4	Reexamine procedures to better ensure recovery of Orion jettisoned hardware for the Artemis II mission.
3	Require EGS conduct additional verification and validation for launch imagery equipment prior to launch attempts should launch conditions change.
2	Conduct analysis of Orion separation bolts using updated models that account for char loss, design modifications, and operational changes to Orion prior to launch of the Artemis II mission.
1	Ensure the root cause of Orion heat shield char liberation is well understood prior to launch of the Artemis II mission.
04	Ensure that the performance plan of the chief of community care has standards related to the metrics for community care.
03	Continue to increase specialty provider availability in VA and the community for veterans assigned to the Martinsburg VA medical facility.
02	Conduct a strategic business evaluation of the community care department's workflow processes to determine if there are alternatives that could improve consult processing and scheduling efficiency and timeliness.
3	We recommend that the PBS NCR Regional Commissioner take the actions listed below to improve asbestos management in Building 40: develop and maintain an accurate, current, and comprehensive ACM inventory; upon completion of the ACM inventory, assess hazards arising from the ACM in the building and implement appropriate actions to mitigate or eliminate those hazards; ensure all required asbestos records are maintained in the Inventory Reporting Information System; enforce the asbestos management requirements established in the Building 40 operations and maintenance contract; update, enforce, and administer the Building 40 asbestos management plan; and notify tenants of ACM inventory annually.
2	We recommend that the PBS NCR Regional Commissioner comprehensively train PBS NCR management and staff so that they have a clear understanding of PBS's asbestos management policy and their roles and responsibilities for effectively and safely managing ACM in GSA-owned facilities.
1	We recommend that the PBS NCR Regional Commissioner conduct a comprehensive assessment of PBS NCR's asbestos management program and implement internal controls to ensure adherence to federal regulations and PBS asbestos management policy.
07	The Chief of Staff ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.
06	The Chief of Staff ensures suicide prevention coordinators conduct, track, and report a minimum of five suicide prevention outreach activities each month.
05	The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.
04	The Medical Center Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on mental health inpatient unit sleeping room doors.
03	The Chief of Staff ensures service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.
02	The Chief of Staff ensures the Clinical Executive Board reviews professional practice evaluation data for licensed independent practitioners.
01	The Chief of Staff ensures service chiefs regularly complete Ongoing Professional Practice Evaluations for licensed independent practitioners.
6	Establish a course of action and timeline for individual Artemis system design changes before beginning integrated system assembly stacking operations.
5	Develop a corrective action plan to mitigate or prevent the recurrence of uninterpretable Orion telemetry data for the Artemis II mission.
07	The VA New Mexico Health Care System Director ensures the facility's Sterile Processing Service identifies and resolves high-level disinfection documentation errors as they occur, prior to use of associated reusable medical devices on patients.
06	The VA New Mexico Health Care System Director ensures Sterile Processing Service leaders demonstrate clear communication of Sterile Processing Service staff roles and responsibilities in accordance with Veterans Health Administration High Reliability Organization principles and values.
05	The VA New Mexico Health Care System Director ensures Sterile Processing Service has a formal process in place to sustain daily quality assurance reviews and monitors compliance.
04	The VA New Mexico Health Care System Director ensures Sterile Processing Service has a process to communicate all instances when high-level disinfection documentation cannot be located to the associated clinical services when the reusable medical devices was used in patient care.
03	The VA Desert Pacific Healthcare Network Director ensures audit results are shared with the Sterile Processing Advisory Board per Veterans Health Administration requirements.
02	The VA Desert Pacific Healthcare Network Director ensures entry of audit results into the Sterile Processing Accountability Tool within the required time frame.
01	The VA Desert Pacific Healthcare Network Director strengthens Sterile Processing Service oversight to ensure timely communication of audit findings with action plan expectations to facility leaders.

7	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, implement baselines, baseline monitoring, and deviation risk tracking as required by TVA policy.
6	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, update TVA policy to align with best practice for baseline configuration reviews.
5	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, identify and review service accounts used for wireless infrastructure to ensure all service accounts are appropriately secured where technically and operationally possible.
4	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, design and implement a process to identify and remediate primary user accounts that should not be included in privileged access groups.
3	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, take action to remediate both instances of insecure protocols in use where technically and operationally possible.
2	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, implement the planned project to upgrade software and hardware to supported versions.
1	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, update and implement internal controls to properly defend, detect, and respond to specific types of wireless attacks.
05	The Under Secretary for Health promotes the establishment of partnerships of VA medical centers with community resources to address social determinants of health/health-related social needs.
04	The Under Secretary for Health promotes the use of health equity tools across VA medical centers.
03	The Under Secretary for Health evaluates barriers to assessing social determinants of health/health-related social needs when patients are discharged from VA medical centers.
02	The Under Secretary for Health considers the implementation of a standardized electronic health record template, such as the Assessing Circumstances and Offering Resources for Needs tool, that includes the assessment of social determinants of health/health-related social needs of hospitalized patients.
01	The Under Secretary for Health considers the need for a national policy establishing the inclusion of social determinants of health/health-related social needs into discharge assessment and planning.
24-21-04	We recommend the Grantee develop policies and procedures to ensure performance progress reports are submitted to ARC no later than 30 days after the close of a reporting period.
24-21-03	The Grantee improve policies and procedures for subrecipients to establish considerations for assigning a PI for subawards including the PI to be independent from the subrecipient organization, define minimum subrecipient monitoring requirements, and provide for secondary review of PI monitoring activities.
24-21-02	The Grantee work with ARC management to resolve the questioned cost of $424 in non-ARC match funds.
24-21-01	The Grantee improve policies and procedures to ensure financial information is accurately reported to ARC including a process for determining whether requests for funds are reimbursements or advances and ensuring costs are not duplicated in between reporting periods.
7	Require OCHCO, Mission Directorates, and Centers collaborate to identify and incorporate critical Agency workforce needs when developing future STEM engagement activities and develop a plan that increases the number of STEM engagement activities aimed at skilled trade occupations.
6	Require all NASA organizations capture STEM engagement activities in STEM Gateway.
5	Re-evaluate jurisdictions eligible for EPSCoR funds to ensure effective and equitable distribution of Agency funds.
4	Develop a standardized grant process that ensures mandatory performance reporting and that expiration dates are tracked and monitored to meet requirements and develop practices to ensure grant recipients are reporting subrecipient awards over $30,000 as required.
3	Determine and apply relevant NASA project management policy requirements to existing project plans or record their exclusion and appropriately address budget risk in project plans, including planning for various funding scenarios.
2	Develop a procedure to ensure OSTEM tracks and reports funding for all Agency STEM engagement activities.
1	Re-evaluate the OSTEM performance goals to ensure they are distinct and well correlated with outcomes.
1	Create processing timeframes for returned funds for current and future disaster programs.
02	The Chief of Staff ensures service chiefs document Focused Professional Practice Evaluation results in licensed independent practitioners' profiles.
01	The Executive Director ensures the Chief of Staff conducts institutional disclosures for applicable sentinel events.
02	The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.
01	The Chief of Staff ensures service chiefs incorporate service-specific criteria in professional practice evaluations.

03	The Under Secretary for Health, Veterans Integrated Service Network directors, and facility leaders ensure staff enter data into the local cancer registry database in a timely manner.
02	The Under Secretary for Health and National Oncology Program staff offer a range of services for patients diagnosed with breast cancer, including rehabilitative services, through the Women's Oncology System of Excellence.
4	The Commissioner, SB/SE Division, and Chief, Criminal Investigation, should identify opportunities to partner with the EPA to use the agency's expertise and data when selecting, conducting examinations and investigations involving taxpayers that claimed biofuel tax credits and revise the MOU as needed.
3	The Commissioner, SB/SE Division, should evaluate if there are opportunities to include biofuel tax credit claims made on the Form 4136 into ongoing examination initiatives involving biofuel.
2	The Commissioner, SB/SE Division, should establish a Compliance Initiative Project to conduct examinations of the 42 taxpayers reported in Figure 5 to ensure the validity of the biofuel tax credits that were claimed and that these taxpayers are properly registered and have the required certificates (that contain a valid registration number).
1	The Commissioner, Wage and Investment Division, should engage with the Department of the Treasury's Office of Tax Policy to develop a legislative proposal to require that taxpayers claiming biofuel tax credits provide information that they are properly registered (if applicable) or that they provided the required Certificate of Biodiesel when income tax returns are filed.
24-A-07-064.02	We recommend that the Missouri Department of Health and Senior Services consider implementing additional monitoring activities whenever the State receives large supplemental funding disbursements.
24-A-07-064.01	We recommend that the Missouri Department of Health and Senior Services require Area Agencies on Aging (AAAs) to track expenditures for supplemental awards by funding source, when required by Federal guidance, especially in instances of pandemic-related or other disaster relief funding. Specifically, none of the 10 AAAs in Missouri could give us separate accounting records that delineated the CARES Act expenditures to support the charges against the Federal award for these nutrition services.
24-A-01-065.02	We recommend that the Centers for Medicare & Medicaid Services improve its procedures, which may require seeking legislative authority, for setting and adjusting rates for new CDLTs during a PHE by providing the MACs with the flexibility needed to set and adjust payment rates that would cover the laboratory costs of providing services when responding to a PHE.
24-A-01-065.01	We recommend that the Centers for Medicare & Medicaid Services establish procedures to improve communication among all stakeholders involved in setting new CDLT rates during a PHE.
24-A-03-059.05	We recommend that the Administration for Strategic Preparedness and Response report any Antideficiency Act violations identified.
24-A-03-059.04	We recommend that the Administration for Strategic Preparedness and Response review the 10 remaining sampled employees that we could not interview to determine whether any salaries were improperly charged to BARDA appropriations and identify potential Antideficiency Act violations.
24-A-03-059.03	We recommend that the Administration for Strategic Preparedness and Response maintain documentation of the work performed by employees whose salaries are paid using BARDA funds to ensure that appropriations are used for their intended purposes in accordance with Federal requirements.
24-A-03-059.02	We recommend that the Administration for Strategic Preparedness and Response review the FY 2018 and 2019 JFA allocation methodologies along with the methodologies used during subsequent FYs to determine whether the costs were allocated to each office based on appropriate methodologies, and correct any improper allocations to avoid potential Antideficiency Act violations.
24-A-03-059.01	We recommend that the Administration for Strategic Preparedness and Response develop internal written policies and procedures for the JFA process that align with Federal requirements and include the use of allocation methodologies that accurately reflect the benefiting offices' use of the product or service.
24-A-18-056.05	We recommend Alabama perform more robust technical testing of web-facing systems that includes the emulation of an adversary's tactics and techniques on a defined reoccurring basis in order to better assess the effectiveness of NIST 800-53 controls.
24-A-18-056.04	We recommend Alabama implement procedures to periodically verify that its developers are adhering to secure coding standards and remediating vulnerabilities before releasing code to production.
24-A-18-056.03	We recommend Alabama require its developers to follow secure coding standards and best practices, at a minimum, such as those recommended by NIST SP 800-218 or the Open Web Application Security Project (OWASP), when developing web applications.
24-A-18-056.02	We recommend Alabama evaluate its current vulnerability scanning tools and update if necessary in order to better detect system flaws (e.g., common web server vulnerabilities) in its MMIS and E&E system and software components.
24-A-18-056.01	We recommend that the Alabama Medicaid Agency remediate the six control findings OIG identified.
24-E-02-014.04	CMS should increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.
24-E-02-014.03	CMS should use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.

24-E-02-014.02	CMS should explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.
24-E-02-014.01	CMS should take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.
24-A-04-052.01	We recommend that Thailand's Ministry of Public Health develop and implement policies and procedures that address the retention of employee timesheets and FFR and audit reporting requirements for Federal awards.
24-E-01-012.02	CMS should require nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight.
24-E-01-012.01	CMS should provide a standard notice template to help nursing homes provide complete and accurate information to residents facing discharge and Ombudsmen.
24-A-07-060.02	We recommend that the Alabama Medicaid Agency improve TCM program oversight by giving additional guidance to TCM providers regarding: billing of services, to verify that they are allowable and nonduplicative; case manager hiring practices, to verify adherence with the State plan's qualification requirements; target group eligibility screening processes, so that only eligible individuals receive TCM services; and the maintenance of supporting documentation for billed services.
24-A-07-060.01	We recommend that the Alabama Medicaid Agency refund to the Federal government $5,039,433 (Federal Share) in overpayments.
24-A-18-057.05	We recommend ACF conduct testing of its cloud information systems that includes the emulation of an adversary's tactics and techniques on a defined reoccurring basis.
24-A-18-057.04	We reccomend ACF leverage cloud security assessment tools to identify misconfigurations and weak cybersecurity controls in its cloud infrastructure.
24-A-18-057.03	We recommend ACF update its cloud security procedures to include detailed steps for operational staff to effectively implement cloud security baselines in accordance with HHS requirements.
24-A-18-057.02	We reccomend ACF remediate the 19 security control findings in accordance with NIST SP 800-53.
24-A-18-057.01	We recommend ACF update and maintain a complete and accurate inventory of information systems hosted in the cloud.
06	The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.
05	The Director ensures staff maintain a safe environment in the Emergency Department for mental health patients.
04	The Director ensures staff maintain a safe environment in the mental health inpatient unit.
03	The Director ensures staff regularly test panic alarms in the mental health inpatient unit and document VA police response times.
02	The Associate Director ensures staff keep patient care areas safe and clean.
01	The Chief of Staff ensures service chiefs document professional practice evaluation results in practitioners' profiles, and the Medical Executive Committee reviews service chiefs' recommendations along with clinical competence information when making privileging recommendations to the Director.
1	Establish formal procedures for obtaining and reviewing appropriate supporting documentation to ensure sales and investments are accurately reported.
7	Review and update ICE's contract with Golden State by assessing housing requirements and determining an appropriate guaranteed minimum to avoid excessive payment for unused bed space.
5	Ensure staff's communication with detainees adheres to standards, including: a. requests are responded to within 3 business days; b. requests are responded to in a detainee's preferred language; and c. copies of detainee requests are kept in the detainee's file.
3	Collect medical grievances within 24 hours of submission by a detainee and ensure staff maintain a copy of all paper medical grievances in the detainee's medical file.
2	Include a timestamp on the classification documentations for initial classification of each detainee and ensure staff maintain all classification paperwork, to include reclassification, in the detainee's file.
1	Establish a plan to reduce wait times for optometry appointments.
07	The District Director identifies reasons for noncompliance, ensures clients are provided a copy of their completed safety plan as required, and monitors compliance across all zone vet centers.
06	The District Director identifies reasons for noncompliance; ensures clinical staff complete safety plans for clients who are assessed at intermediate or high suicide risk level in either acute, chronic, or both categories as required; and monitors compliance across all zone vet centers.
05	The District Director identifies reasons for noncompliance with consultation requirements for clients who are assessed at intermediate or high suicide risk level in either acute, chronic, or both categories; ensures consultation requirements are met; and monitors compliance.
04	The District Director and zone leaders identify reasons for noncompliance, ensure Readjustment Counseling Service policy confidentiality requirements are followed when collaborating care with the support VA medical facility for shared clients at high risk for suicide, and monitor compliance across all zone vet centers.

03	The Readjustment Counseling Service Chief Officer ensures the High Risk Suicide Flag SharePoint site functions as intended and includes accurate data.
02	The District Director identifies reasons for noncompliance with timely documentation requirements of high-risk client contacts and outcomes in the electronic record and High Risk Suicide Flag SharePoint site, ensures requirements are met, and monitors compliance.
01	The District Director monitors compliance with leaders' completion of morbidity and mortality reviews for client deaths by suicide, including timeliness, as required.
2	USAID/India Verify that PSMRI corrects the 1 instance of material noncompliance detailed on pages 40 and 41 of the audit report.
1	USAID India verify that PSMRI corrects the 1 material weakness in internal control detailed on pages 34 and 35 of the audit report.
4	We recommend the Director, Facilities Management, evaluate assets in poor and failed condition and determine if corrective actions are needed.
3	We recommend the Director, Facilities Management, develop guidance for performing roof inspections, including buildings to be inspected and required frequency.
2	We recommend the Director, Facilities Management, develop guidance for performing condition assessments, including the frequency and responsible organization.
1	We recommend the Director, Facilities Management, develop a plan to assess building and infrastructure safety risks.
6	The Assistant Commissioner of the Office of General Supplies and Services should ensure all foreign gifts and decorations sold to the public are reviewed and approved by the Secretary of State in accordance with 5 U.S.C. § 7342.
5	The Assistant Commissioner of the Office of General Supplies and Services should ensure the program's compliance with 41 C.F.R. § 102–42 and internal policies for all foreign gifts and decorations reported to GSA.
4	The Assistant Commissioner of the Office of General Supplies and Services should conduct a security risk assessment to determine the risks of possible theft or loss of foreign gifts and decorations at both storage locations and throughout the lifecycle of the program.
3	The Assistant Commissioner of the Office of General Supplies and Services should conduct an annual foreign gifts inventory, update the database for accuracy, and properly dispose of gifts with no value.
2	The Assistant Commissioner of the Office of General Supplies and Services should properly dispose of all prohibited gifts in inventory and ensure none is accepted moving forward.
1	The Assistant Commissioner of the Office of General Supplies and Services should update and finalize the Foreign Gifts and Decorations Program's standard operating procedures to reflect current practices, ensure compliance with federal requirements, and instill management controls over the disposition of foreign gifts and decorations.
5	Work with relevant stakeholders to determine whether to continue using the feedback loop and, if so, how to increase its effectiveness, including a) determining which categories of cases to prioritize or remove, b) better ensuring cases are sent to the correct staff, and c) minimizing redundancy with other sources to the extent practical.
4	Measure and report performance to senior leadership on the call abandonment rate and the number of calls on hold for long periods. Assess the costs and benefits of improving in these two areas and use that assessment to establish goals to assess performance over time.
3	Work with the Digital Technology department to establish a process to regularly report to Marketing and Operations department officials and senior leadership on the Customer Communications Team's performance meeting the new goals for sending communications to customers about en route delays.
2	Establish thresholds for when to communicate electronically with passengers during en route delays and the frequency of updates about those delays. To track and assess performance, establish goals for how well the Customer Communications Team meets those thresholds.
1	Work with the Digital Technology department to complete the customer communications dashboard to ensure that stakeholders can more easily access and filter data about communications sent to customers during en route delays.
02	The Hospital Director ensures staff conduct environment of care inspections in non patient care areas at least once per fiscal year.
01	The Veterans Integrated Service Network Director ensures the Veterans Integrated Service Network Chief Medical Officer oversees the hospital's privileging process.
4	Evaluate the feasibility of obtaining electronic marriage data to match against Supplemental Security Income and Old-Age, Survivors, and Disability Insurance payment records to prevent improper payments.
3	Evaluate the feasibility of implementing an alert system in other applications that flags an employee review of a marriage and action on the Supplemental Security Record or Master Beneficiary Record, when applicable.
2	Review the 11 internet Social Security Number Replacement Card cases and take any necessary corrective actions.
1	Review the 10 cases from Sample 1, the 20 cases from Sample 2, and the 8 cases from Sample 3 and take necessary corrective actions.

08	The Director ensures providers complete the Comprehensive Suicide Risk Evaluation the same day as a patient's positive suicide risk screen in ambulatory care settings.
06	The Director ensures staff check over-the-door alarms in mental health inpatient units with corridor doors to patient sleeping rooms according to the manufacturer's guidelines.
05	The Associate Director ensures Environmental Management Services staff keep areas used by patients clean and orderly.
02	The Director ensures staff conduct environment of care inspections in patient care areas at least twice per fiscal year.
05	The Hospital Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.
24-A-07-047.02	We recommend that the Kansas Department of Health and Environment improve its oversight of the estate recovery contractor's performance by: verifying that the contractor files liens and initiates probate in a timely manner; confirming that the contractor's current process for MMIS claims verification is accurate; and verifying that the contractor performs applicable estate recovery procedures (including the opening of cases, sending of notices, and independent asset research) for deceased Medicaid recipients.
24-A-07-047.01	We recommend that the Kansas Department of Health and Environment improve its estate recovery program by confirming that all deceased Medicaid recipients who are subject to estate recovery are identified and by providing relevant information on those recipients to the contractor in a timely manner so as to give the contractor adequate time to file liens and initiate probate.
04	The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.
03	The Medical Center Director ensures the Suicide Prevention Coordinator reports suicide-related events to mental health leaders and quality management staff at least monthly.
02	The Medical Center Director ensures staff follow the manufacturer's guidelines for checking over-the-door alarms for patient sleeping rooms in the Inpatient Psychiatry Unit.
01	The Medical Center Director ensures staff document VA police response times to panic alarm testing in the Inpatient Psychiatry Unit.
8	Ensure that electronic and paper detainee requests are placed in detention files.
6	Ensure medical staff and housing officers initial the SMU activity log after daily check-ins are complete.
5	Ensure compliance with standards for legal resources by: a) ensuring the facility consistently provides detainees with a means of saving any legal work in a secure and private electronic format; and b) implementing procedures to facilitate more reliable and confidential communication and visitation between attorneys and detainees.
4	Comply with PBNDS 2011 standards by: a) ensuring Krome's medical department responds to medical grievances within the required time; b) ensuring copies of all paper medical grievances are placed in detainee medical records; c) ensuring all medical grievances are tracked and logged appropriately; d) updating the facility grievance policy to include expectations related to the submission of medical grievances. If the expectation is for detainees to only submit medical grievances through the paper grievance forms, Krome should update the facility's detainee handbook; e) removing the grievance form, revised in 2011, from circulation at Krome and ensuring the facility does not impose a time limit on when a detainee may submit a formal grievance; and f) maintaining an adequate supply of paper grievance forms and writing instruments in housing units.
3	Comply with PBNDS 2011 standards by: a) providing documentation for the new open sick call system and reduction in wait times; b) continuing efforts to fill vacant positions; c) ensuring that urgent dental needs are met in a timely manner; and d) devising and executing a plan to eliminate the medical documentation scanning backlog.
2	Provide additional training on de-escalation techniques and mental health assistance.
08	The Director ensures the Suicide Prevention Coordinator reports suicide-related events monthly to quality management staff.
07	The Associate Director ensures staff document VA police response times for panic alarm testing in the mental health inpatient unit.
06	The Associate Director ensures staff inspect, test, and maintain medical equipment.
05	The Associate Director ensures staff use solid bottom shelves in storage areas.
04	The Associate Director ensures staff keep furnishings and walls in good repair.
03	The Associate Director ensures Environmental Management Service staff keep areas used by patients clean and orderly.
20	We recommend that EAC work with Wyoming to implement procedures to ensure that subgrantees are properly informed of the federal requirements related to interest income and the need for subgrantees to report interest income earned, if applicable.
19	We recommend that EAC work with West Virginia to: a. Determine the proper allocation of interest for September 2018 and to correct the September 30, 2022, and any subsequently filed, Election Security and Section 251 Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports.

18	We recommend that EAC work with Vermont to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Section 251 Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports.
17	We recommend that EAC work with Utah to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income. d. Determine the amount of lost interest due to the delay in investing 2018 Election Security funds and ensure that the amount is deposited into the election fund. e. Implement procedures to ensure that the Treasury is notified in a timely manner of the need to earn interest on future HAVA grants.
16	We recommend that EAC work with South Dakota to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Section 251 Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports.
15	We recommend that EAC work with South Carolina to: a. Develop proper allocation calculation procedures, recalculate the interest allocations from the inception of the 2018 Election Security grant using this methodology, and correct the reporting of interest income on the September 30, 2022, and any subsequently filed, Election Security and Section 251 Federal Financial Reports. b. Implement procedures to ensure that proper supporting documentation is maintained to support the amounts reported to EAC on the Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
14	We recommend that EAC work with Puerto Rico to ensure that interest is now being properly credited to HAVA grant funds in a timely manner and that all lost interest is properly calculated and deposited into the election fund.
13	We recommend that EAC work with New Mexico to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports.
12	We recommend that EAC work with New Hampshire to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security and Section 251 Federal Financial Reports, including determining the proper reporting on the Section 251 Federal Financial Reports for the Voter Checklist sales. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
11	We recommend that EAC work with Mississippi to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports and to ensure that supporting documentation is maintained to support the amounts reported to EAC on the Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income. d. Determine the amount of any lost interest due to the delays in the earning of interest on the 2022 Election Security grant funds, and the amount should be deposited into the election fund. e. Implement procedures to ensure that future EAC grants are deposited into an interest-bearing election fund on a timely basis.
10	We recommend that EAC work with Maine to: a. Determine the amount of lost interest due to the delay in establishing the funds as interest bearing with the Treasury and ensure that the amount is deposited into the election fund. b. Implement procedures to ensure that the Treasury is notified in a timely manner of the need to earn interest on future HAVA grants.
9	We recommend that EAC work with Louisiana to implement procedures to ensure that proper supporting documentation is maintained to support the amounts reported to EAC on the Federal Financial Reports.
8	We recommend that EAC work with Kentucky to: a. Determine that the September 30, 2022, and any subsequently filed, Election Security Federal Financial Reports are properly corrected to reflect the revised interest allocations. b. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
7	We recommend that EAC work with Kansas to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security and Section 251 Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports.
6	We recommend that EAC work with Illinois to ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
5	We recommend that EAC work with Hawaii to: a. Determine the amount of any lost interest due to the delays in the earning of interest on the 2022 Election Security grant funds, and to ensure the amount is deposited into the election fund. b. Determine the amount of Election Security interest that was incorrectly posted to the accounting system fund for the Section 101 and Section 251 grants, move the amounts to the appropriate fund in the accounting system, and file corrected Federal Financial Reports for the September 30, 2022, and any subsequently filed, Election Security, Section 101 and Section 251 grants. c. Implement procedures to ensure that future EAC grants are deposited into an interest-bearing election fund on a timely basis.
4	We recommend that EAC work with Florida to ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
3	We recommend that EAC work with Connecticut to: a. Correct the interest income reported on the September 30, 2022, and any subsequently filed, Election Security Federal Financial Reports. b. Implement procedures to ensure accurate reporting on future Federal Financial Reports and to ensure that supporting documentation is maintained to support the amounts reported to EAC on the Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income. d. Implement procedures to ensure that subgrantees are properly informed of the federal requirements related to interest income and the need for subgrantees to report interest income earned, if applicable.

2	We recommend that EAC work with Alabama to: a. Determine an adequate allocation methodology, recalculate the interest allocations from the inception of the 2018 Election Security grant using this methodology, and correct the reporting of interest income on the September 30, 2022, and any subsequently filed, Election Security and Section 251 Federal Financial Reports. b. Implement procedures to ensure that proper supporting documentation is maintained to support the amounts reported to EAC on the Federal Financial Reports. c. Ensure the implementation of proper written policies and procedures regarding the calculation and reporting of interest income.
1	We recommend that EAC strengthen the procedures for monitoring grantees' compliance with the applicable requirements for interest income earned on HAVA grant funds.
4	The Director of Collection Policy, SB/SE Division, should issue a reminder to Collection employees to consider referring Ghost Employer cases to Examination for potential civil fraud penalties as outlined in IRM 25.1.6.2(3) when working future Ghost Employer cases.
3	The Director of Collection, SB/SE Division, should require SB/SE Division leadership to provide a summary of planned actions in response to the Ghost Employer Project team recommendations as noted in this report.
2	The Director of Collection, SB/SE Division, should use a CIP or similar approach for Ghost Employers, which improves the tracking of enforcement action results and ensures that cases that do not rise to the level of Criminal Investigation involvement are placed into other civil enforcement workstreams.
1	The Commissioner, SB/SE Division should confer with the RAAS function on additional research available and incorporate refinements to filters needed to improve the identification of Ghost Employers.
3	Evaluate and update the current Scanning Visibility performance metrics to better align evaluation criteria for individual units to their specific performance.
1	Reissue Surface Visibility scanning policy, reiterating the importance of completing required "terminate" scans at via facilities, to all logistics and processing employees and certify all employees responsible for scanning have reviewed and understand their scanning responsibilities.
1	establish milestones for realizing savings and conduct a cost-benefit of actual transportation savings and its impact on service performance, including customer demographic impacts.
03	The Associate Director ensures staff check inventory in clean and sterile storerooms and remove expired or outdated items.
02	The Chief of Staff ensures the Executive Committee of the Medical Staff/Credentials Committee recommends continuation of licensed independent practitioners' privileges based on Ongoing Professional Practice Evaluation results.
01	The Chief of Staff ensures service chiefs recommend continued privileges based on Ongoing Professional Practice Evaluation activities.
4.1	Periodically review and update the RTR inspection guidance in accordance with IMC 0040.
3.1	Establish a plan and milestones to fully implement the use of the RPS to support oversight of the RTR inspection program
2.3	Periodically review the RTR training program to ensure consistency, effectiveness, and relevance.
2.2	Track post-qualification and refresher training.
2.1	Update the RTR training guidance to include specific courses and hours for refresher training.
1.2	Establish guidance and training for recording and approving the RTR inspection hours to specific CACs.
1.1	Update and implement guidance applicable to the NRC's current timekeeping system
04	The Director ensures staff check over-the-door alarms on the mental health inpatient unit according to the manufacturer's guidelines.
03	The Associate Director ensures staff keep patient areas clean and free from undue wear.
9	verify training is provided to clerks and supervisors responsible for registry items and the procedures for the security of registry items are followed at the Curseen-Morris Processing and Distribution Center.
8	take action to verify the appropriate number of placards are printed, and extra placards are canceled at the Curseen-Morris Processing and Distribution Center.
7	develop and implement a plan to verify load and unload scanning is consistently completed in accordance with policy at the Curseen-Morris Processing and Distribution Center.
6	complete an annual review of the Postal Vehicle Service transportation schedules and implement any schedule changes at the Curseen-Morris Processing and Distribution Center.
5	verify that delayed mail and missent mail are properly reported in the Mail Condition Visualization system at the Curseen-Morris Processing and Distribution Center.
4	conduct a review at the Curseen-Morris Processing and Distribution Center to identify why delivery units are returning so much mail, take corrective actions, and use the Mail Arrival Quality/Plant Arrival Quality to communicate with delivery units about mail separation.
3	verify daily preventative maintenance is completed on all Delivery Barcode Sorter machines to increase compliance at the Curseen-Morris Processing and Distribution Center.

2	direct management to delegate an employee for manual operations to reduce the manual processing of machinable mail at the Curseen-Morris Processing and Distribution Center.
11	verify exit doors on the dock are secured at the Curseen-Morris Processing and Distribution Center.
10	verify wheel chocks are available for use at all docks and that all drivers use wheel chocks at the Curseen-Morris Processing and Distribution Center.
1	verify staffing is aligned to process mail in the manual letter operations unit for timely dispatch by the Curseen-Morris Processing and Distribution Center.
13	Recommendation is not publicly available.
12	Recommendation is not publicly available.
11	Recommendation is not publicly available.
10	Recommendation is not publicly available.
9	Recommendation is not publicly available.
8	Recommendation is not publicly available.
7	Recommendation is not publicly available.
6	Recommendation is not publicly available.
5	Recommendation is not publicly available.
4	Recommendation is not publicly available.
3	Recommendation is not publicly available.
2	Recommendation is not publicly available.
1	Recommendation is not publicly available.
06	The Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in all ambulatory care settings.
05	The Director ensures staff keep interior spaces in the Inpatient Psychiatry Unit safe and suitable for care.
04	The Director ensures staff test over-the-door alarms in the Inpatient Psychiatry Unit per the manufacturer's recommendations.
03	The Director ensures staff test panic alarms in the Inpatient Psychiatry Unit at least quarterly and record testing in a log, including police response times.
02	The Director ensures staff conduct environment of care inspections in patient care areas as required.
01	The Chief of Staff ensures service chiefs report Focused Professional Practice Evaluation results to an executive committee of the medical staff for consideration in privileging recommendations.
4	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, prioritize and process the business application retirement request backlog.
3	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, update policies to incorporate best practice considerations based on risk.
2	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, update process documentation and implement effective controls to prevent duplicate requests and automatically require field completion.
1	We recommend the Vice President and Chief Information and Digital Officer, Technology and Innovation, implement clear ownership and accountability for the application retirement process by monitoring and managing the process to ensure applications are retired in a timely manner
6	reiterate the process for using existing channels to report significant processing delays to Postal Service customers.
5	develop a comprehensive list, prioritize, and address the safety, security, and maintenance issues identified at the South Houston Local Processing Center.
4	in conjunction with Vice President, Regional Processing Operations Western, analyze current transportation schedules at the South Houston Local Processing Center and implement appropriate changes to reduce dock congestion, minimize delayed mail, and facilitate safety on the workroom floor.
3	develop a process to communicate with and solicit feedback from local managers when developing and implementing changes to the South Houston facility as it shifts from a peak annex to a Local Processing Center.
2	report delayed mail in the Mail Condition Visualization for the South Houston Local Processing Center separately from the North Houston Processing and Distribution Center and confirm its accuracy on an ongoing basis.
1	assess the current backlog and determine whether temporary staffing is necessary to work through the backlog; develop a facility complement; and hire to fill both management and staff positions at South Houston Local Processing Center.

08	The under secretary for health to ensure the Office of Integrated Veteran Care routinely evaluates the third-party administrator's network adequacy performance reports to ensure the reports are sufficiently reliable and comply with contract requirements, and then holds third-party administrators accountable for resolving identified issues.
07	The under secretary for health to ensure the Office of Integrated Veteran Care conducts Advanced Medical Cost Management Solution training for community care staff at each facility on evaluating network adequacy through the tool.
06	The under secretary for health to ensure the Office of Integrated Veteran Care develops its own network adequacy performance reports for each facility and communicates the results to the facilities monthly.
05	The under secretary for health to ensure the Office of Integrated Veteran Care evaluates the effectiveness of the third-party administrators' quarterly and monthly reports for assessing network adequacy and then, if needed, modifies the language in its current contracts and makes changes to the applicable contract language for future Community Care Network contracts.
04	The under secretary for health to ensure the Office of Integrated Veteran Care develops and communicates to facilities a standard process to request and document their needs for additional providers.
03	The under secretary for health to ensure the Office of Integrated Veteran Care develops a mechanism for facilities to effectively report, track, and monitor challenges with access to specialty care services; trains all relevant staff on how to use the mechanism; make sure facilities use the mechanism routinely; and then helps facilities resolve access challenges.
02	The under secretary for health to ensure the Office of Integrated Veteran Care develops a process to make sure the third-party administrators regularly update their Community Care Network provider lists to reflect accurate provider contact information and annotate providers who are not currently accepting VA patients.
01	The under secretary for health to ensure the Office of Integrated Veteran Care holds future third-party administrators accountable for operational readiness and provider network adequacy at each facility by the time the contracts are implemented.
12	The Medical Center Director ensures designated staff complete the Comprehensive Suicide Risk Evaluation on the same calendar day as a positive suicide risk screen, when clinically appropriate, for all ambulatory care patients.
11	The Veterans Integrated Service Network Director ensures compliance with VHA Directive 1860, Biomedical Engineering Performance Monitoring and Improvement, for oversight structure of the medical center's biomedical program.
10	The Veterans Integrated Service Network Director ensures the Medical Center Director has sufficient biomedical staff and confirms they inspect and test all medical equipment for scheduled maintenance.
09	The Medical Center Director ensures staff check all mental health inpatient unit ceiling tiles semiannually.
08	The Medical Center Director ensures staff test over-the-door alarms based on the manufacturer's recommendations for mental health inpatient unit sleeping rooms.
07	The Medical Center Director ensures staff document police response times to panic alarm testing in the mental health inpatient unit.
06	The Associate Director ensures staff keep patient care areas safe and clean.
05	The Associate Director ensures the Comprehensive Environment of Care Rounds Coordinator or designee schedules environment of care inspections and staff complete and document them at the required frequency.
04	The Chief of Staff ensures service chiefs use specialty-specific criteria in the professional practice evaluations of licensed independent practitioners.
03	The Chief of Staff ensures service chiefs complete Ongoing Professional Practice Evaluations prior to reprivileging to ensure continuous delivery of quality care.
02	The Chief of Staff ensures the Medical Staff Executive Committee reviews data provided by the Peer Review Committee to determine the need for further action.
01	The Chief of Staff ensures staff record the Peer Review Committee's formal discussions related to changes in peer review level assignments in the meeting minutes.
02	The Under Secretary for Health reviews previous removals of healthcare providers from VA employment as required by VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 § 108 to determine whether the reason(s) for those removals were for violation of policy related to the safe and appropriate care of veterans, and takes action as warranted.
01	The Under Secretary for Health reviews the criteria and processes used to identify and exclude healthcare providers removed from VA employment for violation of policy related to safe and appropriate care of veterans, and takes action as warranted.
05	The Under Secretary for Health considers establishing policy and clinical practice guidance related to attention deficit hyperactivity disorder diagnostic assessment and treatment with a stimulant and takes action as warranted.
04	The Under Secretary for Health evaluates the adequacy of the referral processes related to complex mental health disorders, such as attention deficit hyperactivity disorder, and takes action as warranted.
03	The Under Secretary for Health evaluates the prescription drug monitoring program query adherence goal for initial stimulant prescribing and takes action as warranted.

02	The Under Secretary for Health ensures Veterans Health Administration prescribers assess risks and contraindications associated with stimulant prescribing.
01	The Under Secretary for Health ensures Veterans Health Administration prescribers establish a diagnosis based on a complete and documented assessment prior to initiation of a stimulant to treat attention deficit hyperactivity disorder.
10	The Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.
02	The Chief of Staff ensures service chiefs recommend reprivileging based, in part, on Ongoing Professional Practice Evaluation activities.
01	The Chief of Staff ensures service chiefs define the time frames for Focused Professional Practice Evaluations.
12	The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.
11	The Medical Center Director ensures staff keep patient care areas safe and clean.
10	The Medical Center Director ensures staff post hazard warning signs on all access doors where potentially infectious materials are located.
09	The Medical Center Director ensures staff maintain a safe environment in the Inpatient Mental Health Unit.
08	The Medical Center Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on Inpatient Mental Health Unit sleeping room doors.
07	The Medical Center Director ensures staff document police response times to panic alarm testing in the Inpatient Mental Health Unit.
06	The Medical Center Director ensures the comprehensive environment of care coordinator schedules environment of care inspections at the required frequency and verifies staff complete and document them.
05	The Veterans Integrated Service Network Chief Medical Officer provides effective oversight of credentialing and privileging processes at the healthcare system.
04	The Chief of Staff ensures staff report licensed independent practitioners' Focused Professional Practice Evaluation results to the Clinical Executive Board.
03	The Chief of Staff ensures service chiefs recommend reprivileging for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation data.
02	The Medical Center Director ensures staff complete a root cause analysis for all patient safety events assigned an actual or potential safety assessment code score of 3.
01	The Medical Center Director ensures leaders identify and evaluate sentinel events and conduct and document institutional disclosures when criteria are met.
03	The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.
02	The Veterans Integrated Service Network Director ensures network staff track and monitor home oxygen vendor completion of root cause analyses when sentinel events occur.
1	Develop and implement procedures to routinely conduct a staffing needs assessment throughout a disaster to ensure recovery centers are adequately staffed based on customer demand and workload.
03	The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a patient's positive suicide risk screen in ambulatory care settings.
02	The Chief of Staff ensures service chiefs recommend continued privileges for licensed independent practitioners based, in part, on Ongoing Professional Practice Evaluation activities.
01	The Chief of Staff ensures providers with equivalent specialized training and similar privileges complete licensed independent practitioners' Ongoing Professional Practice Evaluations.
1	USDA OIG has determined that this recommendation contains sensitive information and will not be publicly released due to privacy concerns.
3	Develop and implement a policy to require Headquarters' concurrence when Division Offices are making procedural revisions to their standard operating procedures for reviewing and approving STIPs to ensure continued alignment with the Agency's standards prescribed in its template.
2	Identify a list of any outstanding technical assistance requests from Division Offices and State DOTs for IIJA guidance clarifications and fulfill them.
2023-CR-001-09	We recommend that FWS require the Department to Implement controls that include maintaining records sufficient to determine the accurate impact of any future potential record of labor mischarging.
2023-CR-001-08	We recommend that FWS require the Department to Implement preventive controls to ensure that employees are performing their assigned tasks and that payroll charges are accurate.

2024-FO-0005-002-B	Update OCFO's travel card monitoring procedures to obtain, review, and monitor the IBA Use report on a regular basis to ensure compliance with purchases required to be made on the government travel card.
2024-FO-0005-002-A	Develop and fully implement a departmentwide policy for the monthly transaction review process that requires program office participation and timely completion of the review and certification.
2024-FO-0005-001-A	Develop a standard operating procedure for the monthly transaction review that aligns with the HUD policy and includes specific procedures on how to (1) identify and review common transactions that raise the level of risk in the program (for example, personal use purchases, other prohibited purchases, unauthorized purchases or services, split purchases, fraudulent purchases, FAR violation purchases, etc.), (2) methodically select transactions for investigation, and (3) follow up on identified potential improper transactions, including record-keeping requirements.
6	Perform oversight procedures as required in OMB Circular A-11 and SOP 90 44. Specifically, ensure that post-implementation reviews, business case closeouts, TechStat sessions, operational analyses, and lessons learned are completed.
5	Establish and implement controls to ensure all investments in the control phase are rated by the Chief Information Officer monthly using baseline factors, such as contractor cost oversight and schedule performance, and apply corrective measures as necessary as required by SOP 90 44.
4	Update procedures to provide specific guidance to agency investment managers on how to utilize earned value principles to measure investment progress against both the current approved baseline and the original baseline for all major investments as required by SOP 90 52 1 and OMB Circular A-130.
3	Ensure program offices create business cases prior to approval of the investment to ensure project scope, risks, and costs are fully vetted as required by SOP 90 44.
2	Ensure the architecture review board reviews new investments to confirm compatibility with agency systems and ensure the Business Technology Investment Council approves new investments prior to purchase, as required by SOPs 90 52 1 and 90 44.
1	Update its business case for the MySBA investment in accordance with SOP 90 44 SBA Information Technology and Capital Planning and Investment Control Standard Operating Procedures.
29(c)	Conducting annual training sessions on financial reporting requirements for subgrantee personnel who are responsible for submitting PERs.
29(b)	Issuing waivers for or enforcing actions on, subgrantees that do not provide accurate financial reports on a timely basis.
29(a)	Contacting subgrantees that are consistently non-compliant with AmeriCorps grant reporting requirements and discussing the reporting requirements outlined in their grants.
29	Require that the Commission strengthen its administrative and management controls and processes over the timeliness of subgrantee financial reporting. Processes should include:
28(b)	Requiring reporting extensions from AmeriCorps if the Commission does not believe that it will be able to meet established FFR due dates.
28(a)	Implementing updated procedures to ensure it submits FFRs to AmeriCorps on a timely basis.

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