

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE FRAUD PREVENTION SYSTEM
IDENTIFIED MILLIONS IN MEDICARE
SAVINGS, BUT THE DEPARTMENT
COULD STRENGTHEN SAVINGS DATA
BY IMPROVING ITS PROCEDURES**

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EXECUTIVE SUMMARY

In the second implementation year of the Fraud Prevention System, we certify \$54.2 million of actual and projected savings in the Medicare fee-for-service program and a return on investment of \$1.34 for every dollar spent on the Fraud Prevention System. We also certify the \$210.7 million in unadjusted savings that the Fraud Prevention System identified.

WHY WE DID THIS REVIEW

The Small Business Jobs Act of 2010 (the Act) requires the Department of Health of Human Services (the Department) to use predictive modeling and other analytics technologies (predictive analytics technologies) to identify improper Medicare fee-for-service claims that providers submit for reimbursement and to prevent the payment of such claims. The Act also requires the Department's Office of Inspector General (OIG) to certify the actual and projected savings with respect to improper payments recovered and avoided and the return on investment related to the Department's use of the Fraud Prevention System (FPS) for each of its first 3 implementation years. In addition, the Act requires OIG to determine whether the Department should continue, expand, or modify its predictive analytics technologies. This report fulfills our responsibilities for the second implementation year.

The objectives of this review were to determine whether the Department (1) complied with the requirements of the Act for reporting actual and projected savings in the Medicare fee-for-service program, the return on investment from the use of predictive analytics technologies, and the return on investment compared to other strategies or technologies; and (2) should continue, expand, or modify its use of the FPS to increase savings or mitigate any adverse impact on Medicare beneficiaries or providers.

BACKGROUND

To fulfill the Act's requirement to use predictive analytics technologies, on June 30, 2011, the Department's Centers for Medicare & Medicaid Services (CMS), through its Center for Program Integrity, established the FPS to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program nationwide. The Department identifies both questionable billing patterns and aberrancies using the FPS and provides this information through Alert Summary Reports (referred to as "leads" in this report) to Zone Program Integrity Contractors and Program Safeguard Contractors for investigations of potential fraud.

The Act requires that the Secretary submit to Congress and make publicly available a report that includes information about the Department's use of predictive analytics technologies for each of the first 3 years of the FPS and that OIG certify specific aspects of this effort for each of the 3 years and recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.

In our report to Congress for the first implementation year, we noted that the Department implemented predictive analytics technologies, but it did not fully comply with the requirements for reporting actual and projected savings in the Medicare fee-for-service program and the return

on investment related to its use of predictive analytics technologies. We made five recommendations in the first implementation year report, and the Department stated that it was committed to working with us to incorporate our recommendations. As of September 30, 2013, the Department implemented four of the five recommendations, including revising its methodologies to incorporate adjustment factors to estimate FPS savings more accurately.

WHAT WE FOUND

In the second implementation year of the FPS, the Department has complied with the requirements of the Act for reporting actual and projected savings in the Medicare fee-for-service program and the return on investment from the use of predictive analytics technologies. Specifically, we certify that the Department's use of its FPS resulted in \$54.2 million of actual and projected savings to the Medicare fee-for-service program and a return on investment of \$1.34 for every dollar spent on the FPS. We also certify the \$210.7 million in unadjusted savings that the FPS identified.

This year, the Department developed adjustment factors to estimate FPS savings more precisely. The \$54.2 million in certified actual and projected savings was calculated by applying the adjustment factors to the \$210.7 million in certified unadjusted savings that the FPS identified. The Department identified additional savings that we were unable to certify because the documentation did not support that the FPS lead contributed to the administrative action.

The Department's ongoing use of the FPS will strengthen efforts to prevent fraud, waste, and abuse in the Medicare fee-for-service program. The Department's use of the FPS generated a positive return on investment, and the Department continues to refine its fraud detection models using its governance process and applicable OIG recommendations to increase savings. The Department has expanded the use of the FPS nationwide to identify fraud, waste, and abuse in the Medicare fee-for-service program and is evaluating whether to expand the use of the FPS in Medicaid. However, although the Department has made significant progress in addressing the challenges of measuring actual and projected savings, its procedures were not always sufficient to ensure that its contractors provided and maintained reliable data to always support FPS savings.

WHAT WE RECOMMEND

To help increase savings and improve its reporting on savings measures, we recommend that the Department:

- provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and
- require contractors to maintain documentation to support how an FPS lead contributes to an administrative action.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS generally concurred with our findings, concurred with our recommendations, and outlined steps for implementing our recommendations.

CMS stated that “the concept of *adjusted savings* is important as it relates to this financial audit, and CMS will continue to refine and use a similar methodology next year [emphasis in original].” However, CMS stated that for a variety of reasons it “will continue to make decisions on expanding the FPS based primarily on the identified savings.”

CMS stated that even though it provided documentation for an additional \$39 million in savings, we did not certify the savings or provide an explanation for our decision. In this regard, CMS cited an example of disallowed savings for which it provided documentation. In addition, CMS stated that it feels that this sentence in our report is inaccurate: “[T]he Department could not ensure that its contractors provided and maintained reliable data to support FPS savings.”

CMS noted that it had implemented the recommendation from our first-year implementation report to require contractors to track recoveries that result from FPS leads. However, CMS recognized that it implemented the recommendation outside of our current audit period.

CMS took exception to our methodology statement regarding the completeness of savings and costs data provided. CMS stated that it had provided complete costs data and that OIG did not make any recommendations to improve costs data.

OUR RESPONSE

The “concept of adjusted savings” is important not only as it relates to a financial audit, but more significantly as a measure of the savings and the return on investment related to the Department’s use of the FPS. Identified savings does not represent a true return on investment because only a portion of those savings are returned to, or prevented from leaving, the Medicare Trust Funds. Therefore, decisions on expanding the FPS should be based primarily on adjusted savings.

We disagree with CMS’s statement that we did not provide an explanation about the \$39 million in savings that we could not certify. As part of our methodology, we reviewed documentation to determine if savings estimates were supportable. Because documentation could not support that the FPS lead contributed to an administrative action for the reported \$39 million in savings, we could not certify these amounts.

As for the example that CMS included in its comments of disallowed savings for which it provided documentation, during our fieldwork we contacted the responsible contractor to determine the impact, if any, that the FPS lead had on the investigation. In its written reply, the contractor stated that it had previously opened an investigation on the provider and that the subsequent FPS lead did not impact the investigation. Therefore, in this example, we concluded the FPS lead did not contribute to the \$3 million administrative action.

We have revised the sentence that CMS suggested was inaccurate: “[T]he Department could not ensure that its contractors always provided and maintained reliable data to support FPS savings.”

For the misunderstanding about the statement regarding costs in the scope and methodology section, we used this statement to inform the reader that we obtained reasonable assurance that the information provided was sufficient but recognize there could be additional data beyond that provided by CMS.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Small Business Jobs Act of 2010 (the Act) requires the Department of Health of Human Services (the Department) to use predictive modeling and other analytics technologies (predictive analytics technologies) to identify improper Medicare fee-for-service claims that providers submit for reimbursement and to prevent the payment of such claims.¹ The Act also requires the Department's Office of Inspector General (OIG) to certify the actual and projected savings with respect to improper payments recovered and avoided and the return on investment related to the Department's use of the Fraud Prevention System (FPS) for each of its first 3 years (the implementation years).² In addition, the Act requires OIG to determine whether the Department should continue, expand, or modify its predictive analytics technologies. This report fulfills our responsibilities for the second implementation year.

OBJECTIVES

Our objectives were to determine whether the Department (1) complied with the requirements of the Act for reporting actual and projected savings in the Medicare fee-for-service program, the return on investment from the use of predictive analytics technologies, and the return on investment compared to other strategies or technologies and (2) should continue, expand, or modify its use of the FPS to increase savings or mitigate any adverse impact on Medicare beneficiaries or providers.

BACKGROUND

Use of Predictive Analytics Technologies in Medicare

The Act requires the Department to use predictive analytics technologies to (1) identify improper Medicare fee-for-service claims that providers submit for reimbursement and (2) prevent the payment of such claims.³ Congress appropriated \$100 million for the Department to carry out the requirements of the Act.⁴ The Department reported \$34.7 million in costs for the first implementation year and \$40.5 million in costs for the second implementation year.

¹ P.L. No. 111-240 § 4241.

² The Act § 4241(e)(1)(B). The Act specifies that the first implementation year was July 1, 2011, to June 30, 2012. The second implementation year was October 1, 2012, to September 30, 2013. The third implementation year is January 1, 2014, to December 31, 2014.

³ The Act § 4241(a). When the FPS prevents improper payments, the Department reports the savings as improper payments avoided. When the FPS identifies improper payments already made, the Department reports the savings as improper payments recovered.

⁴ The Act § 4241(h).

Centers for Medicare & Medicaid Services Fraud Prevention System

To fulfill the Act's requirement to use predictive analytics technologies, on June 30, 2011, the Department's Centers for Medicare & Medicaid Services (CMS), through its Center for Program Integrity, established the FPS to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program nationwide. The Department identifies both questionable billing patterns and aberrancies using the FPS and provides this information through Alert Summary Reports (referred to as "leads" in this report) to Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) for investigation.⁵ These investigations can result in the following administrative actions:

- **Payment suspension**—a temporary hold in an escrow account of all or a portion of the payments to a provider. When a payment suspension is terminated, the amounts withheld are first applied to reduce any outstanding overpayments.
- **Law enforcement referrals**—suspected fraud cases that are referred to law enforcement agencies for potential prosecution. Savings may be recovered as part of the resolution of these cases.
- **Overpayment recoveries**—Medicare payments that providers received in excess of amounts due and payable under statute and regulations. Medicare Administrative Contractors (MACs) issue demand letters to the providers and collect the overpayments.
- **Prepayment edits**—computer edits that suspend all or part of claims. Contractors review the claims before determining whether to make payments.
- **Autodenial edits**—computer edits that automatically deny all or part of the claims without making any payments to providers.
- **Provider revocations**—revocation of a provider's Medicare status. This prevents revoked providers from being paid for any billing for claims.

The Department reports as savings the improper payments recovered or avoided as a result of these administrative actions.

Office of Inspector General Certification of Actual and Projected Savings in the Medicare Fee-for-Service Program

The Act requires that the Secretary submit to Congress and make publicly available a report that includes information about the Department's use of predictive analytics technologies for each of the first 3 FPS implementation years.⁶ In addition, the Act requires OIG to certify the actual and

⁵ In this report, we use the term "contractors" to refer to both ZPICs and PSCs.

⁶ The report for the first implementation year is *Report to Congress: Fraud Prevention System First Implementation Year*, September 2012. Available online at <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>.

projected savings with respect to improper payments recovered and avoided and the return on investment related to the use of predictive analytics technologies in the Medicare fee-for-service program for each of the first 3 implementation years. The Act also requires that OIG recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.⁷

Office of Inspector General’s Certification of the Department’s Report to Congress on the First Implementation Year of the Fraud Prevention System

In our report to Congress for the first implementation year,⁸ we noted that the Department implemented predictive analytics technologies, but it did not fully comply with the requirements for reporting actual and projected savings in the Medicare fee-for-service program and the return on investment related to its use of predictive analytics technologies. The Department did not report all of the savings required and had inconsistencies in its data. In addition, its methodology for calculating other reported savings included invalid assumptions that may have affected the accuracy of those amounts. In those cases, we could not determine the accuracy of the Department’s information, which impeded our ability to quantify the inaccuracies.

We made five recommendations in the first implementation year report, and the Department stated that it was committed to working with us to implement our recommendations. As of September 30, 2013, the Department has implemented four of the five recommendations. Specifically, it revised two of its methodologies by including adjustment factors to estimate FPS savings more accurately,⁹ coordinated with law enforcement to enhance the reporting of referrals that resulted from the FPS, and included appropriate costs for calculating return on investment. The Department stated that it continues to work toward implementing the remaining recommendation.¹⁰ Appendix A includes more detail on our recommendations and the actions taken to address them.

The Department’s Process for Modifying the Fraud Prevention System

The Department established an FPS governance process in the first implementation year to provide oversight, management, and control of selecting and developing new models, enhancing existing models, and implementing system changes to improve the FPS. This governance process enables the Department to use fraud detection models to address identified

⁷ The Act § 4241(e).

⁸ “The Department of Health and Human Services Has Implemented Predictive Analytics Technologies but Can Improve Its Reporting on Related Savings and Return on Investment” (A-17-12-53000), issued December 17, 2012. Available online at <http://oig.hhs.gov/oas/reports/region1/171253000.pdf>.

⁹ The Department also developed adjustment factors for four other savings categories. These factors were not specifically related to our recommendations from our first implementation year report.

¹⁰ CMS stated that on January 1, 2014, after the conclusion of our fieldwork, it implemented a change in the shared systems to require contractors to track recoveries that result from FPS leads.

vulnerabilities, such as those identified in OIG reports and investigations. The resulting models are evaluated for impact and effectiveness before they are incorporated into the FPS.

HOW WE CONDUCTED THIS REVIEW

To satisfy the Act’s certification requirement, we conducted a performance audit to certify the Department’s reported actual and projected savings to the Medicare fee-for-service program and the Department’s return on investment. We define the term “certification” to mean a determination that the Department’s reported actual and projected savings and its return on investment were reasonably estimated.

We reviewed the unadjusted savings¹¹ and cost data that the Department provided to us from October 2012 through September 2013. To evaluate whether the savings that the Department attributed to the FPS were reasonable, we reviewed and discussed the supporting documentation with contractor personnel and analyzed supporting documentation related to selected administrative actions. We reviewed and confirmed that the documentation and historical data used by the Department to establish adjustment factors to estimate FPS savings more accurately were reasonable and supported. To calculate the adjusted savings amount, we applied the Department’s various adjustment factors to the unadjusted savings from administrative actions to estimate the FPS savings more accurately.¹² We also reviewed the reported costs for calculating return on investment. We did not verify that the Department provided us with complete savings and costs data.

To achieve our second objective, we reviewed the Department’s action plans to expand or modify its use of the FPS to increase savings or mitigate any adverse impact on Medicare beneficiaries or providers.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our scope and methodology.

¹¹ The Department’s second implementation year report to Congress refers to unadjusted savings as FPS “identified” savings.

¹² According to the Department, historical data indicate that only a portion of identified improper payments are recovered. The Department uses adjustment factors to determine the amount of identified recoverable savings attributable to the FPS that will actually be collected or avoided. Therefore, the adjusted savings amount provides a more accurate estimate of the dollars that the Department has already returned or is likely to return in the future from the unadjusted savings.

FINDINGS

In the second implementation year of the FPS, the Department complied with the requirements of the Act for reporting actual and projected savings in the Medicare fee-for-service program and the return on investment from the use of predictive analytics technologies. We certify that the Department's use of its FPS resulted in \$54.2 million of actual and projected savings to the Medicare fee-for-service program and a return on investment¹³ of \$1.34 for every dollar spent on the FPS. We also certify the \$210.7 million in unadjusted savings that the FPS identified.

This year, the Department developed adjustment factors to estimate FPS savings more precisely. The \$54.2 million in certified actual and projected savings was calculated by applying the adjustment factors to the \$210.7 million in certified unadjusted savings that the FPS identified. The Department identified additional savings that we were unable to certify because the documentation did not support that the FPS lead contributed to the administrative action.

The Department's continued use of the FPS will enhance its efforts to prevent fraud, waste, and abuse in the Medicare fee-for-service program. The Department's use of the FPS generated a positive return on investment, and the Department continues to refine its fraud detection models. The Department has expanded the use of the FPS nationwide to identify waste, fraud, and abuse in the Medicare fee-for-service program, and the Department is evaluating whether to expand the use of the FPS in Medicaid. In its second year, the Department continued to use its governance process to develop and modify models. Although the Department has made significant progress in addressing the challenges of measuring actual and projected savings, the Department's procedures were not always sufficient to ensure that its contractors provided and maintained reliable data to always support FPS savings.

THE DEPARTMENT COMPLIED WITH REPORTING REQUIREMENTS

The Act requires the Department to report actual and projected savings with respect to improper payments recovered and avoided, actual and projected savings relative to the return on investment, and the return on investment compared to other strategies or technologies.

We certified that the Department's use of the FPS resulted in \$54.2 million of actual and projected savings to the Medicare fee-for-service program. This includes savings for which the FPS lead contributed to the administrative action by initiating an investigation or corroborating, augmenting, and/or expediting an existing investigation. The \$54.2 million certified amount corresponds to \$210.7 million of certified unadjusted savings that the FPS identified before we applied the various adjustment factors to estimate FPS savings more accurately. (See Appendix C.) Through the innovative development of adjustment factors, the Department

¹³ The Department determines the FPS's return on investment by comparing the sum of actual and projected savings to the costs expended to achieve the savings. For the second implementation year, the Department calculated the return on investment by dividing the total \$54.2 million of actual and projected savings by the \$40.5 million of costs.

introduced a new concept to report a more precise estimate of FPS savings. Of the certified actual and projected savings,¹⁴ we found that:

- \$10.1 million of projected improper payments were estimated to be recovered from law enforcement referrals and overpayment recoveries;
- \$14.9 million of actual improper payments were estimated to be avoided through prepayment edits, autodenial edits, and payment suspensions; and
- \$29.2 million of projected improper payments were estimated to be avoided by revoking provider billing privileges.

The Department identified \$39.4 million of additional savings that we were unable to certify because documentation did not support that the information in the FPS lead was new or that it contributed to achieving the administrative action. Specifically, contractors' investigation notes and interviews with the contractors and Department officials did not support that the FPS information was new information that contributed to achieving the administrative actions.

We also certified that the Department's use of its predictive analytics technologies resulted in a return on investment of \$1.34 for every dollar spent on the FPS. The Department reported \$40.5 million in total costs for three categories: (1) \$34.2 million for FPS system contractor costs, (2) \$2.3 million for Department staff costs, and (3) \$4 million for contractor costs.

In the second implementation year, the Department did not compare the FPS to any other similar technologies. The Department stated that direct comparisons with similar technology are difficult to identify. The Department stated that as similar programs mature, it will compare the success of the FPS with other technology being used "in the federal space."

THE DEPARTMENT'S USE OF THE FRAUD PREVENTION SYSTEM

The Act requires that OIG recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.¹⁵

The Department's continued use of the FPS will enhance its efforts to prevent fraud, waste, and abuse in the Medicare fee-for-service program. The Department's use of the FPS generated a positive return on investment, and the Department continues to refine its fraud detection models using its governance process. The Department has expanded the use of the FPS nationwide to identify waste, fraud, and abuse in the Medicare fee-for-service program, and the Department is evaluating whether to expand the use of the FPS in Medicaid.

¹⁴ In the second implementation year, the Department did not identify any actual improper payments recovered. Therefore, we did not certify any actual improper payments recovered.

¹⁵ P.L. No. 111-240 § 4241(e)(1)(B)(iii)

In addition, the Department's modifications of the FPS, which were based on OIG recommendations, will increase savings. For example, the Department established a computer edit designed to reject claims directly through the FPS for those physicians who provided services in their offices but mistakenly billed them as though they had been provided at ambulatory surgical centers.¹⁶

Although the Department has made significant progress in addressing the challenges of measuring actual and projected savings, the Department did not (1) provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and (2) require contractors to maintain documentation to support how an FPS lead contributed to an administrative action. As a result, the Department could not ensure that its contractors provided and maintained reliable data to always support FPS savings.

In some cases, contractors attributed administrative actions to the FPS when the actions taken were not the result of FPS leads and the documentation did not support attributing the actions to the FPS. For example, in one case a contractor opened an investigation in July 2012 on the basis of a beneficiary complaint that the provider was falsifying claims. The FPS had identified the same provider in a lead created in June 2011. However, the contractor did not open an investigation at that time, and the lead was not referenced in the supporting documentation for the investigation. The contractor stated that there was no evidence that the FPS influenced the investigation, despite the existence of an earlier FPS lead. Accordingly, we did not attribute this administrative action to the FPS. Providing better guidance could help ensure that contractors maintain, as appropriate, reliable data supporting attribution of FPS savings.

RECOMMENDATIONS

To help increase savings and improve its reporting on savings measures, we recommend that the Department:

- provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and
- require contractors to maintain documentation to support how the FPS lead contributes to an administrative action.

¹⁶ OIG, "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009" (A-01-10-00516), issued September 7, 2011.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS generally concurred with our findings, concurred with our recommendations, and outlined steps for implementing our recommendations.

CMS stated that “the concept of *adjusted savings* is important as it relates to this financial audit, and CMS will continue to refine and use a similar methodology next year [emphasis in original].” However, CMS stated that for a variety of reasons it “will continue to make decisions on expanding the FPS based primarily on the identified savings.”

CMS stated that even though it provided documentation for an additional \$39 million in savings, we did not certify the savings or provide an explanation for our decision. In this regard, CMS cited an example of disallowed savings for which it provided documentation. In addition, CMS stated that it feels that this sentence in our report is inaccurate: “[T]he Department could not ensure that its contractors provided and maintained reliable data to support FPS savings.”

CMS noted that it had implemented the recommendation from our first-year implementation report to require contractors to track recoveries that result from FPS leads. However, CMS recognized that it implemented the recommendation outside of our current audit period.

CMS took exception to our methodology statement regarding the completeness of savings and costs data provided. CMS stated that it had provided complete costs data and that OIG did not make any recommendations to improve costs data.

CMS’s comments, excluding one technical comment that we addressed as appropriate, are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

The “concept of adjusted savings” is important not only as it relates to a financial audit, but more significantly as a measure of the savings and the return on investment related to the Department’s use of the FPS. Identified savings does not represent a true return on investment because only a portion of those savings are returned to, or prevented from leaving, the Medicare Trust Funds. Therefore, decisions on expanding the FPS should be based primarily on adjusted savings.

We disagree with CMS’s statement that we did not provide an explanation about the \$39 million in savings that we could not certify. As part of our methodology, we reviewed documentation to determine if savings estimates were supportable. Because documentation could not support that the FPS lead contributed to an administrative action for the reported \$39 million in savings, we could not certify these amounts.

As for the example that CMS included in its comments of disallowed savings for which it provided documentation, during our fieldwork we contacted the responsible contractor to determine the impact, if any, that the FPS lead had on the investigation. In its written reply, the contractor stated that it had previously opened an investigation on the provider and that the

subsequent FPS lead did not impact the investigation. Therefore, in this example, we concluded the FPS lead did not contribute to the \$3 million administrative action.

We have revised the sentence that CMS suggested was inaccurate: “[T]he Department could not ensure that its contractors always provided and maintained reliable data to support FPS savings.”

Regarding CMS’s implementation of our prior report’s recommendation, after the conclusion of our fieldwork, CMS stated that on January 1, 2014, it implemented a change in the shared systems to require contractors to track recoveries that result from FPS leads. We will review the effectiveness of CMS’s change during our third-year implementation audit.

For the misunderstanding about the statement regarding costs in the scope and methodology section, we used this statement to inform the reader that we obtained reasonable assurance that the information provided was sufficient but recognize there could be additional data beyond that provided by CMS.

APPENDIX A: OFFICE OF INSPECTOR GENERAL RECOMMENDATIONS AND DEPARTMENT ACTIONS IN THE FIRST-YEAR IMPLEMENTATION REPORT

Table 1: OIG Recommendations and Department Actions for the First Implementation Year

No.	OIG Recommendation	Department Action	Status
1	Require contractors to track recoveries that result from FPS leads.	Developing a corrective action to track overpayment recoveries with the MACs.	Ongoing ¹⁷
2	Coordinate with law enforcement to enhance the reporting of investigative and prosecutorial outcomes in cases predicated on referrals from the FPS.	Coordinated with OIG’s Office of Investigations to enhance the reporting of referrals that resulted from the FPS.	Implemented
3	Revise the methodology used to calculate projected savings with respect to improper payments avoided to recognize that some of the services associated with prior-year claims submitted by a revoked provider may be legitimate and claims denied on the basis of edits may ultimately be paid.	Revised the methodology by including the provider revocation adjustment factor.	Implemented
4	Revise the methodology used to calculate costs avoided from edits and payment suspensions to include verifying that the information in the Department’s records is consistent with records maintained by ZPICs and PSCs.	Revised the methodology by including the adjustment factors for edits and payment suspensions.	Implemented
5	Include all costs associated with the FPS, including reporting costs, indirect costs, and projected costs, in its return-on-investment calculation.	Included all appropriate costs in its return-on-investment calculation.	Implemented

¹⁷ After the conclusion of our fieldwork, CMS stated that on January 1, 2014, it implemented a change in the shared systems to require contractors to track recoveries that result from FPS leads.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the Department's use of predictive analytics technologies during the second implementation year of the FPS (October 1, 2012, through September 30, 2013). We reviewed the unadjusted savings and cost data provided by the Department for that period. On September 5, 2013, the Department provided us with data on the administrative actions taken during the first 9 months of the implementation year. On November 22, 2013, the Department updated the data to include the entire implementation year, except for the revocations data that was provided on December 3, 2013. For the second implementation year, the Department provided us with data that included a total of \$299.2 million in unadjusted savings reported by contractors. In addition, on February 25, 2014, the Department provided us with the final total reported FPS cost data totaling \$40.5 million.

To evaluate whether the savings that the Department attributed to the FPS were reasonable, we reviewed and discussed the supporting documentation with contractor personnel, and analyzed supporting documentation related to selected administrative actions. This analysis resulted in reducing unadjusted savings to \$210.7 million. We reviewed and confirmed that the documentation and the historical data used by the Department to establish adjustment factors to estimate FPS savings more accurately were reasonable and supported. We reduced the \$210.7 million of unadjusted savings by applying the Department's various adjustment factors to the savings from administrative actions to estimate the FPS savings more accurately. As shown in Appendix C, the application of the various adjustment factors to the unadjusted savings resulted in the certified amounts. To assess the return-on-investment calculation, we reviewed supporting documentation for \$40.5 million in total reported costs, which included costs from the FPS system contractors and the Department's staff and contractors to calculate return on investment. We did not verify that the Department provided us with complete savings and cost data.

To achieve our second objective, we reviewed the Department's action plans to expand or modify its use of the FPS to increase savings or mitigate any adverse impact on Medicare beneficiaries or providers.

We conducted this performance audit to certify the amounts that the Department reported as actual and projected savings to the Medicare fee-for-service program and the Department's return on investment, as required by the Act. We have defined the term "certification" as a determination that the Department's reported actual and projected savings and return-on-investment figures were reasonably estimated. We did not apportion savings between the FPS and other sources of detection when multiple sources of information led to the administrative action. Our objectives did not require an understanding or assessment of the overall internal control structure of the Department or its contractors.

Our fieldwork consisted of contacting contractors nationwide. We also visited the Department in Baltimore, Maryland, and four contractors, in Hingham, Massachusetts; Camp Hill, Pennsylvania; Nashville, Tennessee; and Dallas, Texas. We conducted our fieldwork from April through December 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed the Act to gain an understanding of the Department's responsibilities and OIG's responsibilities;
- met with Department officials to learn about the Department's implementation of the FPS;
- reviewed supporting documentation to determine whether the Department's methodologies, dated November 22, 2013, for calculating actual and projected savings, including the various adjustment factors established to reduce unadjusted savings, were reasonable and supportable;
- contacted contractors to learn about their roles related to the FPS and to understand how they attributed administrative actions to the FPS;
- reviewed the supporting documentation for administrative actions designated as being related to the FPS;
- interviewed contractors' management and investigators to assess the impact the FPS supporting documentation had on the investigation;
- reviewed the contractors' notes and supporting documentation to determine whether the FPS information was new information that contributed to achieving the administrative actions;
- met with Department officials to discuss and review the administrative actions that we determined were not related to the FPS to evaluate additional support from the Department;
- applied the Department's methodology to determine whether the savings from selected administrative actions were attributable to the FPS;
- applied the Department's various adjustment factors to the unadjusted savings from administrative actions;
- reviewed invoices and other supporting documentation to determine whether the reported costs from FPS system contractors, the Department's staff, and the Department's contractors for calculating return on investment were reasonable;
- verified that the return on investment was calculated accurately;

- reviewed the Department’s action plans to expand or modify its use of the FPS to increase savings or mitigate any adverse impact on Medicare beneficiaries or providers;
- reviewed the Department’s report to Congress for the second implementation year; and
- discussed the results of our audit with Department officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: CERTIFIED FRAUD PREVENTION SYSTEM SAVINGS

Table 2: Certified FPS Savings by Administrative Action

Administrative Action	Unadjusted Savings	Adjustment Factor	Reduction Amount	Certified FPS Savings ¹⁸
Payment Suspensions	\$2,260,067	3.0%	\$67,802	\$2,192,265
Law Enforcement Referrals¹⁹	73,203,095	94.1%	68,889,938	4,313,157
Overpayment Recoveries	35,615,848	83.8%	29,857,126	5,758,721
Prepayment Edits	16,777,677	31.3%	5,243,642	11,534,036
Autodenial Edits	1,630,629	27.5%	447,965	1,182,663
Provider Revocations	81,239,803	64.0%	52,014,428	29,225,375
Totals	\$210,727,119	74.3%	\$156,520,901	\$54,206,217

The Department developed one adjustment factor for payment suspensions and law enforcement referrals. There is a range of adjustment factors for overpayment recoveries, prepayment edits, autodenial edits, and provider revocations. In Table 2, for those administrative actions with a range of adjustment factors, we showed one adjustment factor that is based on a reduction amount divided by the unadjusted savings. However, we applied the actual adjustment factors to the appropriate administrative actions to calculate the certified FPS savings. The adjustment factors for overpayment recoveries depend on each ZPIC's specific collection history and, therefore, vary by ZPIC. The adjustment factors for prepayment edits and autodenial edits vary by provider and service type. The adjustment factors for provider revocations vary by provider type.

¹⁸ Our application of the Department's various adjustment factors reduced the unadjusted savings by \$156,520,901 or 74.3 percent. Differences in the Certified FPS Savings column are due to rounding.

¹⁹ In a future audit, we plan to determine why the certified FPS savings (collected amount) are such a small percentage (5.9 percent) of the unadjusted savings (identified amount) from law enforcement referrals.

APPENDIX D: AUDITEE COMMENTS



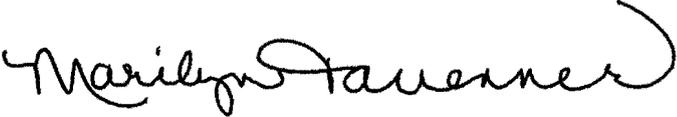
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN - 5 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner 
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: “The Fraud Prevention System Identified Millions in Medicare Savings, but the Department Could Strengthen Savings Data by Improving Its Procedures” (A-01-13-00510)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-mentioned OIG draft report. The Small Business Jobs Act of 2010 requires the Secretary of the Department of Health and Human Services to use predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program. CMS developed the Fraud Prevention System (FPS) in order to implement predictive analytics technologies.

The CMS appreciates OIG’s finding that the “ongoing use of the FPS will strengthen efforts to prevent fraud, waste, and abuse in the Medicare fee-for-service program.” CMS made significant progress using the FPS to identify suspect providers and take administrative action to protect the Medicare Trust Funds. In the second implementation year, which aligned with fiscal year (FY) 2013, CMS took administrative action against 938 providers and suppliers due to the FPS. The identified savings, certified by OIG, associated with these prevention and detection actions due to FPS was \$210.7 million, almost double the amount identified during the first year of the program.

The concept of *adjusted savings* is important as it relates to this financial audit, and CMS will continue to refine and use a similar methodology next year. The FPS is a prevention-oriented tool, identifying providers and suppliers exhibiting aberrant billing behaviors. Recovering money, which is one important result of investigating these leads, is contingent on numerous other processes and limitations. There are also other hard-to-quantify benefits of the FPS activity, such as the sentinel effect it creates, and the highly collaborative environment it has fostered between CMS and law enforcement, as well as between and among CMS and its program integrity contractors. CMS will continue to make decisions on expanding the FPS based primarily on the identified savings.

The OIG states that “the Department could not ensure that its contractors provided and maintained reliable data to support FPS savings” (page 7). We feel that this statement is inaccurate. OIG certified \$210.7 million in identified savings and \$54.2 million in adjusted savings based on sufficient documentation from CMS. CMS also provided documentation to support an additional \$39 million in savings the agency believes is due to the FPS. OIG did not allow the additional savings and did not provide an explanation about the disallowance. The following is an example of disallowed savings for which CMS provided OIG documentation:

A provider had been monitored by the ZPIC since 2011. The FPS later flagged the provider with additional information. The ZPIC confirmed that a provider interview was conducted based on the new information in the FPS. The case was later referred to law enforcement, and included information directly from the FPS. The referral identified more than \$3 million in potential fraud.

The OIG states throughout the report that CMS has implemented four of the five OIG recommendations in the First Year Implementation Report. In Appendix A, the status of the first recommendation is, “Developing a corrective action to track overpayment recoveries with the MACs.” CMS recognizes that the OIG report is as of the end of the second implementation year. However, it is important to clarify that CMS has successfully implemented this recommendation. On January 1, 2014, a change was implemented in the shared systems to track overpayment recoveries back to the contractor that requested the overpayment. Through this systems change, the contractors received technical direction to start including certain information on overpayment requests for recovery submitted on or after January 1, 2014, to allow for the tracking.

The OIG also states on page 4 that it “did not verify that the Department provided us with complete savings and costs data.” CMS provided the Department complete costs data through provision of paid invoices and other documentation. OIG also confirmed that CMS implemented OIG’s recommendation that CMS “include all appropriate costs in its return-on-investment calculation.” OIG did not make any recommendations to improve costs data.

The CMS expects that future activities will substantially increase savings by expanding the use of the innovative technology beyond the initial focus on identifying potential fraud into the areas of waste and abuse. In FY 2013, CMS completed pilot projects to expand the use of the FPS. These pilots included providing leads to the Medicare Administrative Contractors (MACs) for medical review and denying claims directly by the FPS that are not supported by Medicare policy. CMS may expand these pilot projects nationally to improve fraud, waste, and abuse prevention and detection. CMS will also evaluate the feasibility of expanding predictive analytics technology to Medicaid.

Our response to each of the OIG recommendations follows.

OIG Recommendation

Provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS.

CMS Response

The CMS concurs with the recommendation. OIG included savings for which “the FPS lead contributed to the administrative action by initiating an investigation or corroborating, augmenting, and/or expediting an existing investigation.” CMS will issue a Technical Direction Letter to the Zone Program Integrity Contractors and Program Safeguard Contractors providing written instruction on how to determine whether an investigation initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation.

OIG Recommendation

Require contractors to maintain documentation to support how the FPS lead contributes to an administrative action.

CMS Response

The CMS concurs with the recommendation. CMS will issue a Technical Direction Letter to the Zone Program Integrity Contractors and Program Safeguard Contractors providing written instructions on maintaining documentation when an FPS lead initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.