concur	NA	In Progress	FDA shared its testing methods for two drugs with FSIS and as of as of April 2019, FSIS and FDA were using the same method for measuring and confirming these two unapproved drugs. In August 2020, FDA told GAO that the agencies convene quarterly to discuss emerging and ongoing research needs in laboratory method development and the establishment of drug residue limits in seafood. However, GAO found that the agencies continue to use different multi-residue testing methods that look for different numbers of drugs--99 for FSIS and 40 for FDA--which results in the agencies using different maximum residue levels for some drugs. FDA's method can detect drugs that FSIS's does not and can detect some drugs at lower levels. FSIS's multi-residue method can detect 59 more drugs than FDA's method. FDA believes it has found that its multi-residue methods are most appropriate for virtually all of the types of seafood that it, unlike FSIS, regulates. (Catfish is the only type of seafood that is currently under FSIS' jurisdiction,) FDA and FSIS do not have any plans to work

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									on a multi-residue method both agencies can use.
FDA	A-01-16-01502	The Food and Drug Administration's Food-Recall Process Did Not Always Ensure the Safety of the Nation's Food Supply	12/22/2017	211-509-10-1	We recommend that FDA develop a policy for defining and a procedure for identifying retrospectively the date that FDA learns of a potentially hazardous product and consider adding a field for the date to the RES or another FDA system so that FDA staff involved in managing a recall have access to this information.	Concur	2021	In Progress	FDA currently is designing a new reporting process, using data collected in existing FDA systems, to record the date that FDA learns of certain potentially hazardous food. For foods in the first category, it will be the date that the final lab classification is entered into the Field Accomplishments and Compliance Tracking System (FACTS), based on analytical results from an FDA laboratory or a mutually reliant state regulatory laboratory. For foods in the second category, it will be the date that the traceback investigation has produced actionable information about the source of the product. We will consider how best to document these dates in our data systems, including whether to add new data fields in RES.

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FDA	A-01-16-01502	The Food and Drug Administration's Food-Recall Process Did Not Always Ensure the Safety of the Nation's Food Supply	12/22/2017	212-919-11-1	We recommend that FDA establish performance measures for the amount of time between the date FDA learns of a potentially hazardous product and the date a firm initiates a voluntary recall, monitor performance, and refine operating procedures, as needed.	Concur	2021	In Progress	FDA will establish performance measures for the amount of time between the date FDA learns of a potentially hazardous food, as described in response to Recommendation 10, and the date a firm initiates a voluntary recall. Once we have finalized the design of the new report, we will begin monitoring performance against the metric and will refine operating procedures as needed.
FDA	A-01-16-01502	The Food and Drug Administration's Food-Recall Process Did Not Always Ensure the Safety of the Nation's Food Supply	12/22/2017	299-929-10-2	We recommend that FDA ensure, through its recall audit plan, that audit checks are issued at the level specified in the FDA audit program.	Concur	2021	In Progress	FDA is working to make changes in its recall audit plan to include a verification that audit checks are issued at the level specified for that recall. The FDA is also reviewing the process to see if it would be feasible and effective to standardize the number of recall audit checks that should be completed based on the number of direct consignees that were identified as having received the recalled product, resources available to conduct recall audit checks, and the hazard of the recalled product.

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FDA	GAO-18-140	FDA Medical Device Reviews: Evaluations is Needed to Assure Requests for additional Information Follow a Least Burdensome Approach	1/16/2018	1	The Commissioner of FDA should develop performance metrics and use them to evaluate the implementation of the least burdensome requirements, such as during its planned audits of medical device deficiency letters	Concur	NA	In Progress	In July 2019, FDA reported on efforts to increase device staff knowledge of least burdensome requirements and the implementation of a "least burdensome flag," which allows the submitter to flag a submission for FDA if it believes that the agency's request is not the least burdensome or that it was being held to an inappropriate review standard. In August 2020, FDA described its analysis of the flags, including the number of times it was used and the time it took to resolve them relative to FDA's goal. FDA will continue to monitor the usage of the flag program to identify signals or trends that should be addressed.

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FDA	GAO-18-174	Food Safety and Nutrition: FDA Can Build on Existing Efforts to Measure Progress and Implement Key Activities	3/5/2018	2	The Commissioner of FDA should ensure that the FVM Program develops performance measures with associated targets and time frames for all eight of FDA's food safety- and nutrition-related objectives.	Concur	NA	In Progress	As of August 2020, FDA has not fully implemented GAO's recommendation, although FDA is taking several steps. For example, the implementation of Food Safety Modernization Act (FSMA) based preventive controls standards is a top priority for the agency and a key component of the Foods and Veterinary Medicine Program's strategic plan, and for this reason, FSMA-related performance metrics have been prioritized. In addition, FDA reported that in September 2019, the agency published an online Food Safety Dashboard, whose purpose is to measure the progress of each of the FSMA rules, and FDA provides regular updates to the dashboard to promote transparency to the public. As of June 2020, the dashboard contains measures related to Preventive Controls and Current Good Manufacturing Practice Rules and Imported Food Safety Program, and it includes data for human and animal food and, in some cases, data starting in FY 2017. Since the FSMA rules have staggered compliance dates, the measures associated with the rules are developed in phases, and over time, the Food Safety Dashboard

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									will be populated with additional data to show more FSMA-related outcomes. In August 2020, FDA told GAO that, given the agency's 2018 reorganization, FDA has aligned the performance measures and dashboard with the FSMA rules, and the current alignment covers most of the food safety objectives within the strategic plan. FDA also reported to GAO that it is reviewing the strategic plan to ensure alignment with FDA's current priorities and structure, including the recently released New Era of Smarter Food Safety Blueprint.
FDA	GAO-18-199	Food Safety: Federal Efforts to Manage the Risk of Arsenic in Rice	4/16/2018	1	The Commissioner of FDA should develop a timeline for updating the risk assessment on arsenic in rice.	Concur	NA	In Progress	As of August 2020, FDA will update the risk assessment when more scientific evidence becomes available. In the meantime, FDA will continue to monitor research in this area, including ongoing work by the National Academies of Sciences (NAS) Board on Environmental Studies and Toxicology, which is currently reviewing EPA's work on inorganic arsenic, specifically on EPA's IRIS Toxicological Assessments of Inorganic Arsenic.

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FDA	A-18-16-30530	The Food and Drug Administration's Policies and Procedures Should Better Address Postmarket Cybersecurity Risk to Medical Devices	10/29/2018	503-502-10-2	We recommend that FDA establish written procedures and practices for securely sharing sensitive information about cybersecurity events with key stakeholders who have a "need to know."	Concur	2021	In Progress	Per an October 15, 2018 Memorandum of Agreement (MOU 225-19-002) between FDA and Department of Homeland Security's National Protection and Programs Directorate (NPPD), FDA is in the process of drafting a secure information sharing and exchange work standard operating procedure with DHS, which it expected to complete in 2020.
FDA	OEI-01-17-00090	Most Hospitals Obtain Compounded Drugs From Outsourcing Facilities, Which Must Meet FDA Quality Standards	6/6/2019	399-915-11-06-05856	FDA should take appropriate followup action with the unregistered compounding facilities on the list that we provided	Concur	2021	In Progress	FDA reviewed the list of compounding facilities provided by OIG and identified firms for inspection. FDA has completed inspections on a number of these sites and confirmed distribution of non-patient-specific drugs in some cases. Some of FDA's inspections also identified some objectionable conditions which led to recalls. FDA will continue to take appropriate follow up actions with regard to these firms and anticipates that inspections would be completed by September 2020. OIG's recommendation calls for FDA to take appropriate follow-up action with unregistered

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									compounders based on the list OIG provided.
FDA	OEI-01-17-00090	Most Hospitals Obtain Compounded Drugs From Outsourcing Facilities, Which Must Meet FDA Quality Standards	6/6/2019	399-915-11-06-05855	FDA should further communicate to hospitals the importance of obtaining NPS compounded drugs from outsourcing facilities	Concur	2021	In Progress	FDA noted that it regularly engages with hospital and health-system stakeholders regarding drug compounding and applicable law and policy, including at annual listening sessions, which occurred most recently in June 2019. FDA intends to continue these efforts. FDA noted that it regularly engages with hospital and health-system stakeholders regarding drug compounding and applicable law and policy, including at annual listening sessions, which occurred most recently in June 2019. FDA intends to continue these efforts. Additionally, FDA continues to develop policy on compounding in the hospital and health-system setting, which will provide additional clarity to these entities. FDA will continue to post information about its oversight actions relevant to outsourcing facilities on its website, as well as information provided by outsourcing facilities about the

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									products they have recently produced. FDA believes these tools have and will continue to inform hospital considerations about sourcing products from outsourcing facilities. Finally, FDA is establishing a Compounding Quality Center of Excellence that will focus on outsourcing facilities. The center will raise awareness and provide trainings on current good manufacturing practice requirements and host a conference in September 2020.
FDA	GAO-19-391	Food Loss and Waste: Building on Existing Federal Efforts Could Help to Achieve National Reduction Goal	6/21/2019	1	The Commissioner of FDA should work with the Administrator of EPA and Secretary of Agriculture to incorporate leading collaboration practices as they implement their interagency FLW reduction strategic plan, to include (1) agreeing on roles and responsibilities; (2) developing mechanisms to monitor, evaluate, and report on results; (3) clearly defining short- and long-term outcomes; (4) identifying how leadership commitment will be sustained; and (5) ensuring that the relevant stakeholders	Concur	NA	In Progress	

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					have been included in the collaborative effort.				
FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-1	We recommend that FDA update its registered entities' security plans to include procedures for notifying FSAP if a select agent shipment is not received within 48 hours after the expected time of delivery.	Concur	2021	In Progress	

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FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-2	We recommend that FDA update its registered entities' security plans to include procedures for notifying FSAP if a select agent package is received damaged to the extent that a release of the select agent may have occurred.	Concur	2021	In Progress	
FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-3	We recommend that FDA update its registered entities' security plans to include procedures for notifying FSAP if a select agent shipment will not be completed within 30 calendar days after transfer authorization issuance.	Concur	2021	In Progress	

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FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-4	We recommend that FDA update its registered entities' security plans to include procedures for notifying FSAP if a select agent transfer authorization becomes void because the facts supporting the authorization changed.	Concur	2021	In Progress	
FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-5	We recommend that FDA ensure that its registered entities verify and maintain documentation to assure that employees who are required to have select agent training understand the training received.	Concur	2021	In Progress	

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FDA	A-03-16-00354	The Food and Drug Administration Generally Complied With Federal Requirements for the Preparation and Receipt of Select Agent Shipments	6/26/2019	331-908-10-6	We recommend that FDA Update its policies for shipping inactivated select agents to require that its registered entities record a description of the viability testing protocol used, the names of the personnel who inactivated the select agent, and the location of the inactivation.	Concur	2021	In Progress	
FDA	GAO-19-565	Generic Drug Applications: FDA Should Take Additional Steps to Address Factors that May Affect Approval Rates in the First Review Cycle	8/7/2019	1	GAO recommends that FDA take additional steps to address inconsistency in its written comments to generic drug application sponsors.	Concur	NA	In Progress	As of August 2020, FDA is evaluating methods to improve the clarity and content of primary reviewer comments by developing and providing training and work aids on written communication to ensure that FDA conveys deficiency comments in a clear and consistent manner to applicants; best practices on ensuring consistency in deficiency comments will be shared with primary reviewers. In addition, FDA is reviewing current training and providing coaching for secondary reviewers to exchange, compare, discuss, and improve the content and consistency of common

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									deficiencies communicated in primary reviewer comments.
FDA	GAO-19-565	Generic Drug Applications: FDA Should Take Additional Steps to Address Factors that May Affect Approval Rates in the First Review Cycle	8/7/2019	2	GAO recommends that FDA assess the extent to which the timing of brand-name drug companies' drug labeling changes affects the approval of generic drugs and take steps, as appropriate, to limit the effect.	Concur	NA	In Progress	As of August 2020, FDA is identifying and assessing examples of applications in which the brand-name drug company submitted a supplemental application for a labeling change that impacted the timeline of the generic drug approval. After gathering data, FDA officials will assess what particular actions could address this issue, including whether FDA has the authority to take any such identified actions.

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FDA	A-07-18-03231	The Food and Drug Administration Did Not Submit Clearance Documents for Any Audit Recommendations During Fiscal Years 2015 and 2016 but Has Since Made Significant Progress	8/20/2019	214-920-10-1	We recommend that the Food and Drug Administration finalize and implement formal policies and procedures for resolving program and IT audit recommendations, similar to the Framework that FDA has implemented for resolving Single Audit recommendations, which include issuing management decisions and submitting related OCDs to OIG within the required 6-month resolution period.	Concur	2021	In Progress	
FDA	A-07-18-03231	The Food and Drug Administration Did Not Submit Clearance Documents for Any Audit Recommendations During	8/20/2019	214-921-10-2	We recommend that the Food and Drug Administration promptly resolve the 32 outstanding audit recommendations (166 that were past due as of September 30, 2016, less 134 resolved after the end of our audit period).	Concur	2021	In Progress	

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		Fiscal Years 2015 and 2016 but Has Since Made Significant Progress							
FDA	A-07-18-03231	The Food and Drug Administration Did Not Submit Clearance Documents for Any Audit Recommendations During Fiscal Years 2015 and 2016 but Has Since Made Significant Progress	8/20/2019	214-920-10-3	We recommend that the Food and Drug Administration reconcile each month the OIG stewardship reports (or the HHS electronic Single Audit recommendation listing for audits processed on or after October 1, 2018) with FDA's audit resolution records and follow up on any differences noted.	Concur	2021	In Progress	

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FDA	GAO-19-407	Date Labels on Packaged Foods: USDA and FDA Could Take Additional Steps to Reduce Consumer Confusion	9/9/2019	1	The Commissioner of FDA should work with the Secretary of Agriculture to develop a mechanism to facilitate coordination with relevant nonfederal stakeholders, including state, local, and tribal governments, on actions related to date labels as part of their efforts to reduce food loss and waste.	Concur	NA	In Progress	FDA is taking actions to implement the recommendation. As of August 2020, FDA is meeting regularly with USDA and EPA to coordinate activities including to clarify and communicate information on food date labels. FDA also named a representative to the Association of Food and Drug Officials (AFDO) Food Recovery Committee. FDA is encouraging the Committee to explore how date labels on packaged foods can create a barrier to food donation and to track state legislative activities related to date labeling of food.
HRSA	OEI-05-03-00170	Status of the Rural Health Clinic Program	8/1/2005	307-915-12-04-02391	HRSA should publish regulations to revise its shortage-designation criteria.	Concur	2021	In Progress	Health Professional Shortage Areas (HPSAs) are statutorily required to be reviewed annually and updated as necessary. HRSA has no statutory or other authority to mandate updates to Medically Underserved Areas or Medically Underserved Populations once they are designated. CMS, which certifies Rural Health Clinics, has not put forward a regulation outlining a process to decertify Rural Health Clinics once they have been certified. As a result, as shortage designations are reviewed and de-designated for no longer meeting the criteria, a number of Rural Health Clinics will continue

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									to exist outside of Health Professional Shortage Areas or Medically Underserved Areas, regardless of any updates HRSA may make to shortage designation regulations or to the Index of Medical Underservice. HRSA will continue to work with HHS and OIG to close this recommendation.
HRSA	OEI-12-04-00310	HHS Agencies' Compliance with the National Practitioner Data Bank Malpractice Reporting Policy	10/11/2005	399-900-11-04-02675	HRSA should implement a corrective action process that would address unreported cases.	TBD	2021	In Progress	HHS continues to comply with Federal law and the Health Care Quality Improvement Act of 1986, which created the NPDB. Through its Medical Claims Review Panel (MCRP) chartered by the Secretary, HHS reviews claims for damage, injury, or death filed under the Federal Tort Claims Act (FTCA) against an HHS facility or health care practitioner covered under the FTCA.
HRSA	GAO-07-52	Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages	11/30/2006	1	To better account for physicians practicing in underserved areas through the use of J-1 visa waivers, the Secretary of Health and Human Services should collect and maintain data on waiver physicians--including information on their numbers, practice locations, and practice specialties--and use this information when identifying areas	Concur	2021	In Progress	The Department of Homeland Security (DHS) Citizenship and Immigration Services issues J-1 Visa waivers to physicians. DHS does not report data on physicians granted J-1 Visa waivers to HHS. Because HHS does not have legal or regulatory authority to collect detailed data on J-1 Visa-waivered physicians, HRSA is not in a position to maintain a complete and accurate list of physicians granted J-1 Visa waivers. However, HRSA

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					experiencing physician shortages and placing physicians in these areas.				has taken steps to better understand the distribution of J-1 Visa-waivered physicians, including by working with states' Primary Care Offices that report data on physicians with J-1 Visa waivers when submitting information to HRSA for shortage designation purposes. As Conrad 30 J-1 Visa-waivered physicians are cumulatively the greatest bulk of placements nationally, this accounting provides substantial data for the purposes of shortage designation. HRSA will work with HHS and GAO to close this recommendation.

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HRSA	OEI-05-09-00321	State Medicaid Policies and Oversight Activities Related to 340B-Purchased Drugs	6/14/2011	303-905-13-04-02233	HRSA should share 340B ceiling prices with States	Concur	2021	In Progress	HRSA previously explained that the OIG recommendation related to sharing 340B ceiling prices directly with states cannot be implemented without an amendment to the 340B statute. HRSA further explained that it would explore whether a mechanism could be established whereby HRSA would provide the prices to CMS, who in turn, would provide the information to states. HRSA examined the latter option and determined that it is unable to implement that option without a change to the 340B statute. Section 340B(d)(1)(B)(iii) of the Public Health Service Act requires that internet access to the 340B ceiling prices for covered outpatient drugs, as calculated and verified by the Secretary, be limited to covered entities, and the Secretary must assure the "…security and protection of privileged pricing data from unauthorized re-disclosure." The 340B statute is specific to limiting access to this internet pricing data to covered entities and does not permit HRSA to give data access to the states. HRSA is obligated to secure and protect the "privileged pricing data," which includes the underlying data elements HRSA

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									collects from manufacturers and uses to calculate the 340B ceiling prices, as well as the actual 340B ceiling prices. Sharing the ceiling price data with the states would jeopardize disclosure of confidential pricing data as outlined above. Therefore, HRSA continues to believe that this recommendation cannot be implemented without a change to the 340B statute.
HRSA	GAO-11-836	Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs	9/23/2011	2	PPACA contained several important program integrity provisions for the 340B program, and additional steps can also ensure appropriate use of the program. Therefore, the Secretary of HHS should instruct the administrator of HRSA to finalize new, more specific guidance on the definition of a 340B patient.	Concur	NA	In Progress	HRSA conducted an evaluation of its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily administered by guidance. HRSA's enforcement ability is limited, as guidance does not provide HRSA appropriate enforcement capability. Therefore, HRSA has requested regulatory authority in the President's Budget each year since FY 2017 and has

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		Improvement							again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. Therefore, HRSA is not pursing new guidance under the Program at this time. The FY 2021 President's Budget includes a proposal to provide HRSA comprehensive regulatory authority. If this proposal were enacted, HRSA could regulate on patient definition.
HRSA	GAO-11-836	Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement	9/23/2011	4	PPACA contained several important program integrity provisions for the 340B program, and additional steps can also ensure appropriate use of the program. Therefore, the Secretary of HHS should instruct the administrator of HRSA to issue guidance to further specify the criteria that hospitals that are not publicly owned or operated must meet to be eligible for the 340B program.	Concur	NA	In Progress	HRSA conducted an evaluation of its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily administered by guidance. HRSA's enforcement ability is limited, as guidance does not provide HRSA appropriate enforcement capability. Therefore, HRSA has requested regulatory authority in the President's Budget each year since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would

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									provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program. Therefore, HRSA is not pursing new guidance under the Program at this time. The FY 2021 President's Budget includes a proposal to provide HRSA comprehensive regulatory authority. If this proposal were enacted, HRSA could further define hospital eligibility criteria in regulations.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	1	The Administrator of HRSA should require covered entities to register contract pharmacies for each site of the entity for which a contract exists.	Non-Concur	NA	Awaiting Disposition	HRSA continues to believe that our current process is responsive to GAO's recommendation for covered entity types other than hospitals and health centers. Because HRSA recognizes relationships of hospitals and health centers in a different manner (parent and child), and for administrative burden reasons, HRSA only requires that a contract pharmacy register with the parent covered entity, notwithstanding that child sites can still utilize that pharmacy. HRSA does require all covered entity sites and contract pharmacy sites to be listed on the written contract, and this information is audited by HRSA. In addition, for the FY 2019 audit cycle, HRSA strengthened its risk-

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									based audit strategy by including an assumption that all contract pharmacies registered with the parent entity would also be used by the child sites, prior to randomly selecting covered entities for audit.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	5	The Administrator of HRSA should require all covered entities to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans, and incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of noncompliance.	Non-Concur	NA	Awaiting Disposition	Beginning April 1, 2018, HRSA requires entities that are subject to target audits and re-audits to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans and to incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of non-compliance. If implemented, GAO's recommendation could create a significant burden for all covered entities requiring them to produce additional documentation. HRSA has an efficient audit process to ensure that if there is a compliance issue, covered entities are able to resolve the issue quickly and work in good faith with the manufacturer to determine if repayments may be owed.

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HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	6	The Administrator of HRSA should require all covered entities to provide evidence that their corrective action plans have been successfully implemented prior to closing audits, including documentation of the results of the entities' assessments of the full scope of noncompliance identified during each audit.	Non-Concur	NA	Awaiting Disposition	Beginning April 1, 2018, HRSA requires entities that are subject to target audits and re-audits to specify their methodology for identifying the full scope of noncompliance identified during the audit as part of their corrective action plans and to incorporate reviews of the methodology into their audit process to ensure that entities are adequately assessing the full scope of non-compliance. Requiring all entities to provide evidence and documentation could create a significant burden for covered entities to comply with the additional documentation needed as part of the audit. HRSA has an efficient audit process to ensure that if there is a compliance issue, covered entities are able to resolve the issue quickly and work in good faith with the manufacturer to determine if repayments may be owed.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract	6/28/2018	2	The Administrator of HRSA should issue guidance to covered entities on the prevention of duplicate discounts under Medicaid managed care, working with CMS as HRSA deems necessary to coordinate with	Concur	NA	In Progress	HRSA continues to believe that this recommendation can only be accomplished after policy is issued. HRSA conducted an evaluation of its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		Pharmacies Needs Improvement			guidance provided to state Medicaid programs.				administered by guidance. HRSA's enforcement ability is limited, as guidance does not provide HRSA appropriate enforcement capability. Therefore, HRSA has requested regulatory authority in the President's Budget each year since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	3	The Administrator of HRSA should incorporate an assessment of covered entities' compliance with the prohibition on duplicate discounts, as it relates to Medicaid managed care claims, into its audit process after guidance has been issued and ensure that identified violations are rectified by the entities.	Concur	NA	In Progress	HRSA continues to believe that this recommendation can only be accomplished after policy is issued. HRSA updated its audit policy in April 2018 by adding an area for improvement (AFI) when Medicaid managed care claims were identified in audits where the covered entity was at risk for non-compliance. HRSA conducted an evaluation of its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily administered by guidance. HRSA's enforcement ability is limited, as guidance does

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									not provide HRSA appropriate enforcement capability. Therefore, HRSA has requested regulatory authority in the President's Budget each year since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	4	The Administrator of HRSA should issue guidance on the length of time covered entities must look back following an audit to identify the full scope of noncompliance identified during the audit.	Concur	NA	In Progress	HRSA continues to believe that this recommendation can only be accomplished after policy is issued. HRSA conducted an evaluation of its audit process and other program integrity efforts as they relate to HRSA's ability to enforce and require corrective action in a Program that is primarily administered by guidance. HRSA's enforcement ability is limited, as guidance does not provide HRSA appropriate enforcement capability. Therefore, HRSA has requested regulatory authority in the President's Budget each year since FY 2017 and has again requested this in the FY 2021 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would

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									provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.
HRSA	GAO-18-480	Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement	6/28/2018	7	The Administrator of HRSA should provide more specific guidance to covered entities regarding contract pharmacy oversight, including the scope and frequency of such oversight.	Concur	NA	In Progress	HRSA is currently evaluating its audit process and overall program integrity efforts. This evaluation is centered on HRSA's ability to enforce program guidance that is not tied to the statute or regulations. Existing guidance does not provide HRSA appropriate enforcement capability. HRSA has requested regulatory authority in every President's Budget since FY 2017 and has again requested this in the FY 2020 President's Budget. Binding and enforceable regulations for all aspects of the 340B Program would provide HRSA the ability to more clearly define and enforce policy and would significantly strengthen HRSA's oversight of the Program.

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IHS	GAO-14-255	Native American Housing: Additional Actions Needed to Better Support Tribal Efforts	3/27/2014	2	To increase consistency and reduce time and predevelopment cost for NAHASDA grant recipients, an interagency effort similar to that of the federal infrastructure task force but specific to tribal housing should be initiated with participants from Indian Health Service, HUD, Department of the Interior, and the U.S. Department of Agriculture to develop and implement a coordinated environmental review process for all agencies overseeing tribal housing development. In addition, the agencies should determine if it would be appropriate to designate a lead agency in this effort.	Concur	NA	In Progress	In March 2018, GAO informed the IHS that in order to close this recommendation the implementation plan must be finalized by the interagency workgroup. The implementation plan will require additional review by the full workgroup before the workgroup will be able to finalize the plan. The implementation plan is still in final draft, which is under review by the workgroup led by the Department of Housing and Urban Development (HUD). IHS provided additional feedback to HUD regarding the final draft implementation plan in July 2018. In June 2019, the IHS Director sent a letter to the HUD Deputy Assistant Secretary for Native American Programs requesting a status update on HUD actions to move the workgroup forward to finalize the plan. In June 22, 2020, HUD reconvened the NEPA Workgroup. The IHS NEPA Coordinator asked HUD to prioritize approval of the draft implementation plan. HUD agreed, but noted that because the Council on Environmental Quality (CEQ) is revising government-wide NEPA regulations, the draft plan will need

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									to be updated by the Workgroup before being approved.
IHS	GAO-15-588	Buy Indian Act: Bureau of Indian Affairs and Indian Health Services Need Greater Insight into Implementation of Regional Offices	7/9/2015	1	To ensure consistent implementation of the Buy Indian Act procurement authority across the agencies and to enhance oversight of implementation of the Act at regional offices, the Secretaries of the Interior and Health and Human Services should direct the Bureau of Indian Affairs and Indian Health Service respectively, to clarify and codify their policies related to the priority for use of the Buy Indian Act, including whether the Buy Indian Act	Concur	NA	In Progress	HHS published the IHS Buy Indian Act Notice of Proposed Rulemaking (NPRM) to the Federal Register (FR) on November 10, 2020. The 60 day comment period for the FR Buy Indian Act NPRM closes January 11, 2021. The first two of a series of Buy Indian Act Tribal Consultations were conducted on November 9 and 16, 2020. Tribal comments and questions received during the two consultations supported the proposed rule. The IHS plans to conduct additional Tribal Consultations. Once the FR comment period has closed, the IHS will review and respond to all formal comments submitted to the

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					should be used before other set-aside programs.				federal docket and work to finalize and publish the final rule. IHS antipcates requesting GAO close this recommendation as implemented in 2021.
IHS	GAO-15-588	Buy Indian Act: Bureau of Indian Affairs and Indian Health Services Need Greater Insight into Implementation of Regional Offices	7/9/2015	3	To ensure consistent implementation of the Buy Indian Act procurement authority across the agencies and to enhance oversight of implementation of the Act at regional offices, the Secretaries of the Interior and Health and Human Services should direct the Bureau of Indian Affairs and Indian Health Service respectively, to collect data on regional offices' implementation of key requirements, such as challenges to self-certification.	Concur	NA	In Progress	Once the IHS has promulgated its new Buy Indian policy the IHS will revisit how to collect data on regional/area offices' implementation of key policy requirements, including monitoring authentication of contractor credentials.

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IHS	A-07-15-04221	Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported	3/22/2016	081-009-01-1	We recommend that Rocky Boy refund to the Federal Government $37,259 in overpaid travel expenses for FYs 2011 and 2012.	Concur	2017	Awaiting Disposition	Confirmed reimbursement to HHS.
IHS	OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	399-915-11-07-05137	IHS should continue to seek new meaningful ways to monitor hospital quality through the use of outcomes and/or process measures	Concur	2021	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
IHS	OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	399-915-11-07-05138	IHS should continue to invest in training for hospital administration and staff, and assess the value and effectiveness of training efforts	Concur	2021	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.

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IHS	OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	399-915-11-07-05136	IHS should establish standards and expectations for how Area Offices/ Governing Boards oversee and monitor hospitals and monitor adherence to those standards	Concur	2021	In Progress	Implementation plan focused on establishment of the IHS Office of Quality. The reorganization establishing the OQ was effective January 2019. Implementation is underway.
IHS	OEI-06-14-00010	Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care	10/6/2016	399-915-11-07-05135	IHS should implement a quality-focused compliance program to support Federal requirements for health care programs	Concur	2020	In Progress	Implementation plan focused on establishment of the National Compliance Program in January 2020. Implementation is underway.
IHS	OEI-06-14-00011	Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care	10/6/2016	399-915-11-07-05141	IHS should conduct a needs assessment culminating in an agency wide strategic plan with actionable initiatives and target dates	Concur	2019	In Progress	IHS Stategic Plan issued in 2019

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IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	503-503-10-2	We recommend IHS deem a risk of the lack of continuity of operations to be unacceptable and take immediate action to assess all IHS facilities and ensure each facility has a tested and viable continuity of operations program to respond to and recover from a range of disasters.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.
IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and	11/28/2017	503-503-10-4	We recommend that IHS develop and implement logical access-control procedures to ensure compliance with the principle of least privilege and conduct periodic privilege-based access reviews to remove unnecessary access to RPMS.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.

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		Opioid Dispensing but Could Still Improve Controls							
IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	503-503-10-5	We recommend that IHS perform adequate information security risk assessments at all IHS hospitals in accordance with NIST 800-30.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.

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IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	503-503-10-6	We recommend IHS identify all hospitals with unsupported networking equipment and implement a system development life cycle plan to ensure hardware and software replacement before EOL.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.
IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and	11/28/2017	503-503-10-7	We recommend that IHS determine if local IHS hospital system administrators are adequately trained to ensure compliance with all flaw remediation and vulnerability management procedures and, if not, develop and implement a training program.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.

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		Opioid Dispensing but Could Still Improve Controls							
IHS	A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Dispensing but Could Still Improve Controls	11/28/2017	503-503-10-8	We recommend that IHS ensure that all vulnerabilities identified during vulnerability scanning are remediated in accordance with Federal requirements.	Concur	2021	In Progress	Progress report submitted to OIG in September 2020.

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IHS	A-07-16-05091	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied With Federal Requirements and Its Own Policy	4/12/2018	081-918-10-1	We recommend that IHS reemphasize the requirements for the use of the travel card to ensure that all travel cardholders are aware of the requirements	Concur	2020	In Progress	FMD submitted to OIG 11/17/2020.
IHS	A-07-16-05091	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied With Federal	4/12/2018	081-918-10-2	We recommend that IHS ensure that travel card usage is adequately monitored for compliance with the travel card requirements.	Concur	2020	In Progress	FMD submitted to OIG 11/17/2020.

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		Requirements and Its Own Policy							
IHS	GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	1	The Director of IHS should implement a targeted, resource-efficient method to identify additional eligible Indian homes that may have existing deficiencies to include in IHS's Home Inventory Tracking System (HITS).	Concur	NA	Awaiting Disposition	The IHS Headquarters office of Sanitation Facilities Construction (SFC) Program issued a memo in August 2018 to IHS Area SFC Directors, directing them to leverage the annual sanitation needs data gathering and reporting period to work collaboratively with tribes to identify additional eligible Indian homes with deficiencies that can be included in HITS. An analysis shows that an additional 976 eligible Indian homes were identified with existing deficiencies after the memo was issued. IHS antipcates requesting GAO close this recommendation as implemented in 2021.

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IHS	GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on Tribal Projects	6/14/2018	2	The Director of IHS should implement a mechanism to indicate in HITS whether each home with a deficiency level of 0 has been assessed.	Concur	NA	Awaiting Disposition	The IHS implemented a new mechanism to indicate in HITS when a home currently classified with a deficiency level (DL) of 0 has been assessed. IHS antipcates requesting GAO close this recommendation as implemented in 2021.
IHS	GAO-18-309	Drinking Water and Wastewater Infrastructure: Opportunities Exist to Enhance Federal Agency Needs Assessment and Coordination on	6/14/2018	7	The Director of IHS, in cooperation with other members of the tribal infrastructure task force, should review the 2011 task force report and identify and implement additional actions to help increase the task force's collaboration at the national level.	Concur	NA	Awaiting Disposition	The IHS, in cooperation with other members of the tribal infrastructure task force (ITF), reviewed the 2011 task force report recommendations and identified/implemented actions to help increase the task force's collaboration at the national level. The document provided at https://www.epa.gov/tribal/progress-addressing-recommendations summarizes the EPA and ITF's responses to the 2011 Report and it demonstrates the significant progress the ITF has made to address the recommendations. IHS antipcates requesting GAO close

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		Tribal Projects							this recommendation as implemented in 2021.
IHS	A-07-16-05090	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Purchase Card Program Complied With Federal Requirements and Its Own Policy	7/5/2018	217-904-10-1	We recommend that IHS strengthen controls to ensure that purchase cardholders comply with Federal requirements and IHS's own policy by ensuring that purchase card usage is adequately monitored for compliance with Federal requirements and IHS's own policy.	Concur	2020	In Progress	FMD submitted to OIG 11/24/2020.

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IHS	A-07-16-05090	The Indian Health Service's Controls Were Not Effective in Ensuring That Its Purchase Card Program Complied With Federal Requirements and Its Own Policy	7/5/2018	217-904-10-2	We recommend that IHS strengthen controls to ensure that purchase cardholders comply with Federal requirements and IHS's own policy by ensuring that all IHS purchase cardholders complete the HHS-required training on the use of the purchase card to ensure compliance with Federal requirements and IHS's policy.	Concur	2020	In Progress	FMD submitted to OIG 11/24/2020.
IHS	GAO-18-580	Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies	8/15/2018	1	The Director of IHS should obtain, on an agency-wide basis, information on temporary provider contractors, including their associated cost and number of full-time equivalents, and use this information to inform decisions about resource allocation and provider staffing.	Concur	NA	In Progress	The IHS developed a contract provider cost tracking system and pilot tested it in February 2020. Implementation of the tracking system was delayed until June 2020 because of the COVID-19 pandemic, but is now implemented across the agency. IHS antipcates requesting GAO close this recommendation as implemented in 2021.

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IHS	A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	214-909-10-1	We recommend that IHS promptly resolve the 513 outstanding audit recommendations that were past due as of September 30, 2016.	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
IHS	A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	214-919-10-1	We recommend that IHS update policies and procedures related to the Federal audit resolution process to include specifying the detailed steps to be taken to ensure that management decisions are issued within the required 6-month resolution period.	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
IHS	A-07-17-03227	The Indian Health Service Did Not Always Resolve	9/24/2018	214-920-10-1	We recommend that IHS follow its policies and procedures related to the non-Federal audit resolution process to ensure that management decisions are	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		Audit Recommendations in Accordance With Federal Requirements			issued within the required 6-month resolution period.				
IHS	A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal Requirements	9/24/2018	214-920-10-2	We recommend that IHS follow the quarterly reconciliation process that it implemented at the end of our audit period.	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
IHS	A-07-17-03227	The Indian Health Service Did Not Always Resolve Audit Recommendations in Accordance With Federal	9/24/2018	214-920-10-3	We recommend that IHS give higher priority to audit resolution so that the audit resolution process is conducted in accordance with Federal requirements	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.

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		Requirements							
IHS	GAO-19-291	VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans	4/22/2019	1	As VA and IHS revise the MOU and related performance measures, the Director of IHS should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets.	Concur	2021	In Progress	Due to the COVID-19 pandemic, the IHS and VA continue to deliberate on a revised completion date for the updated new MOU in fiscal year 2021. The IHS and VA have considered initial input from prior listening sessions and will conduct Tribal Consultation prior to finalizing the MOU. On December 2, 2020, IHS and VA jointly initiated Tribal Consultation to seek input from Tribal Leaders on a revised DRAFT MOU through Feb. 12, 2021. In parallel, IHS initiated urban confer to seek input from Urban Indian Organization Leaders. The Tribal Consultation includes an informational Webinar on Dec. 9, 2020, followed by a series of listening sessions to launch in January 2021.

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IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-901-10-1	IHS work with hospitals to analyze opioid data to make decisions and oversee providers to minimize prescribing practices that exceed daily MME guidelines established by IHS, co-prescribe opioids and benzodiazepines, and use opioids for acute pain	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	299-904-10-1	IHS work with hospitals to ensure opioid dispensing data are complete, accurate, and submitted in a timely manner to the State PDMP for use by providers and pharmacists	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

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		g Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-905-10-1	We recommend that IHS revise the IHM to: include the type of action a provider should take and what documentation to include in the patient's EHR when a UDS is unfavorable.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-905-10-2	IHS revise the IHM manual to require area offices to submit completed annual reviews to IHS headquarters;	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	299-905-10-3	IHS work with hospitals to: ensure pain management and related documentation is done in accordance with IHS policies and procedures	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

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		g Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-905-10-4	IHS work with hospitals to develop policies and procedures to review the EHRs of patients with opioid prescriptions from non-IHS providers and document the results of the review in the EHR, particularly for those patients who had previously violated their COT agreements	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

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IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-905-10-5	IHS work with hospitals to track all opioids prescribed at the hospital in the patient EHRs, including those being filled at an outside pharmacy	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	299-905-10-6	IHS work with area offices to renegotiate the MOU with Oklahoma and other States that have restrictive MOU language to allow for PDMP self-audits and collection by clinical directors;	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		g Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-905-10-7	IHS work with area offices to complete required annual reviews that are consistent in type and level of detail across all IHS hospitals	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	299-927-10-1	IHS work with hospitals to ensure all opioids are in a locked cabinet, safe, drawer, or other appropriate secure container at all times.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	503-502-10-1	IHS should ensure that all hospitals: Have a complete risk assessment, to include all IT assets, for all risks, both physical and information security, in accordance with IHS and NIST guidance.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		g Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-504-10-1	IHS should: Ensure that physical IT controls are included in each hospital's risk assessment.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-507-10-1	IHS work with hospitals to remediate the IT vulnerabilities identified.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	503-507-10-2	IHS should assign a centralized team (e.g., headquarters, area office) to: Ensure patches are deployed timely to all IHS end points in accordance with NIST guidance and IHS policies and procedures.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		g Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-507-10-3	IHS should assign a centralized team (e.g., headquarters, area office) to: Securely configure and monitor wireless access points at all IHS hospitals.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

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IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-507-10-4	IHS should ensure that all devices on IHS's network are scanned for vulnerabilities, scan reports reviewed by appropriate computer personnel, track vulnerability remediation, and ensure that vulnerabilities are remediated in a timely way.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizin	7/17/2019	503-508-10-1	IHS should assign a centralized team (e.g., headquarters, area office) to: Monitor and track end-of-service-life IT equipment that cannot be maintained centrally (e.g., switches or routers). IHS hospitals and area offices should provide a tracking spreadsheet to IHS headquarters on a periodic basis that highlights equipment that is reaching or has reached end of service	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		g Its Information Technology Functions			life and replace such equipment or provide management approved justification for its continued use.				
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-508-10-2	IHS should ensure that all hospitals: Institute complete and updated contingency plans and test plans in accordance with Federal guidelines.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-508-10-3	IHS should ensure that all hospitals: Store backup tapes off-site in accordance with Federal guidelines.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-915-10-1	IHS increase oversight of IT systems by IHS management, including consideration of centralizing its key IT systems (including RPMS), services, and cybersecurity functions (e.g., patch management, unsupported network equipment and contingency planning) by conducting a cost-benefit analysis and risk assessment of adopting the Cloud First Policy and other means of centralization (e.g., headquarters, area offices). Specifically, determine if a cloud solutions or other modernization approaches are most effective and cost efficient in addressing persistent cybersecurity vulnerabilities and increasing network resiliency.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and	7/17/2019	503-915-10-2	IHS present findings and cost savings analysis to tribal leadership and the IHS user community to get buy-in for any significant IT enterprise changes.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		Dispensing Practices and Consider Centralizing Its Information Technology Functions							
IHS	A-18-17-11400	IHS Needs To Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Functions	7/17/2019	503-915-10-3	implement a strategic and phased approach to centralization of IT systems, services and cybersecurity functions.	Concur	2021	In Progress	FMD submitted to OIG 11/10/2020.

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IHS	OEI-06-17-00270	Case Study: Indian Health Service Management of Rosebud Hospital Emergency Department Closure and Reopening	7/17/2019	399-915-11-07-05956	IHS should enhance training and orientation for new hospital leaders to ensure that they follow IHS directives and continue improvement efforts	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
IHS	OEI-06-17-00270	Case Study: Indian Health Service Management of Rosebud Hospital Emergency Department Closure and Reopening	7/17/2019	399-915-11-07-05958	IHS should develop procedures for temporary ED closures and communicate those plans with receiving hospitals and EMS to ensure that they are adequately prepared to receive diverted patients during such events	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
IHS	OEI-06-17-00270	Case Study: Indian Health Service Manageme	7/17/2019	399-915-11-07-05957	IHS should continue to take steps to ensure early intervention when IHS identifies problems at hospitals	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		nt of Rosebud Hospital Emergency Department Closure and Reopening							
IHS	OEI-06-17-00270	Case Study: Indian Health Service Management of Rosebud Hospital Emergency Department Closure and Reopening	7/17/2019	399-915-11-07-05955	IHS should as a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals	Concur	2021	In Progress	FMD under development and expected to be completed by 12/31/2020.
NIH	OEI-12-04-00310	HHS Agencies' Compliance with the National Practitioner Data Bank Malpractice Reporting Policy	10/11/2005	399-900-11-08-01148	NIH should implement a corrective action process that would address unreported cases.	Non-Concur	NA	Awaiting Disposition	Requires legislative action

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NIH	OEI-12-04-00310	HHS Agencies' Compliance with the National Practitioner Data Bank Malpractice Reporting Policy	10/11/2005	399-904-11-08-01149	NIH should improve internal controls involving case file management.	Non-Concur	NA	Awaiting Disposition	Requires legislative action
NIH	OEI-03-07-00700	How Grantee's Manage Financial Conflicts of Interest in Research Funded by the National Institutes of Health	11/18/2009	299-902-11-08-01505	NIH should develop and disseminate guidance on methods to verify researchers' financial interests.	Non-Concur	NA	Awaiting Disposition	Non-concur, recommendation is no longer valid
NIH	OEI-03-09-00480	Institutional Conflicts of Interest at NIH Grantees	1/20/2011	299-902-12-08-01911	NIH should promulgate regulations that address institutional financial conflicts of interest.	Non-Concur	NA	Awaiting Disposition	Requires legislative action

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NIH	GAO-13-760	Biomedical Research: NIH Should Assess the Impact of Growth in Indirect Costs on Its Mission	9/24/2013	1	To help address the uncertainty NIH faces, related to the potential impact of increasing indirect costs on its funding of future research, the Director of NIH should assess the impact of growth in indirect costs on its research mission, including, as necessary, planning for how to deal with potential future increases in indirect costs that could limit the amount of funding available for total research, including the direct costs of research projects.	Concur	NA	Awaiting Disposition	
NIH	GAO-16-13	National Institutes of Health: Better Oversight Needed to Help Ensure Continued Progress Including Women in Health Research	10/23/2015	5	To ensure effective implementation of the Inclusion Policy in a manner consistent with the Revitalization Act's provisions regarding the design of certain clinical trials, the NIH Director should report on this summary data and the results of this analysis in NIH's regular biennial report to Congress on the inclusion of women in research.	Concur	2021	In Progress	In October 2021, NIH will publish its biennial report to Congress on the inclusion of women in research to provide data on awardees' plans to conduct valid analysis by sex/gender.

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NIH	GAO-16-616	NIH Biomedical Research: Agencies Involved in Indirect Cost Rate Setting Process Need to Improve Controls	9/28/2016	7	As NIH-DFAS begins formalizing its internal guidance, the Director of NIH-DFAS should establish a mechanism for tracking key milestones in the indirect cost rate-setting process, such as when indirect cost rate proposals are due.	Concur	2021	In Progress	NIH is making system enhancements to track key milestones in the indirect cost rate setting process.
NIH	GAO-17-352	Youth With Autism: Federal Agencies Should Take Additional Action To Support Transition-Age Youth	5/4/2017	4	To implement the goals and policy priorities of the 2020 Federal Youth Transition Plan, the Federal Partners in Transition (FPT) workgroup--the Secretaries of HHS, Education, Department of Labor, and the Commissioner of the Social Security Administration--should develop a long-term implementation plan that includes milestones and specific agency roles and assignments.	Concur	2020	In Progress	HHS formalized and assigned certain FPT roles and responsibilities, is currently evaluating the 2020 plan priorities, is developing a charter to further define FPT milestones and federal agency roles and responsibilities, and the Office of Disability Employment Policy website will be updated to highlight FPT milestones and timelines.

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NIH	A-04-16-04046	The National Institutes of Health Did Not Always Administer Superfund Appropriations During Fiscal Year 2015 In Accordance With Federal Requirements	2/16/2018	299-909-10-08	Issue new or updated guidance, as applicable, that provides clear examples to NIH grants management personnel of circumstances that require the review of Federal Cash Transaction Reports, corrective or enforcement actions against noncompliant grantees, and grant closeout procedures when grantees fail to provide final reports.	Concur	2020	In Progress	HHS is actively developing a new approach to recipient reporting of expenditure data through Re-Invent Grants Management initiatives
NIH	A-04-16-04046	The National Institutes of Health Did Not Always Administer Superfund Appropriations During Fiscal Year 2015 In Accordance With Federal	2/16/2018	299-923-10-08	Formalize procedures for identifying and resolving negative unliquidated obligation balances recorded in NIH's accounting system.	Concur	2020	In Progress	HHS is actively developing a new approach to recipient reporting of expenditure data through Re-Invent Grants Management initiatives

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		Requirements							
NIH	OEI-01-19-00160	Vetting Peer Reviewers at NIH's Center for Scientific Review: Strengths and Limitations	9/25/2019	399-915-11-08-06103	Work with the HHS Office of National Security to develop a risk-based approach for identifying those peer reviewer nominees who warrant additional vetting	Concur	2020	Awaiting Disposition	NIH is and has taken a number of actions to identify, in a risk-based manner, scientists (who would be peer review nominees) who warrant extra scrutiny.
NIH	A-03-19-03003	The National Institutes of Health Has Limited Policies, Procedures, and Controls in Place for Helping To Ensure That Institutions	9/25/2019	212-908-10-1	We recommend NIH implement procedures to ensure that institutions have FCOI policies and make them publicly accessible.	Concur	2020	In Progress	NIH revised the NIH Grants Policy Statement (a term and condition of all NIH grant awards) dated December 2019, Section 4.1.10, to include language that highlights the requirement that all institutions subject to the FCOI regulation must post their FCOI policy on a publicly accessible web site. NIH is developing an enhancement to its eRA Commons Institutional Profile to ensure that all institutions that are required to have an FCOI policy have them.

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		Report All Sources of Research Support, Financial Interests, and Affiliations							
NIH	A-03-19-03003	The National Institutes of Health Has Limited Policies, Procedures, and Controls in Place for Helping To Ensure That Institutions Report All Sources of Research Support, Financial Interests, and	9/25/2019	212-908-10-2	We recommend NIH enhance the FCOI program to ensure that institutions resolve identified deficiencies.	Concur	2020	In Progress	NIH will continue to review institutional FCOI policies for compliance with regulatory requirements, provide feedback to institutions, and ensure that institutions resolve identified deficiencies. NIH will implement a procedure in the standing FCOI policy review process to ensure institutions resolve any identified policy deficiencies.

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		Affiliations							
NIH	A-03-19-03003	The National Institutes of Health Has Limited Policies, Procedures, and Controls in Place for Helping To Ensure That Institutions Report All Sources of Research Support, Financial Interests, and	9/25/2019	212-908-11-1	We recommend NIH enhance its FCOI compliance program to review grantee websites and ensure that they have FCOI policies.	Concur	2020	In Progress	NIH is developing an enhancement to its eRA Commons Institutional Profile to ensure that all institutions that are required to have an FCOI policy have them.

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		Affiliations							
NIH	A-03-19-03003	The National Institutes of Health Has Limited Policies, Procedures, and Controls in Place for Helping To Ensure That Institutions Report All Sources of Research Support, Financial Interests, and	9/25/2019	513-904-10-1	We recommend NIH determine whether the 1,013 institutions identified by this review as not having FCOI policies on their website have FCOI policies and have the institutions post their policies.	Concur	2021	In Progress	NIH plans to contact the Authorized Organization Representative (the individual who is authorized to act for the applicant) for those organizations to remind them of the requirement and request the URL for their posted policy. For those organizations without active grant support, NIH will withhold future grant support until the organization demonstrates compliance with the requirement to publicly post their FCOI policy. NIH will continue to track compliance checks.

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		Affiliations							
NIH	OEI-01-19-00160	Vetting Peer Reviewers at NIH's Center for Scientific Review: Strengths and Limitations	9/25/2019	399-915-11-08-06102	Update its guidance on vetting peer reviewer nominees to identify potential foreign threats to research integrity, in consultation with national security experts, as needed	Concur	2021	In Progress	NIH is taking a number of steps to improve its ability to identify and mitigate potential foreign threats to research and peer review integrity.
NIH	OEI-03-19-00150	NIH Has Made Strides in Reviewing Financial Conflicts of Interest in Extramural Research, But Could Do More	9/25/2019	399-902-11-08-06105	NIH should use information regarding foreign affiliations and support that it collects during the pre-award process to decide whether to revise its FCOI review process to address concerns regarding foreign influence	Concur	2020	In Progress	NIH is drafting procedures that detail the types of periodic quality assurance reviews of information in the FCOI Module performed by NIH staff.

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OASH	OEI-05-10-00050	Guidance and Standards on Language Access Services: Medicare Providers	7/1/2010	099-905-11-11-01733	In addition, to help Medicare providers offer language access services, we recommend that: OMH offer model translated written materials and signs to providers.	Concur	2020	In Progress	No current OMH staff have awareness of this commitment. OMH will coordinate with CMS to determine the specific need and best path forward.
OASH	OEI-01-15-00350	OHRP Generally Conducted Its Compliance Activities Independently, But Changes Would Strengthen Its Independence	7/27/2017	399-915-11-33-05335	HHS should address factors that may limit OHRP's ability to operate independently	Concur	2021	In Progress	See SWIFT #Swift 05302019B002. SACHRP was asked to make recommendations regarding the four specific ways identified in the OIG report that HHS could address the factors that limit or appear to limit OHRP's ability to operate independently. OHRP forwarded SACHRP's recommendations to OASH and provided the link on our website to the SACHRP's recommendations.
OASH	OEI-01-15-00351	OHRP Should Inform Potential Complainants of How They Can Seek Whistleblower Protections	9/18/2017	399-915-11-33-05396	Request that HHS consider the adequacy of whistleblower protections for complainants who make disclosures to OHRP about human subjects protections	Concur	2021	In Progress	See SWIFT #07252017B004. In a memo dated August 28, 2017, from Dr. Wright (then acting ASH) to Inspector General Levinson. Dr. Wright indicated that he "will ask HHS leadership to consider the adequacy of the proposed whistleblower protections for complainants making disclosures about human subject protections to OHRP."

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OCIO	GAO-12-791	Organizational Transformation: Enterprise Architecture Value Needs to Be Measured and Reported	9/26/2012	50	To enhance federal agencies' ability to realize enterprise architecture benefits, the Secretaries of the Departments of Health and Human Services and Housing and Urban Development should ensure that enterprise architecture outcomes are periodically measured and reported to top agency officials.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-15-431	Telecommunications: Agencies Need Better Controls to Achieve Significant Savings on Mobile Devices and Services	5/21/2015	9	To help the department effectively manage spending on mobile devices and services, the Secretary of Health and Human Services should ensure procedures to monitor and control spending are established department-wide. Specifically, ensure that (1) procedures include assessing devices for zero, under, and over usage; (2) personnel with authority and responsibility for performing the procedures are identified; and (3) the specific steps to be taken to perform the process are documented.	Concur	2020	In Progress	OCIO is actively working to implement the recommendation.

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OCIO	GAO-16-325	Cloud Computing: Agencies Need to Incorporate Key Practices to Ensure Effective Performance	4/7/2016	4	To help ensure continued progress in the implementation of effective cloud computing SLAs, the Secretaries of Health and Human Services, Homeland Security, Treasury, and Veterans Affairs should direct appropriate officials to develop SLA guidance and ensure key practices are fully incorporated as the contract and associated SLAs expire.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-16-494	IT Dashboard: Agencies Need to Fully Consider Risks When Rating Their Major Investments	6/2/2016	4	To better ensure that the Dashboard ratings more accurately reflect risk, the Secretaries of the Departments of Agriculture, Education, Energy, Health and Human Services, the Interior, State, and Veterans Affairs; and the Director of the Office of Personnel Management should direct their CIOs to factor active risks into their IT Dashboard CIO ratings.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.

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OCIO	GAO-16-494	IT Dashboard: Agencies Need to Fully Consider Risks When Rating Their Major Investments	6/2/2016	19	To better ensure that the Dashboard ratings more accurately reflect risk, the Secretary of the Department of Health and Human Services, should direct their CIOs to ensure that their CIO ratings reflect the level of risk facing an investment relative to that investment's ability to accomplish its goals.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-16-469	Information Technology Reform: Agencies Need to Increase their use of Developmental Practices	9/15/2016	11	To improve the certification of adequate incremental development, the Secretaries of Defense, Education, Health and Human Services, and the Treasury should direct their CIOs to establish a department policy and process for the certification of major IT investments' adequate use of incremental development, in accordance with OMB's guidance on the implementation of the Federal Information Technology Acquisition Reform Act.	Concur	NA	Awaiting Disposition	OCIO submitted the IT Portfolio Management Policy update to GAO in September 2020; still awaiting response from GAO.

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OCIO	GAO-17-8	IT Workforce: Key Practices Help Ensure Strong Integrated Program Teams; Selected Departments Need to Assess Skill Gaps	11/30/2016	3	To facilitate the analysis of gaps between current skills and future needs, the development of strategies for filling the gaps, and succession planning, the Secretary of Health and Human Services should require the Chief Information Officer, Chief Human Capital Officer, and other senior managers as appropriate to address the shortfalls in IT workforce planning noted in this report, including the following actions: (1) establish and maintain a workforce planning process inclusive of all staff; (2) develop staffing requirements for all positions; (3) assess staffing needs regularly; (4) assess gaps in competencies and staffing for all components of the workforce; (5) develop strategies and plans to address gaps in competencies and staffing; (6) implement activities that address gaps, including an IT acquisition cadre, if justified and cost-effective; (7) monitor the department's	Concur	NA	In Progress	OCIO is actively working to implement this recommendation with the Office of Acquisition.

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					progress in addressing competency and staffing gaps; and (8) report to department leadership on progress in addressing competency and staffing gaps.				

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OCIO	GAO-17-448	Data Center Optimization: Agencies Need to Address Challenges and Improve Progress to Achieve Cost Savings Goal	9/6/2017	7	The Secretaries of Agriculture, Commerce, Defense, Homeland Security, Energy, HHS, Interior, Labor, State, Transportation, Treasury, and VA; the Attorney General of the United States; the Administrators of EPA, GSA, and SBA; the Director of OPM; and the Chairman of NRC should take action to, within existing OMB reporting mechanisms, complete plans describing how the agency will achieve OMB's requirement to implement automated monitoring tools at all agency-owned data centers by the end of fiscal year 2018.	Concur	2020	Awaiting Disposition	HHS is reporting energy metering on all but two of its applicable data centers under M-19-19. We are working with that OpDiv to ensure those data centers can be metered. The initial recommendation was to implement an automated solution under M-16-19, which is no longer applicable. Instead under the new guidance we have been steadily working to increase the number of data centers reporting. We hope to have the remaining handled as soon as possible, in which we intend to approach GAO and request closure given full compliance with the new guidance.
OCIO	GAO-18-42	Information Technology: Agencies Need to Involve Chief Information Officers in Reviewing	1/10/2018	10	The Secretary of HHS should ensure that IT acquisition plans or strategies are reviewed and approved according to OMB's guidance.	Concur	2020	In Progress	OCIO is actively working this recommendation and has shared information with GAO.

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		Billions of Dollars in Acquisitions							
OCIO	GAO-18-93	Federal Chief Information Officers: Critical Actions Needed to Address Shortcomings and Challenges in Implementing Responsibilities	8/2/2018	9	The Secretary of Health and Human Services should ensure that the department's IT management policies address the role of the CIO for key responsibilities in the six areas we identified.	Concur	NA	In Progress	OCIO is actively working this recommendation and has shared information with GAO.
OCIO	GAO-18-381	Paperwork Reduction Act: Agencies Could Better Leverage Review Processes and Public Outreach to Improve	8/10/2018	5	The Secretary of Health and Human Services should review the policies, procedures, and related control activities to ensure that the agency's Paperwork Reduction Act review process is operating effectively.	Concur	NA	In Progress	OCIO is actively working this recommendation.

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		Burden Estimates							
OCIO	GAO-18-381	Paperwork Reduction Act: Agencies Could Better Leverage Review Processes and Public Outreach to Improve Burden Estimates	8/10/2018	6	The Secretary of Health and Human Services should leverage existing consultation with stakeholders and the public to explicitly seek input on the estimated burden imposed by information collections.	Concur	NA	In Progress	OCIO is actively working this recommendation.
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval	11/13/2018	16	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that establish department-wide policy for the level of detail of planned expenditure reporting to the CIO for all transactions that	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.

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		of IT Budgets			include IT resources. (Recommendation 16)				
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	17	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that include the CIO in the planning and budgeting stages for all programs that are fully or partially supported with IT resources. (Recommendation 17)	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.

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OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	18	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that include the CIO as a member of governance boards that inform decisions regarding all IT resources, including component-level boards. (Recommendation 18)	Concur		In Progress	Administration / Office of the Chief Information Officer as a member. The HHS CIO has two titles; CIO and DASIT, and thus is an active voting member of the FGB. The HHS CIO delegates CIO authorities as granted by FITARA and Executive Number 13833 (Enhancing the Effectiveness of Agency Chief Information Officers) to the OpDiv CIOs. During the Annual IT Budget Review the HHS CIOs confirms the Operating Division CIOs participation and leadership with governing and making decisions on IT resources.
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	19	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that document the processes by which program leadership works with the CIO to plan an overall portfolio of IT resources. (Recommendation 19)	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year. The HHS CIO Council meets the first Wednesday of the month and consist of all Operating Division level CIOs. The council provides a platform for senior technology leadership to discuss

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									innovation and develop strategic goals to support HHS mission. The meeting consists of all OpDiv CIOs from the Enterprise Infrastructure Solution to topics that are of concern to OpDiv CIOs individually or discussing shared services amongst OpDivs.
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	20	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that document the process for the CIO's review and approval of the major IT investments portion of the budget request. (Recommendation 20)	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.

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OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	21	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that document the CIO's role in reviewing IT resources that are to support major program objectives and significant increases and decreases in IT resources. (Recommendation 21)	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	22	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, address gaps in the department's FITARA plans by developing and implementing policies and procedures that document the steps the CIO is to take to ensure whether the IT portfolio includes appropriate estimates of all IT resources included in the budget request. (Recommendation 22)	Concur		In Progress	The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.

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OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	23	The Secretary of Health and Human Services should direct the department CIO to establish, for any OMB common baseline requirements that are related to IT budgeting that have been delegated, a plan that specifies the requirement being delegated, demonstrates how the CIO intends to retain accountability for the requirement, and ensures through quality assurance processes that the delegated official will execute such responsibilities with the appropriate level of rigor. (Recommendation 23)	Concur		In Progress	Updated HHS Chief Information Officer FITARA Delegation of Authority Memorandum to Operating Divisions Chief Information Officers
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval	11/13/2018	24	The Secretary of Health and Human Services should direct the Office of the CIO and other offices, as appropriate, to take steps to ensure that the actions taken to comply with OMB's common baseline for implementing FITARA on individual investments are adequately documented. (Recommendation 24)	Concur		In Progress	The HHS IT Acquisition Review (ITAR) Policy is being submitted, along with the Standard Operating Procedures for the formal ITAR process, which can be found in Appendix A of the aforementioned policy.

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		of IT Budgets							
OCIO	GAO-19-49	INFORMATION TECHNOLOGY: Departments Need to Improve Chief Information Officers' Review and Approval of IT Budgets	11/13/2018	25	The Secretary of Health and Human Services should ensure that the Office of the CIO and other offices, as appropriate, establish quality assurance processes--such as data quality checks, reviews of estimation methods, linkages between the IT portfolio and procurement system data, and linkages between the IT portfolio and financial system data--for ensuring the annual IT budget is informed by complete and reliable information on anticipated government labor, contract, and other relevant IT expenditures. (Recommendation 25)	Concur		In Progress	The CPIC Policy is currently being updated. The updated HHS CPIC Policy will have language that will speak to specific policy updates (including CIO Evaluation Rating, TBM, and Incremental Development) per GAO recommendation. The policy will be shared with GAO once it has been approved and published later this year.

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OCIO	A-18-18-08500	Summary Report for Office of Inspector General Penetration Testing of Eight HHS Operating Division Networks	3/1/2019	503-502-10-1	Ensure OPDIVs implement properly-configured web application firewalls in accordance with an agreed-upon baseline standard established by HHS.	Concur	2021	In Progress	OCIO is actively working this recommendation.
OCIO	A-18-18-08500	Summary Report for Office of Inspector General Penetration Testing of Eight HHS Operating Division Networks	3/1/2019	503-502-10-2	Ensure all future web application developments incorporate security requirements from an industry recognized web application security standard (e.g., Open Web Application Security Project (OWASP) and SystemAdmin, Audit, Network and Security (SANS)).	Concur	2021	In Progress	OCIO is actively working this recommendation.
OCIO	A-18-18-08500	Summary Report for Office of Inspector General Penetration Testing of Eight HHS Operating Division Networks	3/1/2019	503-502-10-3	Ensure all future web application development contractors include appropriate procurement provisions that outline application security standards and procedures that must be adhered to during development and throughout the system development life cycle.	Concur	2021	In Progress	OCIO is actively working this recommendation.

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OCIO	A-18-18-08500	Summary Report for Office of Inspector General Penetration Testing of Eight HHS Operating Division Networks	3/1/2019	503-502-10-4	Improve continuous monitoring procedures and require OPDIVs to test for default credentials as part of the Assessment and Authorizations process, system risk assessments, Office of Management and Budget A-123 reviews, follow-up testing for Plan of Action and Milestones, and other mechanisms that are in place to monitor and test for internal cybersecurity vulnerabilities.	Concur	2021	In Progress	OCIO is actively working this recommendation.
OCIO	GAO-19-241	Data Center Optimization: Additional Agency Actions Needed to Meet OMB Goals	4/11/2019	8	The Secretary of the Department of Health and Human Services (HHS) should take action to meet the data center closure targets established under DCOI by OMB.	Non-Concur	NA	Awaiting Disposition	HHS considers this recommendation closed - implemented. The Department considers this item closed as it relates to M-16-19. The targets outlined in M- 16-19, effective August 1, 2016 and closed on June 24, 2019 referenced in this report have expired. The targets have been replaced by M-19-19, which is effective June 25, 2019 through October 1, 2020, and HHS considers the requirements under M-16-19 closed. HHS met the tiered data center closure targets outlined in M-16-19; however, non-tiered data centers no longer apply under the new memo. Several targeted metrics and goals have

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									been updated or changed under the new memo, M-19-19. The new goal under M-19-19 is to close two data centers, and one is already closed. The second data center, currently operated by the National Institutes of Health, is targeted for closure in Q4 2020
OCIO	GAO-19-241	Data Center Optimization: Additional Agency Actions Needed to Meet OMB Goals	4/11/2019	9	The Secretary of HHS should take action to meet the data center optimization metric targets established under DCOI by OMB.	Non-Concur	NA	Awaiting Disposition	HHS considers this recommendation closed - implemented. The Department considers this item closed as it relates to M-16-19. The targets outlined in M- 16-19, effective August 1, 2016 and referenced in this report have expired as of June 24, 2019, and HHS considers the requirements under M-16-19 closed. For the now-expired M-16-19 requirements, HHS met the following requirements: Virtualization, Server Utilization, Availability, and Closures. Items that were not met and have subsequently been redefined and replaced under M-19-19 include Power Usage Effectiveness, Facility Utilization, and Energy Metering. The updated performance metrics under M-19-19 are currently being evaluated and are in progress of being measured as outlined.

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OCIO	GAO-19-58	Cloud Computing: Agencies Have Increased Usage and Realized Benefits, but Cost and Savings Data Need to be Better Tracked	5/6/2019	13	The Secretary of the Department of Health and Human Services (HHS) should ensure that the CIO of HHS establishes guidance on assessing new and existing IT investments for suitability for cloud computing services, in accordance with OMB guidance. (Recommendation 13)	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-19-58	Cloud Computing: Agencies Have Increased Usage and Realized Benefits, but Cost and Savings Data Need to be Better Tracked	5/6/2019	14	The Secretary of Health and Human Services should ensure that the CIO of HHS completes an assessment of all IT investments for suitability for migration to a cloud computing service, in accordance with OMB guidance. (Recommendation 14)	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.

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OCIO	GAO-19-58	Cloud Computing: Agencies Have Increased Usage and Realized Benefits, but Cost and Savings Data Need to be Better Tracked	5/6/2019	15	The Secretary of Health and Human Services should ensure that the CIO of HHS establishes a consistent and repeatable mechanism to track savings and cost avoidances from the migration and deployment of cloud services. (Recommendation 15)	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-19-384	Cybersecurity: Agencies Need to Fully Establish Risk Management Programs and Address Challenges	7/25/2019	10	The Secretary of Health and Human Services should develop a cybersecurity risk management strategy that includes the key elements identified in this report.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	GAO-19-384	Cybersecurity: Agencies Need to Fully Establish	7/25/2019	11	The Secretary of Health and Human Services should update the department's policies to require (1) an organization-wide cybersecurity risk	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.

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		Risk Management Programs and Address Challenges			assessment and (2) the use of risk assessments to inform security control tailoring.				
OCIO	GAO-19-384	Cybersecurity: Agencies Need to Fully Establish Risk Management Programs and Address Challenges	7/25/2019	12	The Secretary of Health and Human Services should establish a process for conducting an organization-wide cybersecurity risk assessment.	Concur	NA	In Progress	OCIO is actively working to implement the recommendation.
OCIO	A-18-18-11050	Department of Health and Human Services Had Email Requirements for Political Appointees, but Office of the Secretary Lacked	9/23/2019	503-503-10-1	We recommend that HHS implement a policy requiring all HHS agencies and offices to implement automated controls to block employees from accessing personal email accounts from HHS networks;	Concur	2021	In Progress	OCIO is actively working this recommendation.

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		Effective Monitoring and Enforcement							
OCIO	A-18-18-11050	Department of Health and Human Services Had Email Requirements for Political Appointees, but Office of the Secretary Lacked Effective Monitoring and Enforcement	9/23/2019	503-503-10-2	We recommend that OS implement a process to ensure that all OS political appointees, employees, and contractors complete the required security awareness trainings in a timely manner; and	Concur	2021	In Progress	OCIO is actively working this recommendation.

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OCIO	A-18-18-11050	Department of Health and Human Services Had Email Requirements for Political Appointees, but Office of the Secretary Lacked Effective Monitoring and Enforcement	9/23/2019	503-503-10-3	We recommend that OS implement procedures to ensure that all its staff are properly listed and classified in the categories of political appointees, employees, contractors, and supervisors.	Concur	2021	In Progress	OCIO is actively working this recommendation.

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OCR	OEI-09-10-00510	OCR Should Strengthen Its Oversight of Covered Entities' Compliance With the HIPAA Privacy Standards	9/28/2015	399-915-11-20-04683	OCR should fully implement a permanent audit program	Concur	2020/2021	In Progress	OCR's implementation of this OIG recommendation remains in progress. The HITECH Act required OCR to perform periodic audits. In 2011, OCR conducted comprehensive on-site audits of 115 covered entities. Findings included a pattern of insufficient risk analyses, poor security of mobile electronic devices, improper disposal, inadequate physical access safeguards and insufficient training of workforce members. In 2016, OCR conducted desk audits of 166 covered entities and 41 business associates on selected provisions of the HIPAA Privacy, Security and Breach Notification Rules. The audits gave OCR an opportunity to examine mechanisms for compliance, identify promising practices for protecting the privacy and security of health information, and discover risks and vulnerabilities that may not have been revealed by OCR's other enforcement activities. These audits were designed to complement OCR's enforcement program, which investigates specific covered entities or business associates through complaint investigations and compliance reviews, seeks resolution of

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									potential violations through corrective action plans and settlements, and in some instances, imposes civil money penalties. OCR developed a comprehensive audit protocol for use in the desk audits to analyze an entity's compliance with the processes, controls, and policies relating to the HIPAA Rules. The audit protocol addresses every standard of the HIPAA Rules and provides measurable criteria and key questions an entity can apply when developing and reviewing its compliance activities. Findings included a pattern of insufficient risk analysis and risk management and inconsistent provision of an individual's right of access to their medical records. OCR has sent individual reports to each auditee notifying the entity of OCR's findings, and OCR is presently finishing a report to the industry that will discuss OCR's findings in each provision of the HIPAA Rules that was audited. The next phase of OCR's audit program will build upon the lessons learned from the first two phases of the audits. Additionally, OCR has publicly announced the continuation of the audit program

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									as an enforcement tool. OCR will provide GAO with additional information to confirm that the OCR audit program is permanent and will continue to conduct periodic audits.

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OCR	GAO-16-771	Electronic Health Information: HHS Needs to Strengthen Security and Privacy Guidance and Oversight	9/26/2016	4	To improve the effectiveness of HHS guidance and oversight of privacy and security for health information the Secretary of Health and Human Services should establish performance measures for the Office of Civil Rights (OCR) audit program	Concur	2020/2021	In Progress	OCR's implementation of this GAO recommendation remains in progress. OCR created an audit program to measure compliance with the HIPAA privacy, security, and breach notification requirements by regulated entities. OCR finished field work in 2013 and spent the balance of the year conducting a formal program evaluation. The evaluation concluded in 2014. The evaluation noted strengths of the program design and suggestions that were utilized in the next round of audits. OCR launched Phase 2 of the audit program in 2014. Key activities included updating the audit protocols, refining the pool of potential auditees, and implementing a screening tool to assess size, entity type, and other information about potential audit subjects. Selected entities received notification and data requests in spring 2016. OCR completed Phase 2 of the Audit Program in 2017. OCR finalized the results of Phase 2 and developed final reports for the regulated community based on the data collected in 2018. These reports included measurable performance goals for each entity. OCR is currently evaluating the

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									two previous audits to develop new performance measures for the next audits. One of the objectives of the first two phases of the audit program was to ascertain whether there were compliance or enforcement concerns that were not being captured by other aspects of the enforcement program. The results of the audits largely mirrored the trends seen in the enforcement program generally. For example, most covered entities that maintained a website about their customer services or benefits also satisfy the requirement to prominently post their Notice of Privacy Practices (NPP) on their website. However, the audits revealed that most covered entities failed to meet other selected provisions, adequately safeguarding protected health information, ensuring the individual right of access and providing appropriate content in a Notice of Privacy Practices. The audits also found that covered entities and business associates failed to implement the HIPAA Security Rule requirements for risk analysis and risk management. OCR released a final report on the findings of the audit program on

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									December 17, 2020. This report presents information about OCR's Phase 2 audits, the achievements and weaknesses identified and methods audited entities may implement to strengthen compliance. The report identifies technical assistance and resources for covered entities and business associates to improve compliance with the HIPAA Rules. As OCR is developing the next phase of the audit program, OCR will consult with GAO to ensure that the program incorporates the performance measures contemplated in the recommendation.

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OGC	OEI-04-10-00010	Conflict-of-Interest Waivers Granted to HHS Employees in 2009	8/24/2011	399-905-11-21-02311	Require OPDIVs and STAFFDIVs to document conflict-of interest waivers as recommended in Government wide Federal ethics regulations and the Secretary's instructions.	Concur	2021	In Progress	
OGC	OEI-04-10-00010	Conflict-of-Interest Waivers Granted to HHS Employees in 2009	8/24/2011	399-905-11-21-02313	Take action to revise the conflict-of-interest waivers in our review that were not documented as recommended in Government wide Federal ethics regulations and the Secretary's instructions, if the waivers are still in effect.	Concur	2019	In Progress	These waivers are no longer in effect and a request will be made to close this recommendation.
OGC	OEI-04-10-00010	Conflict-of-Interest Waivers Granted to HHS Employees in 2009	8/24/2011	399-905-11-21-02315	Require all employees to sign and date, or similarly document, their conflict of interest waivers.	Concur	2019	In Progress	OGC requires all employees to sign and date a waiver that has been granted, in which the employee acknowledges the waiver and agrees to abide by the terms of the waiver.
OHRP	OEI-01-15-00350	OHRP Generally Conducted Its Compliance Activities Independently, But Changes Would Strengthen	7/27/2017	399-915-11-26-05336	OHRP should post the following on its website: (a) a description of its approach to oversight and (b) data (in aggregate) on the full array of its compliance activities	Concur	2021	In Progress	Partially implemented. OHRP is now posting aggregate data on an array of its compliance activities. The data posted is limited by the current DCO tracking system. OHRP is continuing to have internal discussions regarding the first part of this recommendation, which advised that OHRP develop a separate section on its website to include "(a) a description of its

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		Its Independence							approach to oversight," that specifically addresses "OHRP's alternatives to conducting a compliance evaluation...".
ONC	OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology	12/9/2013	399-915-11-28-03636	Audit logs be operational whenever EHR technology is available for updates or viewing.	Concur	N/A	Awaiting Disposition	ONC submitted an NFA to OIG in 2016 informing OIG no further action would be taken, but OIG has not yet closed out the recommendations.
ONC	OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology	12/9/2013	399-915-11-28-03638	ONC and CMS strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.	Concur	N/A	Awaiting Disposition	ONC submitted an NFA to OIG in 2019 informing OIG no further action would be taken, but OIG has not yet closed out the recommendations.

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OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulations for Chartered Aircraft and Other Government Travel Related to Former Secretary Price	7/11/2018	079-908-10-1	Train responsible HHS personnel and put controls in place to ensure that the following requirements are met for future travel: conducting a cost analysis and maintaining documentation to support each use of chartered aircraft that is consistent with each charter justification and ensure compliance with the FTR and the HHS Travel Policy Manual; following the HHS Travel Policy Manual when making travel decisions for the Secretary and accompanying staff when they are not traveling from or to their official duty stations; ensuring authorizations and vouchers are completed in accordance with the FTR and the HHS Travel Policy Manual; cancelling travel reservations to ensure that the value of an unused ticket is not charged to HHS's centrally billed account and then paid, in accordance with the FTR; ensuring existing and newly assigned individuals complete all required	Concur	2021	In Progress	OS and HHS travel personnel are actively reviewing the HHS Travel Policy Manual and increasing trainings for staff involved in scheduling, preparing, procuring, and approving travel. Additional reporting requests for chartered aircraft have also been implemented

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					training before Government travel in compliance with OMB Circular No. A-123 and the HHS Travel Policy Manual; and ensuring HHS individuals responsible for approving travel receive initial and refresher training to comply with OMB Circular No. A-123 and the HHS Travel Policy Manual.				

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OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulations for Chartered Aircraft and Other Government Travel Related to Former Secretary Price	7/11/2018	510-900-10-1	Assess the roles, responsibilities, and actions of Federal personnel involved in scheduling, preparing, procuring, and approving the use of chartered aircraft for former Secretary Price's travel and take all appropriate actions related to their performance or conduct.	Concur	2021	In Progress	The Office of the Secretary (OS) is actively working towards resolving this recommendation. OS is currently working with the Office of the General Counsel (OGC).
OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulation	7/11/2018	510-905-10-1	Train responsible HHS personnel and put controls in place to ensure that the following requirements are met for future procurements: preparing and maintaining documentation regarding the rationale for quote selections when the lowest quote is not selected is prepared and included in the contract file as required by the FAR; and	Concur	2021	In Progress	OS and HHS travel personnel are actively reviewing the HHS Travel Policy Manual, identifying what training and how much training need to be implemented for staff involved in scheduling, preparing, procuring, and approving travel. Additional reporting requests for chartered aircraft have also been implemented.

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		s for Chartered Aircraft and Other Government Travel Related to Former Secretary Price			verifying that sole-source justification requirements are adhered to and documentation related to sole-source awards is prepared in accordance with the FAR.				

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulations for Chartered Aircraft and Other Government Travel Related to Former Secretary Price	7/13/2018	081-908-01-1	We recommend that the Office of the Secretary review the lack of compliance with the OMB Circular A-126, Federal Travel Regulations, and HHS Travel Policy Manual related to the authorization and use of chartered aircraft during former Secretary Price's tenure, and on the basis of the review, determine and take appropriate administrative actions to recoup $333,014 of identified waste, including: the $12,178 for the June 6 trip to Nashville for which the chartered aircraft was not cancelled after receiving confirmation that the White House event would not occur providing an opportunity for the use of commercial flights, the $36,313 for the June 24–26 trip to San Diego, Aspen, and Salt Lake City that included only 3.5 hours of official engagements, the $10,001 for the September 15 trip to Philadelphia for not using options other than chartered aircraft, the	Concur	2021	In Progress	The Office of the Secretary (OS) is actively working towards resolving this recommendation. OS is currently working with the Office of the General Counsel (OGC).

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
					$12,346 for the Raleigh to Brunswick travel leg in which former Secretary Price used the chartered aircraft to attend an event in a personal capacity, the net cost of the cancelled leg of approximately $8,675 from the Marathon and Stillwater trip starting on September 18, and the remaining $253,501 for not comparing the cost of chartered aircraft to the cost of commercial travel and not selecting the most cost-effective mode of travel.				

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulations for Chartered Aircraft and Other Government Travel Related to Former Secretary Price	7/13/2018	081-908-01-2	Review the lack of compliance with the HHS Travel Policy Manual related to travel that started or ended in locations other than former Secretary Price's official duty station, and on the basis of the review, determine and take appropriate administrative actions to recoup $4,926 identified as waste: the $818 for the July 6 trip to Chattanooga in travel costs for an employee to travel to Atlanta on July 5, the $580 for the Raleigh to Brunswick leg in which HHS travelers had to fly commercially back to DC because former Secretary Price used the chartered aircraft to attend an event in a personal capacity, and the $3,528 for the September 18 trip to Marathon and Stillwater.	Concur	2021	In Progress	The Office of the Secretary (OS) is actively working towards resolving this recommendation. OS is currently working with the Office of the General Counsel (OGC).

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulations for Chartered Aircraft and Other Government Travel Related to Former Secretary Price	7/13/2018	081-908-01-3	Review the lack of compliance with the FTR and the HHS Travel Policy Manual related to other excess travel costs, and on the basis of the review, determine and take appropriate action to recoup $2,960 of identified waste: the $1,568 of excess lodging costs that were not pre-authorized, the $727 of excess costs incurred for a rental vehicle and pre-paid fuel, and the $665 to Government travelers for travel costs that included unallowable meal costs and incorrect amounts entered on vouchers.	Concur	2021	In Progress	The Office of the Secretary (OS) is actively working towards resolving this recommendation. OS is currently working with the Office of the General Counsel (OGC).
OS	A-12-17-00002	The Office of the Secretary of Health and Human Services Did Not Comply with Federal Regulation	7/13/2018	081-908-01-4	Request a repayment totaling $716 for former Secretary Price's wife's use of one flight aboard a chartered aircraft.	Concur	2021	In Progress	The Office of the Secretary (OS) is actively working towards resolving this recommendation. OS is currently working with the Office of the General Counsel (OGC).

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		s for Chartered Aircraft and Other Government Travel Related to Former Secretary Price							
OS, IHS	OEI-06-14-00011	Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care	10/6/2016	399-915-11-11-05140	As part of OS' newly formed Executive Council, lead an examination of the quality of care delivered in IHS hospitals and use the findings to identify and implement innovative strategies to mitigate IHS's longstanding challenges	Concur	2019	Awaiting Disposition	HHS has submitted documentation requesting this recommendation be closed as implemented. The Executive Council is no longer active but the work of the Council has been institutionalized in the IHS Office of Quality effective January 2019. The IHS Office of Quality will provide leadership and promote consistency in health care quality across the agency by consolidating and enhancing oversight of these efforts at IHS headquarters working to mitigate historical IHS challenges. In addition, earlier this year the Department reinstituted the Intradepartmental Council on Native American Affairs (ICNAA), which had been dormant for almost a decade. The ICNAA is statutorily authorized by the Native American Programs Act of 1974 and serves as

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
									the internal body within the Department for coordination of health and human services issues, including developing and promoting Departmental policies to provide greater access to quality services for American Indians and Alaska Natives.
SAMHSA	GAO-15-113	Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness	2/5/2015	3	To help determine if programs are effective at supporting those individuals with serious mental illness, the Secretaries of Defense, Health and Human Services, Veterans Affairs, and the Attorney General--which oversee programs targeting individuals with serious mental illness--should document which of their programs targeted for individuals with serious mental illness should be evaluated and how often such evaluations should be completed.	Non-Concur	2021	Awaiting Disposition	Update provided to GAO in December of 2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
SAMHSA	GAO-18-32	Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome	10/4/2017	1	The Secretary of HHS should expeditiously develop a plan--that includes priorities, timeframes, clear roles and responsibilities, and methods for assessing progress--to effectively implement the NAS-related recommendations identified in the Protecting Our Infants Act: Final Strategy.	Concur	2020	Awaiting Disposition	HHS's understanding is that the only pending item is the updated list of agency activities (described below as "annual summary of information for quarterly calls"), which is still in clearance. We are happy to share this with GAO as soon as it is cleared. It is, however, merely a new version of the types of activities in the previous POIA report to Congress, which has been published on ASPE's website and GAO has seen. We believe GAO can close the recommendation without the update, as the previous version met the statutory requirement. Updates are required 'periodically' per sec 7062 of the SUPPORT Act, so there's no pending deadline.
SAMHSA	GAO-18-450	Mental Health: Federal Procedures to Oversee Protection and Advocacy Program Could be Further Improved	5/24/2018	1	The Assistant Secretary for Mental Health and Substance Use should establish procedures to better ensure that mid-performance changes to program priority goals, objectives, and targets are examined across multiple years.	Concur	2020	In Progress	Update will be provided to GAO in early 2021.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
SAMHSA	A-02-17-02009	New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds	3/20/2019	212-919-10-1	We recommend that SAMHSA provide formal guidance to the State agency on accounting for SABG expenditures.	Non-Concur	2021	In Progress	Update will be provided to OIG in early 2021.
SAMHSA	A-02-17-02009	New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds	3/20/2019	212-919-10-2	We recommend that SAMHSA provide formal guidance to the State agency on alerting SAMHSA about any unexpended funds.	Non-Concur	2021	In Progress	Update will be provided to OIG in early 2021.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
SAMHSA	A-02-17-02009	New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds	3/20/2019	212-919-10-3	We recommend that SAMHSA provide formal guidance to the State agency on amending the FFR to reflect actual SABG expenditures.	Non-Concur	2021	In Progress	Update will be provided to OIG in early 2021.
SAMHSA	A-02-17-02009	New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds	3/20/2019	314-009-01-1	We recommend that SAMHSA recover $1,800,212 from the State agency.	Concur	2020	In Progress	Update will be provided to OIG in early 2021.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
SAMHSA	A-07-19-03233	The Substance Abuse and Mental Health Services Administration Resolved Approximately One-Third of Its Audit Recommendations, None in Accordance With Federal Timeframe Requirements	7/18/2019	214-920-10-1	We recommend that SAMHSA finalize and follow its policies and procedures related to the audit resolution process to ensure that all management decisions are issued within the required 6-month resolution period.	Concur	2021	Awaiting Disposition	Update provided to OIG in November 2020.
SAMHSA	A-07-19-03233	The Substance Abuse and Mental Health Services Administration Resolved Approximately One-Third of Its	7/18/2019	214-920-10-2	We recommend that SAMHSA promptly resolve the 188 outstanding audit recommendations that were past due as of September 30, 2016.	Concur	2021	Awaiting Disposition	Update provided to OIG in November 2020.

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints as of December 2020.
		Audit Recommendations, None in Accordance With Federal Timeframe Requirements							
SAMHSA	A-07-19-03233	The Substance Abuse and Mental Health Services Administration Resolved Approximately One-Third of Its Audit Recommendations, None in Accordance With Federal Timeframe Requirements	7/18/2019	214-920-10-3	We recommend that SAMHSA reconcile each month the OIG stewardship reports (or the HHS electronic Single Audit recommendation listing for audits processed on or after October 1, 2018) with SAMHSA's audit resolution records and follow up on any differences noted.	Concur	2021	Awaiting Disposition	Update provided to OIG in November 2020.

Appendix 2: OIG-GAO Closed, Unimplemented Recommendations

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
ACF	GAO-15-273	Foster Care: HHS Needs to Improve the Consistency and Timeliness of Assistance to Tribes	2/25/2015	2	To improve the consistency of assistance provided to tribes, the Secretary of Health and Human Services should take steps to provide consistent title IV-E guidance to tribes across its regional offices.	Closed, Unimplemented	OpDiv considers requested actions completed
ACF	GAO-15-273	Foster Care: HHS Needs to Improve the Consistency and Timeliness of Assistance to Tribes	2/25/2015	3	To improve the timeliness of assistance provided to tribes, the Secretary of Health and Human Services should establish procedures to ensure reviews of draft title IV-E plans are conducted by regional office staff in a timely manner.	Closed, Unimplemented	Non-concur
ACL	HEHS-94-37	OLDER AMERICANS ACT: Title III Funds Not Distributed According to Statute	1/18/1994	1	AOA should revise its current method of calculating state grant funds under title III of the Older Americans Act to allot more funds in proportion to current elderly populations, as required by law, while still satisfying the statutory minimum requirements. Such a revised method should compute title III allotments first on current shares of states' elderly populations, then raise only those state allotments that do not meet the hold-harmless and/or 0.5-percent minimum funding levels, and, finally, lower allotments of nonminimum states proportionally.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
ACL	GAO-11-237	OLDER AMERICANS ACT: More Should Be Done to Measure the Extent of Unmet Need for Services	3/30/2011	2	To help ensure that agencies have adequate and consistent information about older adults' needs and the extent to which they are met, the Secretary of Health and Human Services should partner with other government agencies that provide services to Older Americans and, as appropriate, convene a panel or work group of researchers, agency officials, and others to develop consistent definitions of need and unmet need and to propose interim and long-term uniform data collection procedures for obtaining information on older adults with unmet needs for services provided from sources like Title III.	Closed, Unimplemented	Recommendation not feasible
ASFR	GAO-11-548R	Mentor-Protégé Programs Have Policies that Aim to Benefit Participants but Do Not Require Post agreement Tracking	6/15/2011	5	To more fully evaluate the effectiveness of their mentor-protégé programs, the OSDBU and Mentor-Protégé Program Directors of DHS, DOE, DOS, EPA, FAA, GSA, HHS, SBA, Treasury, and VA should consider collecting and maintaining protégé post completion information	Closed, Unimplemented	Non-concur, recommendation is no longer valid

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	T-AIMD-00-118	Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability	3/15/2000	1	To improve financial management and accountability in the Medicare program, the Administrator, HCFA, should direct the Chief Financial Officer to improve procedures for evaluating and resolving findings from annual financial statements audits by developing, documenting, and implementing procedures so that managers promptly evaluate audit findings, determine proper actions in response to audit findings, and complete within established timeframes all actions that resolve the findings brought to management's attention.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	AIMD-00-66	Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability	3/15/2000	1	To improve financial management and accountability in the Medicare program, the Administrator, HCFA, should direct the Chief Financial Officer to improve procedures for evaluating and resolving findings from annual financial statements audits by developing, documenting, and implementing procedures so that managers promptly evaluate audit findings, determine proper actions in response to audit findings, and complete within established timeframes all actions that resolve the findings brought to management's attention.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	HEHS/OSI-00-69	Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight	4/5/2000	1	In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, the Administrator, HCFA, should allow the use of bundled rates as one of several alternative payment approaches, provided that HCFA establishes consistent principles for bundling that effectively address: (1) provisions for rates that reflect or recognize varying levels of services to accommodate children; and (2) assurances that children receive appropriate and needed services.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	HEHS/OSI-00-69	Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight	4/5/2000	3	In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, the Administrator, HCFA, should clarify the agency's policy on specialized transportation, with the goal of establishing policies that offer equitable treatment for children with different types of disabilities.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	HEHS-00-9	Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available	4/7/2000	2	In order to minimize unintended consequences on beneficiaries, HHAs, and Medicare, and to narrow information gaps in the PPS design, the Administrator, HCFA, should incorporate a risk-sharing arrangement into the PPS design, consistent with methods tested in the demonstration, until available analyses indicate that it is no longer needed to protect beneficiaries, HHAs, or the Medicare program.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	HEHS-00-114	Medicare Quality of Care: Oversight of Kidney Dialysis Facilities Needs Improvement	6/23/2000	1	The Administrator, HCFA, should strengthen HCFA's oversight of ESRD facilities by developing procedures on how and when to use HCFA's existing authority to impose partial or complete payment reductions for ESRD facilities that do not meet Medicare quality standards for dialyzer reuse.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	HEHS/AIMD-00-304	Medicare: HCFA Could Do More to Identify and Collect Overpayments	9/7/2000	1	To improve overpayment identification and collection, the Administrator, HCFA, should require that the effectiveness of prepayment and postpayment activities be evaluated to determine the relative benefits of various prepayment and postpayment safeguards.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	1	To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should amend the approval of Arizona's Health Insurance Flexibility and Accountability waiver to prevent future use of SCHIP funds on childless adults.	Closed, Unimplemented	Non-concur
CMS	GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	2	To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should deny any pending or future state proposals to spend SCHIP funds for this purpose.	Closed, Unimplemented	Non-concur
CMS	GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	4	To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human services should reconsider Utah and Illinois's budget neutrality justifications, in light of GAO's conclusions that certain costs were inappropriate or impermissible and, to the extent appropriate, adjust the limit on the federal government's financial obligation for these waivers.	Closed, Unimplemented	Non-concur
CMS	GAO-01-816	Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated	8/22/2001	1	To help ensure that services are provided in the most appropriate setting, the Administrator of CMS should exclude services from the PPS if they meet the exclusion criteria, regardless of where they are provided.	Closed, Unimplemented	Requires legislative action

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-01-816	Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated	8/22/2001	2	To refine and adjust the SNF PPS and to ensure adequate beneficiary access to appropriate medical services, the Administrator of CMS should develop a strategy to collect and analyze cost and utilization data on all services provided to Medicare beneficiaries during a SNF stay.	Closed, Unimplemented	Requires legislative action
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	1	To ensure the success of the agency's IT modernization, the Administrator of CMS and its senior management should become more involved in IT planning and management efforts, and thus elevate the priority given to these efforts throughout the agency.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	2	To improve development and implementation of the agency's enterprise architecture, the Administrator should direct center and administrative unit officials to complete, in conjunction with the Office of Information Services, the enterprise architecture documentation, particularly of the business functions, information flows, and data elements for the systems for which their respective units are responsible.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	3	To improve development and implementation of the agency's enterprise architecture, the Administrator should direct the Chief Information Officer (CIO) to specify in a migration plan the priorities for, and sequencing of, IT projects.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	5	To improve the investment management process, the Administrator of CMS should require that major IT projects undergo a technical review before the agency approves them for further development.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	6	To improve the investment management process, the Administrator of CMS should direct the CIO and the Federal Management Investment Board to develop sufficient information to monitor the status of IT projects.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	7	To improve the investment management process, the Administrator of CMS should establish a systematic process for evaluating completed IT projects that includes cost, milestone, and performance data.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	1	To improve the utility of the audit reports and usefulness of their findings, the Centers for Medicare and Medicaid Services (CMS) Administrator should fully implement plans to calculate the net effect by plan and potential impact of Adjusted Community Rate Proposal (ACRP) audit findings and adjustments.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	2	To improve the utility of the audit reports and usefulness of their findings, the CMS Administrator should develop and implement a follow-up mechanism to address the audit findings in a timely manner.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	3	To improve the utility of the audit reports and usefulness of their findings, the CMS Administrator should communicate to each Managed Care Organizations (MCO) specific corrective actions needed for future ACRP submissions.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-116	Civil Fines and Penalties Debt: Review of CMS' Management and Collection Processes	12/31/2001	7	The Administrator of CMS should establish and implement formal written debt collection policies and procedures for handling instances in which a discount greater than 35-percent is allowed, including the documentation, review, and approval of such settlements.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-300	Medicaid Financial Management: Better Oversight Needed of State Claims for Federal Reimbursement	1/10/2002	11	The CMS administrator should develop mechanisms to routinely monitor, measure, and evaluate the quality and effectiveness of financial oversight, including audit resolution, by revising Division of Audit Liaison audit tracking reports to ensure that all audits with Medicaid related findings are identified and promptly reported to the regions for timely resolution.	Closed, Unimplemented	Non-concur
CMS	GAO-02-249	Medicare: Communications with Physicians Can Be Improved	2/1/2002	4	In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should strengthen its contractor evaluation and management process by relying on expert teams to conduct more substantive contractor performance evaluation reviews on all physician communications activities.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	1	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should review the adequacy of current state efforts to ensure the accuracy of MDS data, and provide, where necessary, additional guidance, training, and technical assistance.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	2	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should monitor the adequacy of state MDS accuracy activities on an ongoing basis, such as through the use of the established federal comparative survey process.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	3	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should provide guidance to state agencies and nursing homes that sufficient evidentiary documentation to support the full MDS assessment be included in residents' medical records.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-249	Medicare: Communications with Physicians Can Be Improved	2/27/2002	2	In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should establish new performance standards for carrier call centers that emphasize providing complete and accurate answers to physician inquiries. Carriers' monitoring of their carrier call center operations should also be expanded to assure that these performance standards and policies are followed.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-300	Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	7	The CMS administrator should restructure oversight control activities by using comprehensive Medicaid payment data that states must provide in the legislatively mandated national Medicaid Statistical Information System database.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-300	Medicaid Financial Management: Better Oversight Needed of State Claims for Federal Reimbursement	2/28/2002	13	The CMS administrator should establish mechanisms to help ensure accountability and clarify authority and internal control responsibility between regional office and headquarters financial managers by developing a written plan and strategy, which clearly defines and communicates the goals of Medicaid financial oversight and responsibilities for implementing and sustaining improvements.	Closed, Unimplemented	Non-concur
CMS	GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	7	The CMS administrator should restructure oversight control activities by using comprehensive Medicaid payment data that states must provide in the legislatively mandated national Medicaid Statistical Information System database.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	11	The CMS administrator should develop mechanisms to routinely monitor, measure, and evaluate the quality and effectiveness of financial oversight, including audit resolution, by revising Division of Audit Liaison audit tracking reports to ensure that all audits with Medicaid related findings are identified and promptly reported to the regions for timely resolution.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	13	The CMS administrator should establish mechanisms to help ensure accountability and clarify authority and internal control responsibility between regional office and headquarters financial managers by developing a written plan and strategy, which clearly defines and communicates the goals of Medicaid financial oversight and responsibilities for implementing and sustaining improvements.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-312	N+E50:H67ursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	1	To better protect nursing home residents, the Centers for Medicare and Medicaid Services (CMS) Administrator should ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	2	To better protect nursing home residents, the CMS Administrator should accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	3	To better protect nursing home residents, the CMS Administrator should systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	5	To better protect nursing home residents, the CMS Administrator should shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	8	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should baseline the current costs of the service being outsourced, including the cost of internal agency operations.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	14	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should perform an analysis of expected costs and benefits.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	20	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should perform an analysis of risks, including developing plans to mitigate risks identified.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-382	Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues	7/19/2002	4	To strengthen the ability of the HHA survey process to identify and address problems that affect the quality of care, the Administrator of CMS should ensure that resources are adequate for states to fully comply with the requirement to survey all HHAs at least once every 36 months and certain HHAs more frequently.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-02-963	Medicare Hospital Payments: Refinements Needed to Better Account for Geographic Differences in Wages	9/30/2002	1	To improve the adequacy of Medicare's labor cost adjustments, the Administrator of the Centers for Medicare and Medicaid Services should refine the geographic areas used to more accurately reflect the labor markets in which hospitals compete for employees and the geographic variation in hospitals' labor costs. This could include separating large towns in a state into their own labor market area and removing certain outlying counties in metropolitan statistical areas from the metropolitan geographic area if they exhibit wage costs that are significantly different from the rest of the metropolitan area.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-03-187	Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature	10/31/2002	1	To ensure that publicly reported quality indicator data accurately reflect the status of quality in nursing homes and fairly compare homes to one another, the Administrator of CMS should delay the implementation of nationwide reporting of quality indicators until there is greater assurance that the quality indicators are appropriate for public reporting--including the validity of the indicators selected and the use of an appropriate risk-adjustment methodology--based on input from the NQF and other experts and, if necessary, additional analysis and testing.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-03-187	Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature	10/31/2002	2	To ensure that publicly reported quality indicator data accurately reflect the status of quality in nursing homes and fairly compare homes to one another, the Administrator of CMS should delay the implementation of nationwide reporting of quality indicators until a more thorough evaluation of the pilot is completed to help improve the initiative's effectiveness, including an assessment of the presentation of information on the Web site and the resources needed to assist consumers' use of the information.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-03-185	Medicare Provider Enrollment: Opportunities to Enhance Program Integrity Efforts	3/17/2003	1	To facilitate improvements in program integrity, the CMS Administrator should propose legislation permitting the reassignment of benefits to staffing companies that retain contractor physicians to treat Medicare beneficiaries and requiring that these companies seek enrollment in Medicare.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-03-175	Medicare: Divided Authority for Policies on Coverage of Procedures and Devices Results in Inequities	4/11/2003	1	To ensure that all Medicare beneficiaries are treated equitably, the Administrator of CMS should eliminate the ability of claims administration contractors to develop new coverage policies for procedures and devices that have established codes.	Closed, Unimplemented	Non-concur
CMS	GAO-03-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	2	To better ensure that state survey and complaint activities adequately address quality-of-care problems, the Administrator of CMS should require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-03-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	4	To better ensure that states comply with statutory, regulatory, and other CMS nursing home requirements designed to protect resident health and safety, the Administrator of CMS should further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-13-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	2	To better ensure that state survey and complaint activities adequately address quality-of-care problems, the Administrator of CMS should require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	1	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for making administrative processes, such as file tracking and transfer, compatible across all appeals bodies.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	3	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for negotiating responsibilities and strategies for reducing the backlog of pending cases, especially at OHA and the MAC, and establish the priority for adjudicating pre-BIPA cases relative to BIPA-governed cases.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	5	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for establishing requirements for reporting specific and comparable program and performance data to CMS, SSA, and HHS so that management can identify opportunities for improvement, and determine the resource requirements necessary to ensure that all appeals bodies will be able to meet BIPA's requirements.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-103R	Medicare: Discrepancy in Hospital Outpatient Prospective Payment System Methodology Leads to Inaccurate Beneficiary Copayments and Medicate Payments	10/6/2003	1	For the purpose of calculating the 2004 OPPS beneficiary copayment amounts, the Administrator of CMS should first apply the 2002 copayment methodology to the 2003 APCs for which beneficiaries were inaccurately charged. The 2004 copayment amounts should then be based on these revised 2003 copayment amounts.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-228	Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed	2/13/2004	4	To protect the fiscal integrity of the Medicaid program, the Administrator of CMS should establish criteria for making transition period decisions that are consistent with the objectives described in CMS's January 2001 UPL regulation.	Closed, Unimplemented	Non-concur
CMS	GAO-04-228	Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed	2/13/2004	3	To protect the fiscal integrity of the Medicaid program, the Administrator of CMS should reconsider the agency's initial decisions to grant Nebraska and Wisconsin 8-year transition periods.	Closed, Unimplemented	Non-concur
CMS	GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	3	To ensure that approved Pharmacy Plus and other Medicaid section 1115 demonstrations fulfill the objectives stated in their evaluation plans, the Secretary of HHS should ensure that states are taking appropriate steps to develop evaluation designs and to implement them by collecting and reporting the specific information needed for a full evaluation of the demonstration objectives.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	4	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should document and make public the basis for any section 1115 demonstration approvals, including the basis for the cost and enrollment growth rates used to arrive at the spending limits.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	5	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should consider applying these criteria to the four approved Pharmacy Plus demonstrations and reconsider the approval decisions, as appropriate.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	6	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should, for future demonstrations, clarify criteria for reviewing and approving states' proposed spending limits.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	5	To create incentives for facilities to maintain compliance with Medicare quality standards, the Administrator of CMS should establish a goal for state agencies to reduce the time between surveys for facilities with condition-level deficiencies.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	4	To create incentives for facilities to maintain compliance with Medicare quality standards, the Administrator of CMS should publish facilities' survey results on its Dialysis Facility Compare Web site.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	3	To help surveyors identify and systematically document deficiencies, the Administrator of CMS should strongly encourage states to assign ESRD inspections to a designated subset of surveyors who specialize in conducting ESRD surveys.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	1	To enhance the support and monitoring of state survey agencies, the administrator of CMS should amend its regulations to require that networks share facility-specific data with state agencies on a routine basis.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	6	To enhance the support and monitoring of state survey agencies, the administrator of CMS should ensure that regional offices both adequately monitor state performance and provide state agencies ongoing assistance on policy and technical issues through regularly scheduled contacts with state surveyors.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	1	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare conditions of participation (COPs), the Administrator of CMS should modify the method used to measure the rate of disparity between validation survey findings and accreditation program findings to provide a reasonable assurance that Medicare COPs are being met and consider whether additional measures are needed to accurately reflect an accreditation program's ability to detect deficiencies in Medicare COPs.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	2	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare COPs, the Administrator of CMS should provide in the annual report to Congress an estimate, based on the validation survey sample, of the performance of all JCAHO-accredited hospitals, including the limitations and protocols for these estimates based on generally accepted sampling and statistical methodologies; and develop a written protocol for these calculations.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	3	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare COPs, the Administrator of CMS should annually conduct traditional validation surveys on a sample of JCAHO-accredited hospitals that is equal to at least 5 percent of all JCAHO-accredited hospitals.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-709	Comprehensive Outpatient Rehabilitation Facilities: High Medicare Payments in Florida Raise Program Integrity Concerns	8/12/2004	1	To ensure that Medicare only pays for medically necessary care as outlined in program rules, the Centers for Medicare and Medicaid Services should direct the Florida claims administration contractor to medically review a larger number of CORF claims.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	1	The Administrator of CMS should gather the necessary data and perform an analysis that compares the types and costs of services on single-service claims to those on multiple-service claims.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	2	The Administrator of CMS should analyze the effect that the variation in hospital charge-setting practices has on the OPPS rate-setting methodology.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	3	The Administrator of CMS should, in the context of the first two recommendations, analyze whether the OPPS rate-setting methodology results in payment rates that uniformly reflect hospitals' costs of the outpatient services they provide to Medicare beneficiaries, and, if it does not, make appropriate changes in that methodology.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	1	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should prepare a detailed project plan to include interim and final milestones, individuals or groups responsible for completing key elements essential to the transfer, and contingency plans.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	3	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should validate data and perform analyses to support decisions regarding key elements, such as workload, staffing needs, and costs.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	5	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should outline a strategy that addresses the possible need for two separate processing systems at HHS--one for appeals that follows the current processing practices and one that complies with BIPA's time frames and other requirements--in the event that the BIPA provisions establishing the QICs are not implemented as scheduled.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	7	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should identify where staff and hearing facilities--including videoconference equipment--are needed as well as opportunities to share staff and office space.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	9	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should develop an approach to ensure that ALJs and support staff with Medicare expertise can be hired, and that all staff are adequately trained to process and adjudicate Medicare appeals.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	11	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should define the relationship of HHS's ALJ unit to the other organizations within the department, and identify safeguards that will be established to ensure decisional independence.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-43	Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs	11/17/2004	1	To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, the Administrator of CMS should develop a process within CMS to focus on trends in Medicare spending and disproportionate or suspicious Medicare payments; develop strategies to address the trends that may indicate possible improper payments for DME; and take timely action, when warranted.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-43	Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs	11/17/2004	3	To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, the Administrator of CMS should strengthen the standards for Medicare DME suppliers to include prohibiting certain misleading or abusive marketing practices.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-60	Medicare Physician Fee Schedule: CMS Needs a Plan for Updating Practice Expense Component	12/13/2004	2	To improve and update the physician fee schedule, the CMS Administrator should base any revisions to the resource estimates for individual services on sufficient data analysis and a documented and transparent rationale.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-119	Medicare Physician Fees: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement	3/11/2005	2	The Secretary of Health and Human Services should seek to improve the GPCI's data and methods by adding data on physician assistants' wages to improve the measurement of the practice expense GPCI.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-366	Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities	4/22/2005	2	To help ensure that IRFs can be classified appropriately and that only patients needing intensive inpatient rehabilitation are admitted to IRFs, the CMS Administrator should conduct additional activities to encourage research on the effectiveness of intensive inpatient rehabilitation and the factors that predict patient need for intensive inpatient rehabilitation.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-366	Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities	4/22/2005	3	To help ensure that IRFs can be classified appropriately and that only patients needing intensive inpatient rehabilitation are admitted to IRFs, the CMS Administrator should use the information obtained from reviews for medical necessity, research activities, and other sources to refine the rule to describe more thoroughly the subgroups of patients within a condition that are appropriate for IRFs rather than other settings, and may consider using other factors in the descriptions, such as functional status.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	1	To provide for a more appropriate basis for adjusting BIPA PPS payment rates for FQHCs and RHCs, the Administrator of CMS should explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs and propose to	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
					Congress, as appropriate, any needed revisions to the statute.		
CMS	GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	2	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' Medicaid plans provide sufficient information describing their methodologies for paying FQHCs and RHCs for Medicaid services, including, at a minimum, whether the state is using the BIPA PPS or an alternative methodology.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	3	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should develop guidance for states describing what constitutes a change in scope of services provided by FQHCs and RHCs, including the definition of the specific elements that affect such a change.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	4	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' FQHC and RHC BIPA PPS payment rates do not inappropriately exclude the costs of Medicaid-covered services.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	5	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' alternative payment methodologies are paying FQHCs and RHCs at least as much as what would be paid under the BIPA PPS, including any needed adjustments due to a change in scope of services.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	1	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents, such as state plan amendment proposals.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	2	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents, such as cost allocation proposals.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	4	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents and in the event that states do not voluntarily provide this information, seek legislative authority to require disclosure.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	6	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should enhance CMS review of states' Medicaid documents, such as such as cost allocation plans, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	7	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should enhance CMS review of states' Medicaid documents, such as expenditure reports, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	10	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should establish or clarify and then communicate CMS policies on rehabilitation services and ensure that the policies are applied consistently across all states.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	13	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should require that states identify--in Medicaid-related documents such as expenditure reports-- claims for payments to units of state or local government, such as state- and local-government-owned or -operated facilities.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need	6/28/2005	14	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should enhance CMS review of state Medicaid documents for which states have used a contingency-fee consultant and take appropriate action to prevent or recover	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		for Improved Federal Oversight			federal reimbursements associated with unallowable claims.		
CMS	GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	15	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should ensure that states submit cost allocation plans as required and establish a procedure for their prompt review.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-05-873	Medicare Contracting Reform: CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain	8/17/2005	1	To better ensure the effective implementation of Medicare contracting reform, CMS should extend its implementation schedule to complete its workload transitions by October 2011, so that the agency can be better prepared to manage this initiative.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceuticals Used in Hospitals	10/31/2005	1	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should reconsider the level of proposed payment rates for drug SCODs, in relation to survey data on average purchase price, the role of rebates in determining acquisition costs, and the desirability of setting payment rates for SCODs at average acquisition costs.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceuticals Used in Hospitals	10/31/2005	2	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should reconsider the decision to base payment rates for radiopharmaceutical SCODs exclusively on estimated costs, in light of the availability of data on actual prices paid for key radiopharmaceuticals.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceut	10/31/2005	3	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should collect information on ASP components and ASP by purchaser type to validate the reasonableness of reported ASPs as a measure of hospital acquisition costs.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		icals Used in Hospitals					
CMS	GAO-06-54	Hospital Quality Data: CMS Needs More Rigorous Methods to Ensure Reliability of Publicly Released Data	1/31/2006	3	In order for CMS to help ensure the reliability of the quality data it uses to produce information on hospital performance, the CMS Administrator should assess the level of incomplete data submitted by hospitals for the APU program to determine the magnitude of underreporting, if any, in order to refine how completeness assessments may be done in future reporting efforts.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-06-372	Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-Setting Challenges for CMS	4/28/2006	1	To ensure that Medicare payments for SCOD products are based on sufficiently accurate data, the Secretary of Health and Human Services should validate, on an occasional basis, manufacturers' reported drug ASPs as a measure of hospitals' acquisition costs using a survey of hospitals or other method that CMS determines to be similarly accurate and efficient.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-06-372	Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-Setting Challenges for CMS	4/28/2006	2	To ensure that Medicare payments for SCOD products are based on sufficiently accurate data, the Secretary of Health and Human Services should use unit-dose prices paid by hospitals when available as the data source for setting and updating Medicare payment rates for radiopharmaceutical SCODs.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	5	To ensure consistency in the oversight of labs by survey organizations, the CMS Administrator should require all survey organizations to develop, and require labs to prominently display, posters instructing lab workers on how to file anonymous complaints.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	6	To improve oversight of labs and survey organizations, the CMS Administrator should, consistent with CLIA, require quarterly proficiency testing, except when technical and scientific considerations suggest that less frequent testing is appropriate for particular examinations or procedures.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	11	To improve oversight of labs and survey organizations, the CMS Administrator should require that almost all validation reviews of each accrediting organizations' surveys be an independent assessment of performance.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents	3/26/2007	1	To address weaknesses that undermine the effectiveness of the immediate sanctions policy, the Administrator of CMS should reassess and revise the policy to ensure that it accomplishes the following three objectives: (1) reduce the lag time between citation of a double G and the implementation of a sanction, (2) prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions, and (3) hold states accountable for reporting in federal data systems serious deficiencies identified during complaint investigations so that all complaint findings are considered in determining when immediate sanctions are warranted.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some	3/26/2007	3	To strengthen the deterrent effect of available sanctions and to ensure that sanctions are used to their fullest potential, the Administrator of CMS should increase use of discretionary DPNAs to help ensure the speedier	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Homes from Repeatedly Harming Residents			implementation of appropriate sanctions.		
CMS	GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents	3/26/2007	4	To strengthen the deterrent effect of available sanctions and to ensure that sanctions are used to their fullest potential, the Administrator of CMS should strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-214	Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency	3/30/2007	1	To enhance the transparency of CMS oversight and clarify and communicate the types of allowable state financing arrangements, the Administrator of CMS should issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-07-272	Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries	5/4/2007	6	To support states with the relevant authority that want to use alternative enrollment methods to reassign dual-eligible beneficiaries to PDPs, the Administrator of CMS should facilitate the sharing of data between PDPs and states.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-383	Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly	5/23/2007	1	In light of the variability in ambulance providers' Medicare margins and the potential for negative margins to have an impact on beneficiary access, the Administrator of the Centers for Medicare and Medicaid Services should monitor utilization of ambulance transports to ensure that Medicare payments are adequate to provide for beneficiary access to ambulance services, particularly in super-rural areas.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-373	Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations	5/29/2007	4	To improve monitoring of QIO assistance to nursing homes and to overcome limitations of the QMs as an evaluation tool, the Administrator of CMS should collect more complete and detailed data on the interventions QIOs are using to assist homes.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-07-734	Medicare Ultrasound Procedures: Consideration of Payment Reforms and Technician Qualification Requirements	6/28/2007	1	The Administrator of CMS should require that sonographers paid by Medicare either be credentialed or work in an accredited facility. The Administrator should weigh the advantages and disadvantages of implementing a National Coverage Determination compared with promulgating regulations that this requirement be a condition for Medicare payment.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-466	Medicare: Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised	6/29/2007	1	To help ensure that Medicare's payments to physicians more accurately reflect geographic differences in physicians' costs of operating a private medical practice, the Administrator of CMS should examine and revise the physician payment localities using an approach that is uniformly applied to all states and based on the most current data.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-07-466	Medicare: Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised	6/29/2007	2	To help ensure that Medicare's payments to physicians more accurately reflect geographic differences in physicians' costs of operating a private medical practice, the Administrator of CMS should examine and, if necessary, update the physician payment localities on a periodic basis with no more than 10 years between updates.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-07-945	Medicare Advantage: Required Audits of Limited Value	7/30/2007	3	To help fulfill CMS's responsibilities, the Administrator of CMS should amend the implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with Medicare Advantage organizations and prescription drug plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. If CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do so.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-08-87	Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns	1/31/2008	1	To help ensure that the Florida demonstration will maintain the fiscal integrity of the Medicaid program, the Secretary of HHS should ensure that the level of supplemental payments for which the state could have obtained federal Medicaid funds in the absence of the proposed demonstration is calculated using appropriate methods and accurate data sources, and adjust the approved spending limit appropriately.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-25	Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans	2/15/2008	1	The Acting Administrator of Centers for Medicare and Medicaid Services (CMS) should investigate the extent to which beneficiaries in PFFS plans are faced with unexpected out-of-pocket costs due to the denial of coverage when they did not obtain an advance coverage determination from their plan.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-09-25	Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans	2/15/2008	3	The Acting Administrator of Centers for Medicare and Medicaid Services (CMS) should mail to Medicare beneficiaries MA plan disenrollment rates for the previous 2 years for MA plans that are or will be available in their areas, as required by statute, and update disenrollment rates provided to Medicare beneficiaries through MOC.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-08-529	Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities	5/23/2008	3	To provide additional oversight of the quality of care provided to these individuals, the Administrator of CMS should establish as an expectation for HCBS waivers that state Medicaid agencies report all deaths among individuals with developmental disabilities receiving such waiver services to their state office of protection and advocacy.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-08-614	Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments	5/30/2008	2	To improve the oversight of states' Medicaid supplemental payments, the Administrator of CMS should develop a strategy to identify all of the supplemental payment programs established in states' Medicaid plans and to review those programs that have not been subject to review under CMS's August 2003 initiative.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-118	Debt Management: Treasury's Cash Management Challenges and Timing of Payments to Medicare Private Plans	1/30/2009	1	The Secretary of the Treasury and the Administrator of CMS should expeditiously convene a joint interagency effort to study options identified by GAO and any other options that would improve Treasury's ability to manage cash flow and reduce overall interest costs while not unduly increasing administrative burden for CMS. For each option, the joint study should include discussion of (1) operational impacts on and likely consequences for cash management, CMS, and Treasury operations; (2) plan sponsors' likely responses and the consequences of these for the Medicare program and beneficiaries; (3) the expected change in federal costs and the distribution of any increases or decreases; (4) analysis of feasibility and mechanics of varying payment schedule by size/scale of plan; and (5) what would be needed for implementation, including which options would require statutory change and if so the specific changes necessary. Based on the work done and our discussions with Treasury officials, we believe it is reasonable for this study to be completed by the end of CY 2009.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	3	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to ensure that Congress has adequate information on the impact of funding on facility oversight, the CMS Administrator should inform Congress of the projected cost of surveying all facilities that lack statutorily mandated survey frequencies a minimum of at least once every 3 years.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	4	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to ensure that Congress has adequate information on the impact of funding on facility oversight, the CMS Administrator should include information in the President's budget request on projected state complaints and the cost of completing the associated workload.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	7	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to improve CMS's ability to differentiate between funding and management issues and help ensure the quality of surveys, the CMS Administrator should provide Congress with an estimate of the cost of implementing, over 3 years, the Quality Indicator Survey methodology for nursing homes.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	1	To improve the targeting of scarce survey resources, the Administrator of CMS should consider an alternative approach for allocating the 136 SFFs across states, by placing more emphasis on the relative performance of homes nationally rather than on a state-by-state basis, which could result in some states having only one or not any SFFs and other states having more than they are currently allocated.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	2	To improve the SFF methodology's ability to identify the most poorly performing nursing homes, the Administrator of CMS should assign points to G-level deficiencies in substandard quality of care (SQC) areas equivalent to those additional points assigned to H- and I-level deficiencies in SQC areas.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	3	To improve the SFF methodology's ability to identify the most poorly performing nursing homes, the Administrator of CMS should account for a nursing home's full compliance history regardless of technical status changes.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	5	To ensure consistency with the SFF methodology, CMS should consider making two of these modifications--the SQC and full compliance history changes--to its Five Star System.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-70	Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment	11/24/2009	3	To address surveyor workforce shortages and insufficient training, the Administrator of CMS should consider establishing a pool of additional national surveyors that could augment state survey teams or identify other approaches to help states experiencing workforce shortages.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	OEI-03-08-00480	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2010	2/4/2010		The OIG recommends that CMS seek a legislative change to directly require all manufacturers of Part B-covered drugs to submit ASPs.	Closed (Unimplemented)	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	1	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational structure and the relationships to the facility and to one another of all persons or entities with direct or indirect ownership or control interests in the provider (as defined in the act), such that the hierarchy of all intermediate persons and entities from the provider level up to the chain and the ultimate owner is described.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	4	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the names and titles of the members of the chains' governing body.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	5	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational affiliation of individuals with an ownership or control interest (as defined in the act).	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	7	To ensure that all providers that belong to the same nursing home chain can be readily identified, the Administrator of CMS should require each provider to report the identity of other nursing homes that are part of the same chain.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and	9/30/2010	9	To improve the usability and accuracy of the ownership and control information collected and stored in PECOS, the Administrator of CMS should examine state systems to identify best practices for the collection and public dissemination of nursing home ownership and chain information,	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Completeness of Ownership Data			including ways in which states make the hierarchy among owners more apparent.		
CMS	GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	11	To help ensure that the requirements for the collection of ownership and control information from nursing home providers that participate in Medicare and Medicaid keep pace with evolving ownership structures, the Administrator of CMS should periodically review the requirements related to reporting on the agency's provider enrollment form to ensure that it promotes accurate and complete reporting of nursing home ownership information consistent with the statute.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and	10/27/2010	1	The Secretary should consider mandating the reporting of the following types of information: The organizational structure and the relationships to the facility and to one another of all persons or entities with direct or indirect ownership or control interests in the provider, such that the hierarchy of all intermediate persons and entities from the provider level up	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Completeness of Ownership Data			to the chain and the ultimate owner is described;		
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	4	The Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the names and titles of the members of the chains' governing body.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and	10/27/2010	5	The Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational affiliation of individuals with an ownership or control interest (as defined in the act).	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Completeness of Ownership Data					
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	7	To ensure that all providers that belong to the same nursing home chain can be readily identified, the Administrator of CMS should require each provider to report the identity of other nursing homes that are part of the same chain.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and	10/27/2010	9	To improve the usability and accuracy of the ownership and control information collected and stored in PECOS, the Administrator of CMS should examine state systems to identify best practices for the collection and public dissemination of nursing home ownership and chain information, including ways in which states make the hierarchy among owners more apparent.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Completeness of Ownership Data					
CMS	GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	11	To help ensure that the requirements for the collection of ownership and control information from nursing home providers that participate in Medicare and Medicaid keep pace with evolving ownership structures, the Administrator of CMS should periodically review the requirements related to reporting on the agency's provider enrollment form to ensure that it promotes accurate and complete reporting of nursing home ownership information consistent with the statute.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-11-56	Medicare Home Oxygen: Refining Payment Methodology Has Potential to Lower Program and Beneficiary Spending	1/21/2011	1	To establish rates that more accurately reflect the distinct costs of providing each type of home oxygen equipment, the Administrator of CMS should restructure Medicare's home oxygen payment methodology. This should include removing the payment for portable oxygen refills from that for stationary equipment and paying for	Closed, Unimplemented	Non-concur, recommendation is no longer valid

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
					refills only for the equipment types that require them.		
CMS	GAO-11-159	Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology	2/17/2011	4	To help ensure that Electronic Prescribing Program resources are used appropriately, the Administrator of CMS should develop a risk-based strategy to audit a sample of providers who received incentive payments from the Electronic Prescribing Program to help ensure that providers who receive incentive payments meet that program's requirements. A risk-based strategy could, for example, focus on those providers who received larger incentive payments.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-11-365	End-Stage Renal Disease: CMS Should Assess Adequacy of Payment When Certain Oral Drugs Are Included and Ensure Availability of	3/23/2011	2	In order to ensure effective monitoring of treatment of mineral and bone disorder, the Administrator of CMS should continue collecting data for quality measures related to this condition from sources such as the Elab Project until CROWNWeb is fully implemented and concerns about its data reliability have been adequately addressed.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Quality Monitoring Data					
CMS	GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/17/2011	3	To strengthen CMS's assessment of state survey agencies' performance in the management of nursing home complaints, the Administrator of CMS should assess state survey agencies' performance in certain areas--specifically, documentation of deficiencies, prioritization of complaints, and quality of investigations--less frequently than once a year.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-11-446	Health Care Fraud and Abuse Control Program: Improvements Needed in Controls over Reporting Deposits and Expenditures	5/10/2011	1	To improve controls over the accounting and reporting of HCFAC activities, the Secretary of HHS should direct the Administrator of CMS to revise procedures for properly maintaining supporting documentation for HCFAC deposits and expenditures, to include specifying the titles of staff responsible for maintaining supporting documentation.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-11-446	Health Care Fraud and Abuse Control Program: Improvements Needed in Controls over Reporting Deposits and Expenditures	5/10/2011	5	To improve controls over the accounting and reporting of HCFAC activities, the Secretary of HHS should direct the Acting General Counsel to develop written procedures that incorporate monitoring controls for the Office of the General Counsel staff hours related to HCFAC activities captured in workload tracking systems, including the reconciliation to staff hours captured in the department wide payroll system.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-11-475	Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use	6/12/2011	6	To help ensure that the development and implementation of IDR and One PI are successful in helping the agency meet the goals and objectives of its program integrity initiatives, the Administrator of CMS should define any measurable financial benefits expected from the implementation of IDR and One PI.	Closed, Unimplemented	Updated action, recommended closure to GAO
CMS	GAO-11-475	Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use	6/30/2011	6	To help ensure that the development and implementation of IDR and One PI are successful in helping the agency meet the goals and objectives of its program integrity initiatives, the Administrator of CMS should define any measurable financial benefits expected from the implementation of IDR and One PI.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	OEI-03-11-00410	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	11/10/2011	399-905-13-02	Consider seeking a legislative change to directly require all manufacturers of Part B-covered drugs to submit both ASPs and AMPs.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-627	NATIONAL MEDICAID AUDIT PROGRAM: CMS Should Improve Reporting and Focus on Audit Collaboration with States	12/1/2011	1	The CMS Administrator should ensure that the MIG's planned update of its comprehensive plan: 1) quantifies the NMAP's expenditures and recoveries; 2) addresses any program improvements; and 3) outlines plans for effectively monitoring the NMAP program, including how to validate and use any lessons learned or feedback from the States to continuously improve the audits.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-61	Medicare: Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations	12/15/2011	1	To help improve the ability of Medicare beneficiaries to obtain routinely recommended vaccinations, the Administrator of CMS should explore options and take appropriate steps to address administrative challenges, such as physicians' difficulty in verifying beneficiaries' coverage and billing for Part D-covered vaccinations.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	OEI-03-08-00030	Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors	12/15/2011	2	Require all benefit integrity contractors to report monetary impact, when calculable, in a consistent format	Closed, Unimplemented	Non-concur
CMS	GAO-12-409R	Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings	3/21/2012	1	The Secretary of HHS should cancel the MA Quality Bonus Payment Demonstration and allow the MA quality bonus payment system established by PPACA to take effect. If, at a future date, the Secretary finds that this system does not adequately promote quality improvement, HHS should determine ways to modify the system, which could include conducting an appropriately designed demonstration.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-390	Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met	3/23/2012	1	In order to strengthen CMS's efforts to improve the Five-Star System, the Administrator of CMS should use strategic planning practices to establish -- through planning documents -- how its planned efforts will help CMS achieve the goals of the Five-Star System.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-12-390	Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met	3/23/2012	2	In order to strengthen CMS's efforts to improve the Five-Star System, the Administrator of CMS should use strategic planning practices to develop milestones and timelines for each of its planned efforts.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-481	Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements	4/30/2012	3	In order to improve the efficiency and effectiveness of processes to verify whether providers meet program requirements for the Medicare and Medicaid EHR programs, the Administrator of CMS should collect the additional information from Medicare providers during attestation that CMS suggested states collect from Medicaid providers during attestation.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-481	Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements	4/30/2012	4	In order to improve the efficiency and effectiveness of processes to verify whether providers meet program requirements for the Medicare and Medicaid EHR programs, the Administrator of CMS should offer states the option of having CMS collect meaningful use attestations from Medicaid providers on their behalf.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-12-627	National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States	6/14/2012	`1	To effectively redirect the NMAP toward more productive outcomes and to improve reporting under the Deficit Reduction Act of 2005 (DRA), the CMS Administrator should ensure that the MIG's planned update of its comprehensive plan (1) quantifies the NMAP's expenditures and audit outcomes; (2) addresses any program improvements; and (3) outlines plans for effectively monitoring the NMAP program, including how to validate and use any lessons learned or feedback from the states to continuously improve the audits.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-831	Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards	8/1/2012	2	In order for CMS to implement an option for removing SSNs from Medicare cards, the Administrator of CMS should develop an accurate, well-documented cost estimate for such an option using standard cost-estimating procedures.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	1	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should require D-SNPs to state explicitly in their models of care the extent of services they expect to provide, to increase accountability and to facilitate evaluation.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	2	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should require D-SNPs to collect and report to CMS standard performance and outcome measures to be outlined in their models of care that are relevant to the population they serve, including measures of beneficiary health risk, beneficiary vulnerability, and plan performance.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	3	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should systematically analyze these data and make the results routinely available to the public.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	OEI-03-12-00670	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	2/6/2013	399-915-11-02	The OIG recommends that CMS consider expanding the price substitution policy to include certain HCPCS codes with partial AMP data.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	OEI-03-12-00670	Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2012	2/6/2013	399-915-11-02	The OIG recommends that CMS consider expanding the price substitution policy to include certain HCPCS codes with partial AMP data.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-13-522	Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency	7/23/2013	2	In order to improve the efficiency and effectiveness of Medicare program integrity efforts and simplify compliance for providers, the Administrator of CMS should communicate publicly CMS's findings and its time frame for taking further action.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-14-111	Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	10/25/2013	1	To help ensure that CMS's fraud prevention activities are effective and that CMS is comprehensively assessing ZPIC performance, the Administrator of CMS should collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, such as how soon investigations are initiated after ZPICs identify potential fraud and how swiftly ZPICs initiate administrative actions after identifying potentially fraudulent providers.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-14-111	Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	10/25/2013	2	To help ensure that CMS's fraud prevention activities are effective and that CMS is comprehensively assessing ZPIC performance, the Administrator of CMS should develop ZPIC performance measures that explicitly link their work to the agency's Medicare fee-for-service program integrity performance measures and targets for its GPRA goal	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
					of fighting fraud and working to eliminate improper payments.		
CMS	GAO-14-111	MEDICARE PROGRAM INTEGRITY: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	11/25/2013	1	The CMS should collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, such as how soon investigations are initiated after ZPICs identify potential fraud and how swiftly ZPICs initiate administrative actions after identifying potentially fraudulent providers.	Closed, Unimplemented	Updated action, recommended closure to GAO
CMS	GAO-14-111	MEDICARE PROGRAM INTEGRITY: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	11/25/2013	2	The CMS should develop ZPIC performance measures that explicitly link their work to the agency's Medicare fee-for-service program integrity performance measures and targets for its GPRA goal of fighting fraud and working to eliminate improper payments.	Closed, Unimplemented	Updated action, recommended closure to GAO

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	OEI-03-13-00570	Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2013	3/14/2014		The OIG recommends that CMS expand the price substitution policy to include HCPCS codes with complete AMP data that exceed the threshold in a single quarter.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-14-697	Patient Protection And Affordable Care Act: Procedures for Reporting Certain Financial Management Information Should Be Improved	9/22/2014	1	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare and Medicaid Services to identify and evaluate options to facilitate more timely and independently verifiable reporting of CCIIO-related financial management information, such as enhancing Healthcare Integrated General Ledger Accounting System's standard reporting or custom reporting capabilities.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-15-85	Compounded Drugs: Payment Practices Vary across Public Programs and Private Insurers, and Medicare Part B Policy Should Be Clarified	10/10/2014	1	To help ensure that Medicare Part B is able to appropriately apply its payment policy for compounded drugs, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to clarify the Medicare Part B payment policy for compounded drugs and, as necessary, align payment practices with the policy. For example, CMS should consider updating the Medicare Part B payment policy to either explicitly allow or restrict payment for compounded drugs containing bulk drug substances and, as appropriate, develop a mechanism to indicate on Medicare Part B claims both whether a beneficiary received a compounded drug and the drug's individual ingredients in order to properly apply this policy and determine payment.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-15-207	Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness	1/30/2015	1	To ensure that the federal government's and states' investments in information systems result in outcomes that are effective in supporting efforts to save funds through the prevention and detection of improper payments in the Medicaid program, the Secretary of Health and Human Services should direct the Administrator of CMS to require states to measure quantifiable benefits, such as cost reductions or avoidance, achieved as a result of operating information systems to help prevent and detect improper payments. Such measurement of benefits should reflect a consistent and repeatable approach and should be reported when requesting approval for matching federal funds to support ongoing operation and maintenance of systems that were implemented to support Medicaid program integrity purposes.	Closed, Unimplemented	Non-concur
CMS	OEI-03-14-00520	Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2013	2/26/2015	399-915-12-23	The OIG recommends that CMS consider pursuing rulemaking to expand the price substitution policy to include at least some additional drug codes.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	OEI-02-13-00611	Skilled Nursing Facility Billing for Changes In Therapy: Improvements Are Needed	6/30/2015	399-915-11-63	Reduce the financial incentive for SNFs to use assessments differently when decreasing and increasing therapy.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	OEI-07-13-00120	NOT ALL STATES REPORTED MEDICAID MANAGED CARE ENCOUNTER DATA AS REQUIRED	7/3/2015	399-915-11-66	The OIG recommends that CMS monitor encounter data to ensure states report all managed care entities.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	GAO-15-527	CMS Should Improve Oversight of State Information Technology Projects	9/16/2015	2	To improve the oversight of states' marketplace IT projects, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to ensure that all CMS senior executives from IT and business units who are involved in the establishment of state marketplace IT projects review and approve funding decisions for these projects.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-15-527	State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects	9/16/2015	2	To improve the oversight of states' marketplace IT projects, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to ensure that all CMS senior executives from IT and business units who are involved in the establishment of state marketplace IT projects review and approve funding decisions for these projects.	Closed, Unimplemented	Updated action, recommended closure to GAO
CMS	A-06-16-05003	Medicare Contractors' Payments to Providers for Hospital Outpatient Dental Services Generally Did Not Comply With Medicare Requirements	3/1/2017	2	Work with the Medicare contractors to develop or strengthen their local edits to ensure that payments made to providers for dental services comply with Medicare requirements.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-06-16-05003	Medicare Contractors' Payments to Providers for Hospital Outpatient Dental Services Generally Did Not Comply	3/1/2017	1	The OIG recommends that CMS implement national edits for hospital outpatient dental services.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		With Medicare Requirements					
CMS	A-07-14-02800	Vulnerabilities Remain in Medicare Hospital Outlier Payments	9/14/2017	500-915-10-4	The OIG recommends that CMS maintain a system that identifies and tracks all cost reports that Medicare contractors have referred for reconciliation and that recalculates outlier payments on the basis of claim submissions made by hospitals.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-07-14-02800	Vulnerabilities Remain in Medicare Hospital Outlier Payments	9/14/2017	500-915-10-2	The OIG recommends that CMS determine whether the cost reports that had exceeded the 3-year reopening limit may be reopened due to similar fault and, if so, work with the Medicare contractors to reopen them.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-07-14-02800	Vulnerabilities Remain in Medicare Hospital Outlier Payments	9/14/2017	500-915-10-1	The OIG recommends that CMS ensure that the Medicare contractors are continuing to take the corrective actions that we recommended in our previous series of reviews, to include collecting identified overpayments and returning those funds to either Medicare or hospitals.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	OEI-03-17-00360	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2015 Average Sales Prices	9/27/2017	399-915-11-15	The OIG recommends that CMS expand the price substitution policy to include additional drugs.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-09-16-02042	Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services	2/12/2018	2	CMS should educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-coveredServices.	Closed, Unimplemented	Non-concur
CMS	A-09-16-02042	Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services	2/12/2018	3	CMS should identify chiropractors with aberrant billing patterns or high service-denial rates, select a statistically valid random sample of services provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and request that the chiropractors refund the amounts overpaid by Medicare.	Closed, Unimplemented	Non-concur

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	A-05-14-00041	Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements	3/14/2018	1	Instruct the MACs to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments made in accordance with this recommendation.	Closed, Unimplemented	Non-concur
CMS	A-09-17-03002	Medicare Improperly Paid Providers for Items and Services Ordered by Chiropractors	7/5/2018	3	We recommend that CMS revise the claims processing edits to ensure that all claims for items and services ordered by chiropractors are denied.	Closed, Unimplemented	Non-concur
CMS	A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	1	The OIG recommends that CMS direct the Medicare contractors to recover the portion of the $8,633,940 in improper payments made to providers for claim lines that are within the 4-year claim-reopening period.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	2	The OIG recommends that for the remaining portion of the $8,633,940, which is outside of the Medicare reopening and recovery periods, CMS instruct the Medicare contractors to notify providers of potential improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	322-908-10-1	The OIG recommends that CMS direct the Medicare contractors to review claim lines for nonemergency ambulance transports to destinations not covered by Medicare after the audit period and recover any improper payments identified.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not	7/11/2018	322-009-01-1	The OIG recommends that CMS direct the Medicare contractors to recover the portion of the $8,633,940 in improper payments made to providers for claim lines that are within the 4-year claim-reopening period.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Covered by Medicare					
CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	322-009-01-1	We recommend that CMS direct the Medicare contractors to recover the portion of the $975,154 in improper payments made to providers for claim lines for emergency ambulance transports to destinations not covered by Medicare that are within the 4-year claim-reopening period.	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or	8/15/2018	322-009-03-1	We recommend that CMS direct the Medicare contractors to review claim lines that are within the 4-year claim-reopening period for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports and recover any improper payments identified, which could represent $928,092 in improper payments.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Skilled Nursing Facilities					
CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	322-908-10-1	We recommend that CMS for the remaining portion of the $1,903,246, which is outside of the Medicare reopening and recovery periods, instruct the Medicare contractors to notify providers of potentially improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation	Closed, Unimplemented	OpDiv considers requested actions completed
CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to	8/15/2018	4	We recommend that CMS direct the Medicare contractors to review claim lines after our audit period for emergency ambulance transports to destinations not covered by Medicare and recover any improper payments identified.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
		Destinations Other Than Hospitals or Skilled Nursing Facilities					
CMS	A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	6	We recommend that CMS based on the results of the Medicare contractors' review of emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports, consider (1) directing the Medicare contractors to review claim lines after our audit period and recover any improper payments identified and (2) requiring the Medicare contractors to implement nation-wide prepayment edits specific to emergency ambulance transports that would either deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports.	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
CMS	GAO-02-249	Medicare: Communications with Physicians Can Be Improved		3	In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should set standards and provide technical assistance to carriers to promote consistency, accuracy, and user-friendliness of carrier Web sites, which should be limited to local Medicare information and should be designed to link to CMS's Web site for national program information.	Closed, Unimplemented	OpDiv considers requested actions completed
FDA	GAO-16-399	Imported Food Safety: FDA's Targeting Tool Has Enhanced Screening, but Further Improvements Are Possible	5/26/2016	1	To further enhance FDA's PREDICT tool and its ability to ensure the safety of imported food, the Secretary of Health and Human Services should direct the Commissioner of FDA to document the process for identifying the type of open source data to collect, obtaining such data, and determining how PREDICT is to use the data.	Closed, Unimplemented	

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
IHS	GAO-12-446	INDIAN HEALTH SERVICE: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program	6/15/2012	1	To make IHS's allocation of CHS program funds more equitable, the Secretary of Health and Human Services should direct the Director of the Indian Health Service to require IHS to use actual counts of CHS users, rather than all IHS users, in any formula for allocating CHS funds that relies on the number of active users.	Closed, Unimplemented	Non-concur, recommendation is no longer valid
IHS	GAO-12-446	INDIAN HEALTH SERVICE: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program	6/15/2012	2	To make IHS's allocation of CHS program funds more equitable, the Secretary of Health and Human Services should direct the Director of the Indian Health Service to require IHS to use variations in levels of available hospital services, rather than just the existence of a qualifying hospital, in any formula for allocating CHS funds that contains a hospital access component.	Closed, Unimplemented	Non-concur, recommendation is no longer valid
NIH	GAO-16-573	Federal Research Grants: Opportunities Remain for Agencies to Streamline Administrative Requirements	7/22/2016	2	To reduce pre-award administrative workload and costs, particularly for applications that do not result in awards, the Secretary of Energy, the NASA Administrator, and the Secretary of Health and Human Services should conduct agency-wide reviews of possible actions, such as further use of preliminary proposals, to postpone pre-award requirements until after a preliminary decision about an applicant's likelihood of funding and,	Closed, Unimplemented	

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
					through OSTP's Research Business Models working group, coordinate and report on these efforts.		
OCIO	GAO-16-323	Data Center Consolidation: Agencies Making Progress, but Planned Savings Goals Need to Be Established	3/3/2016	18	The Secretaries of the Departments of Agriculture, Commerce, Defense, Education, Energy, Health and Human Services, Homeland Security, Housing and Urban Development, the Interior, Labor, State, Transportation, the Treasury, and Veterans Affairs; the Attorney General of the United States; the Administrators of the Environmental Protection Agency, General Services Administration, National Aeronautics and Space Administration, and U.S. Agency for International Development; the Director of the Office of Personnel Management; the Chairman of the Nuclear Regulatory Commission; and the Commissioner of the Social Security Administration should take action to improve progress in the data center optimization areas	Closed, Unimplemented	OpDiv considers requested actions completed

HHS Operating or Staff Division	Report Number	Report Title	Report Date	Recommendation Number	Recommendation Text	Implementation Status	Reason for non-implementation
					that we reported as not meeting OMB's established targets, including addressing any identified challenges.		
OCR	GAO-16-771	Electronic Health Information: HHS Needs to Strengthen Security and Privacy Guidance and Oversight	9/26/2016	3	To improve the effectiveness of HHS guidance and oversight of privacy and security for health information the Secretary of Health and Human Services should revise the current enforcement program to include following up on the implementation of corrective actions.	Closed, Unimplemented	OCR contests this recommendation being closed unimplemented and is in the process of reviewing this status with GAO as they believe it should be closed implemented.