

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES HAS
IMPLEMENTED PREDICTIVE
ANALYTICS TECHNOLOGIES BUT
CAN IMPROVE ITS REPORTING ON
RELATED SAVINGS AND
RETURN ON INVESTMENT**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Daniel R. Levinson
Inspector General

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Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

BACKGROUND

The Small Business Jobs Act of 2010 (the Act) requires the Department of Health and Human Services (the Department) to use predictive modeling and other analytics technologies (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. To implement predictive analytics technologies, the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, developed the Fraud Prevention System (FPS). In the Department's *Report to Congress: Fraud Prevention System First Implementation Year* (the first implementation report), mandated by the Act, CMS reported that it uses the FPS to review in real time all Medicare fee-for-service claims before payment. The FPS reviews claims processed nationwide.

Not later than 3 months after the completion of the first implementation year (July 1, 2011, through June 30, 2012), the Office of Inspector General (OIG) of the Department must certify the actual and projected improper payments recovered and avoided and the return on investment related to the Department's use of predictive analytics technologies in the Medicare fee-for-service program. OIG must do this for the first 3 implementation years. OIG must also recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.

OBJECTIVES

Our objectives were to determine whether the Department: (1) complied with the requirements of the Act for reporting actual and projected improper payments recovered and avoided in the Medicare fee-for-service program and its return on investment related to its use of predictive analytics 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.

SUMMARY OF FINDINGS

In the first year of its implementation of the Act's requirements, the Department has implemented predictive analytics technologies, but it did not fully comply with the requirements for reporting actual and projected improper payments recovered and avoided in the Medicare fee-for-service program and its return on investment related to its use of predictive analytics technologies. Reporting such amounts in accordance with the requirements is inherently challenging because, primarily, it is a new venture and because of the decentralized nature of the FPS business processes. The Department did not report some of the amounts required and had inconsistencies in its data; in addition, its methodology for calculating other reported amounts included some invalid assumptions that may have affected the accuracy of those amounts. In these cases, we could not determine the accuracy of the Department's information, which impeded our ability to quantify the amount of the inaccuracies noted in this report.

Although we could not determine whether the savings-related information that the Department reported was accurate, using the FPS will help the Department combat fraud, waste, and abuse in the fee-for-service program. The Department has integrated the FPS into its overall fraud prevention strategy, and the FPS now covers all 50 States, the District of Columbia, and the territories. In its first implementation report, the Department has described its plans to expand and enhance the FPS. We expect to analyze any modifications or refinements in future implementation years.

RECOMMENDATIONS

Developing initial year measurements for actual and projected savings and cost avoidance that have accrued from the use of predictive analytics is inherently difficult, and we recognize that refining such measures will be challenging. To help the Department address this challenge and improve its reporting on these measures, we recommend that the Department:

- require contractors to track recoveries that result from FPS leads;
- coordinate with law enforcement to enhance reporting of investigative and prosecutorial outcomes in cases predicated on referrals from the FPS;
- 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;
- 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 that maintained by the Zone Program Integrity Contractors and the Program Safeguard Contractors; and
- include all costs associated with the FPS, including reporting costs, indirect costs, and projected costs, in its return on investment calculation.

DEPARTMENT COMMENTS

In written comments on our draft report, the Department concurred with our recommendations and noted it is committed to working with OIG to ensure that the recommendations are incorporated into future FPS reports. In response to the Department's technical comments, we made changes to the report as appropriate.

The Department's comments are included as the Appendix of this report.

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INTRODUCTION

BACKGROUND

Use of Predictive Analytics Technologies in the Medicare Program

Section 4241 of the Small Business Jobs Act of 2010 (the Act) (P.L. No. 111-240) requires the Department of Health and Human Services (the Department) to use predictive modeling and other analytics technologies (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. The Act required the Department to issue, no later than January 1, 2011, requests for proposals on how to implement predictive analytics technologies. The Act required the Department to implement predictive analytics technologies by July 1, 2011, in the 10 States that the Secretary of the Department (Secretary) identified as having the highest risk of Medicare fee-for-service fraud, waste, and abuse. Congress appropriated \$100 million to the Department to carry out the requirements of the Act.

The Centers for Medicare & Medicaid Services Fraud Prevention System

To implement predictive analytics technologies, the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, developed the Fraud Prevention System (FPS). In its *Report to Congress: Fraud Prevention System First Implementation Year*¹ (the first implementation report), CMS reported that it uses the FPS to review in real time all Medicare fee-for-service claims before payment. The FPS reviews claims processed in all 50 States, the District of Columbia, and the territories. The FPS detects both patterns and aberrancies² (referred to as “leads” in this report) that CMS provides to Zone Program Integrity Contractors (ZPIC) and Program Safeguard Contractors (PSC)³ for investigation. These investigations can result in administrative actions, including payment suspensions, provider/supplier revocations, and referrals to law enforcement. Investigations can also result in the introduction of programming that screens claims automatically for specific problems (payment edits).

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

The Act requires that not later than 3 months after the completion of the first implementation year,⁴ the Secretary submit to Congress and make available to the public a report that includes information about the Department’s use of predictive analytics technologies. In addition, the Act requires the Office of Inspector General (OIG) of the Department to certify the actual and projected improper payments recovered and avoided and the return on investment related to the

¹ CMS, *Report to Congress: Fraud Prevention System First Implementation Year*, September 2012.

² Aberrancies are claims that deviate from the norm.

³ Both ZPICs and PSCs are responsible for performing program integrity activities for CMS.

⁴ The first implementation year was July 1, 2011, through June 30, 2012.

Department's use of predictive analytics technologies in the Medicare fee-for-service program for the first 3 implementation years (section 4241(e) of the Act). The Act also requires that OIG recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the Department: (1) complied with the requirements of the Act for reporting actual and projected improper payments recovered and avoided in the Medicare fee-for-service program and its return on investment related to its use of predictive analytics 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.

Scope

We reviewed the first implementation report, as of September 27, 2012. Our report is based on the data and information provided to us as of that date and does not reflect any subsequent revisions to the Department's report, if any such changes have been made. Specifically, we reviewed section 3, "FPS Outcomes." Our review was limited to this section because it contained the information that we were required to certify. We did not audit information reported in other sections and therefore do not provide any assurance about the information in those sections. The first implementation report covered CMS's use of predictive analytics technologies from July 1, 2011, through June 30, 2012.

As stated earlier, the Act requires us 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. However, the term "certification" is not defined in the Act or in generally accepted government auditing standards. To satisfy the Act's certification requirement, we have conducted a performance audit to evaluate the accuracy of the savings and return on investment figures that the Department reported. We have defined the term "certification" as a determination that the actual and projected savings and return on investment figures reported by the Department are accurate.

Because the OIG certification date and the Department reporting date are the same (90 days after the end of the first implementation year), we limited our procedures to those necessary to evaluate the accuracy of the information reported by the Department. We did not perform procedures to quantify errors in that information.

The first implementation report included the Department's determination of actual and projected savings and return on investment. The Department's underlying assumptions for determining projected savings were based on current events and circumstances. Because future events and circumstances frequently do not occur as expected, projected and actual results often differ. Those differences may be material. We have no responsibility to update this report for events and circumstances that occur after the date of this report. Our audits of subsequent

implementation years will provide a perspective on these projections.

We performed our fieldwork from March through August 2012.

Methodology

To accomplish our objectives, we:

- reviewed the Act to gain an understanding of the Department's and OIG's responsibilities,
- met with Department officials to learn about the Department's implementation of the FPS,
- evaluated the first implementation report and the Department's supporting documentation to determine the accuracy of the estimated actual and projected savings and return on investment figures reported,
- analyzed the Department's methodologies for calculating actual and projected savings to determine whether the underlying assumptions were valid,
- reviewed the Department's methodology for calculating return on investment to determine whether it would include all costs and savings associated with the FPS and whether the underlying assumptions were valid,
- visited a ZPIC and a PSC to review case files and to compare their data to the Department's data,
- reviewed the Department's actual and planned activities to expand and modify or refine the FPS, 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.

FINDINGS AND RECOMMENDATIONS

In the first year of its implementation of the Act's requirements, the Department has implemented predictive analytics technologies, but it did not fully comply with the requirements for reporting actual and projected improper payments recovered and avoided in the Medicare fee-for-service program and its return on investment related to its use of predictive analytics technologies. Reporting such amounts in accordance with the requirements is inherently

challenging because, primarily, it is a new venture and because of the decentralized nature of the FPS business processes. The Department did not report some of the amounts required and had inconsistencies in its data; in addition, its methodology for calculating other reported amounts included invalid assumptions that may have affected the accuracy of those amounts. In these cases, we could not determine the accuracy of the Department's information, which impeded our ability to quantify the amount of the inaccuracies noted in this report.

Although we could not determine whether the savings-related information that the Department reported was accurate, using the FPS will help the Department combat fraud, waste, and abuse in the fee-for-service program. The Department has integrated the FPS into its overall fraud prevention strategy, and the FPS now covers all 50 States, the District of Columbia, and the territories. In its first implementation report, the Department has described its plans to expand and enhance the FPS. We expect to analyze any modifications or refinements in future implementation years.

THE DEPARTMENT DID NOT FULLY COMPLY WITH REPORTING REQUIREMENTS

Federal Requirements

Subsections (i) and (ii) of sections 4241(e)(1)(B) of the Act require the Department to report the following information:

- actual savings with respect to improper payments recovered,
- projected savings with respect to improper payments recovered,
- actual savings with respect to improper payments avoided,
- projected savings with respect to improper payments avoided,
- actual and projected savings relative to the return on investment for the use of predictive analytics technologies, and
- actual and projected savings relative to the return on investment for the use of predictive analytics technologies in comparison to other strategies or technologies.

Improper Payments Recovered: Actual Savings

In its first implementation report, the Department could not present actual savings with respect to improper payments recovered. The Department acknowledged in the first implementation report that it did not report this information because it does not require contractors to track recoveries by source (i.e., the entity that identified the improper payment). Departmental officials advised us that this problem, related to the attribution of the sources, affects other CMS recoveries and that they are considering corrective actions that may address this issue.

Improper Payments Recovered: Projected Savings

In its first implementation report, the Department reported estimated projected savings of \$72.6 million with respect to improper payments recovered. This amount consisted of the following:

- \$4.4 million in overpayments that the ZPICs and PSCs had referred to other contractors for collection after they had investigated leads and
- \$68.2 million related to the ZPICs' and PSCs' referrals to law enforcement.

The Department cannot track the collection of overpayments resulting from leads because it does not require contractors to track recoveries by source. Without this information, the Department cannot develop an accurate estimate of the funds referred for collection that will be collected. Therefore, we could not determine whether the \$4.4 million that ZPICs and PSCs had referred to other contractors was an accurate projection of savings.

We also could not determine whether the \$68.2 million in projected savings from law enforcement referrals was an accurate projection of savings. This amount represents the total value of claims identified during the investigation of leads. The Department's methodology assumes that 100 percent of the amount referred to law enforcement will be recovered. The Department did not provide any support for this assumption, such as historical data. The methodology does not reasonably account for known variables that may impede the 100-percent recovery of the amount referred. For example, law enforcement has discretion not to pursue a case based on a referral or a referral might result in a case that is settled before it goes to trial. Both examples would likely decrease the total percentage of actual recoveries based on law enforcement referrals. Furthermore, amounts collected resulting from law enforcement referrals may be higher than 100 percent of improper payments recovered in some cases because supplemental amounts, such as treble damages and additional fines or penalties that can be levied by the judicial system, may be returned to the Medicare trust fund. These amounts would not be accounted for in the presentation of projected savings from improper payments recovered as they are not improper payments identified by the FPS. Department officials advised us that they will have to work with law enforcement officials to develop a more accurate estimate of recoveries from law enforcement referrals.

Improper Payments Avoided: Actual Savings

In its first implementation report, the Department reported \$31.8 million in estimated actual savings with respect to improper payments avoided. This amount consisted of the following:

- Cost avoidance from revoking provider billing privileges: \$7.3 million,
- Cost avoidance from changes in provider behaviors:⁵ \$6.7 million,

⁵ This refers to a national prepayment edit that CMS implemented in 2012.

- Amount denied by prepayment edits:⁶ \$11.5 million,
- Amount denied by autodenial edits:⁷ \$4.7 million, and
- Payment suspensions: \$1.6 million.

Developing a methodology and accumulating data for these reported amounts for the initial implementation year was an inherently challenging process. Some of these amounts may not represent actual savings with respect to improper payments avoided in the first implementation year.

Cost Avoidance From Revoking Provider Billing Privileges

We could not determine whether the \$7.3 million reported as actual costs avoided by revoking provider billing privileges was accurate because the Department's methodology assumes that not one of the claims submitted by the provider was a legitimate claim that would have been paid if the beneficiary had received the services from another provider. The Department did not provide support for this assumption, and we found evidence that it may not be valid. We examined the prior-year claims submitted by one provider whose billing privileges had been revoked and found that some of the beneficiaries treated by that provider received the same type of services from other providers following the revocation. The Department's methodology assumes that 100 percent of the prior-year claims submitted by a revoked provider were not proper.

Cost Avoidance From Changes in Provider Behaviors

We could not determine whether the \$6.7 million reported as actual costs avoided from changes in provider behaviors was accurate. The Department's methodology is based on an edit added to the MACs' Medicare fee-for-service claims processing system. We examined the payments to one provider affected by this edit after it was implemented and found that the provider received payment for some services that this edit was designed to deny. Our concern is that the Department's methodology assumes that 100 percent of the claims denied by the edit were improper. If any of these payments were proper, the \$6.7 million reported as actual costs avoided by this edit would be overstated.

Amounts Denied by Edits and Payment Suspensions

We could not determine whether the \$17.8 million reported as actual costs avoided through edits and payment suspensions was accurate. The supporting information maintained by the Department was not consistent with the supporting information provided and certified by the

⁶ Prepayment edits automatically flag all or part of a claim for further CMS review or automatically hold payment for all or part of a claim (the first implementation report, section 3.1). Prepayment edits, unless otherwise specified, are applied by individual Medicare administrative contractors (MAC) (i.e., a local edit). MACs are companies that process and pay Medicare fee-for-service claims.

⁷ Autodenial edits automatically deny all or part of claims; no review is necessary (the first implementation report, section 3.1).

ZPICs and PSCs. Specifically, the information provided by the ZPIC and PSC we visited included the names of sanctioned providers that were not included in the information maintained by the Department. The Department's methodology for determining costs avoided from edits and payment suspensions did not include obtaining a list of sanctioned providers and associated costs avoided from the ZPICs and PSCs and verifying that this information was consistent with the Department's information. Instead, the Department relied on ZPIC and PSC certification of the data that ZPICs and PSCs provided. The \$17.8 million that the Department reported reflects adjustments it made in response to those errors that we identified during our review.

Improper Payments Avoided: Projected Savings

In its first implementation report, the Department reported \$11 million in projected savings with respect to improper payments avoided. This amount consisted of the following:

- cost avoidance from revoking provider billing privileges: \$6.6 million and
- cost avoidance from changes in provider behaviors: \$4.4 million.

These amounts represent the portion of estimated avoided costs that are expected to occur in the second implementation year.⁸ We could not determine whether the \$11 million was accurate because, similar to the issues noted with the Department's reporting of actual costs avoided by revoking provider billing privileges and changing provider behavior, the Department's methodology here also assumes that 100 percent of the claims were improper. Performing an in-depth analysis of historical data used in developing the assumptions that affect billing privilege revocation and the propriety of claims denied by certain edits could provide useful information to be able to project savings with more precision.

Return on Investment for the Use of Predictive Analytics Technologies: Actual and Projected Savings

In the first implementation report, the Department reported an estimated return on investment of \$3.30 for every dollar spent on the FPS in its first implementation year. This figure was not accurate because it was calculated by dividing the total of both actual and projected savings that were reported by a summary of the costs used to implement the FPS during its first year, and, as previously discussed, there were inconsistencies and unverified assumptions in the methodology used to accumulate the actual and projected savings. In addition, the Department did not include all costs associated with the FPS in its calculation. Specifically, the Department did not include the cost of the contract for preparing the first implementation report and the first-year indirect costs (e.g., office space, furnishings, and equipment) that should have been allocated among the various fraud-fighting programs, including the FPS. Finally, because the Department used both actual and projected savings to calculate return on investment, it should also have reported actual

⁸ The estimates from which these projections are derived were based on actions taken in the first implementation year. Thus, the amounts projected for the second implementation year do not include any estimates of improper payments avoided that are related to revocations or edits made in the second implementation year.

and projected costs to ensure that all costs were properly included in the return on investment calculation.

Return on Investment for the Use of Predictive Analytics Technologies in Comparison to Other Strategies or Technologies: Actual and Projected Savings

In its first implementation report, the Department compared the return on investment from the FPS to the first-year return on investment for the Health Care Fraud and Abuse Control program⁹ and concluded that the FPS outperformed the Health Care Fraud and Abuse Control program. We could not determine whether this comparison was accurate because of our concerns, noted in the previous section, with the Department’s calculation of return on investment for the FPS.

THE DEPARTMENT’S USE OF THE FRAUD PREVENTION SYSTEM

Section 4241(e)(1)(B)(iii) of the Act requires OIG to recommend whether the Department should continue to use predictive analytics technologies, whether the use of such technologies should be expanded,¹⁰ and whether any modifications or refinements should be made to increase the amount of actual or projected savings or mitigate any adverse impact on Medicare beneficiaries or providers. OIG recognizes that the use of new technologies has tremendous potential for enhancing fraud-fighting efforts and has adopted certain information technology and analytics to better identify potentially fraudulent activities and target our oversight efforts.

Although we noted some inaccuracies in the savings-related information that the Department reported, continuing to use the FPS will strengthen the Department’s efforts to combat fraud, waste, and abuse in the Medicare fee-for-service program. In the first implementation year, the Department has integrated the FPS into its overall fraud-prevention strategy. The FPS has provided ZPICs and PSCs with valuable data that they have used in ongoing investigations and in initiating investigations that have identified potential recoveries and costs that could be avoided.

CMS has expanded the use of predictive analytics technologies to all 50 States, the District of Columbia, and the territories. CMS was required only to implement predictive analytics technologies in 10 States identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service program. Instead, CMS implemented the FPS nationwide.

In its first implementation report, the Department describes a number of modifications or refinements it has planned to enhance the FPS, such as enhancing FPS integration with the Medicare Claims Processing System and expanding and enhancing FPS models. The Department did not indicate whether these modifications or refinements were designed to increase the amount of actual projected savings or to mitigate any adverse impact on Medicare beneficiaries or providers. We have not performed a detailed analysis of the Department’s plans because the data from the first

⁹ The Health Care Fraud and Abuse Control program was implemented in 1997 by the Department and the US Department of Justice.

¹⁰ “Expansion” under the Act means the incremental implementation of predictive analytics beyond the initial 10 States.

implementation year were not sufficient. However, we expect to analyze any modifications or refinements made by CMS in future implementation years.

RECOMMENDATIONS

Developing initial-year measurements for actual and projected savings and cost avoidance that have accrued from the use of predictive analytics is inherently difficult, and we recognize that refining such measures will be challenging. To help the Department address this challenge and improve its reporting on these measures, we recommend that the Department:

- require contractors to track recoveries that result from FPS leads;
- coordinate with law enforcement to enhance reporting of investigative and prosecutorial outcomes in cases predicated on referrals from the FPS;
- 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 based on edits may ultimately be paid;
- 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 that maintained by the ZPICs and PSCs; and
- include all costs associated with the FPS, including reporting costs, indirect costs, and projected costs, in its return on investment calculation.

DEPARTMENT COMMENTS

In written comments on our draft report, the Department concurred with our recommendations and noted it is committed to working with OIG to ensure that the recommendations are incorporated into future FPS reports. In response to the Department's technical comments, we made changes to the report as appropriate.

The Department's comments are included as the Appendix of this report.

APPENDIX

APPENDIX: DEPARTMENT COMMENTS



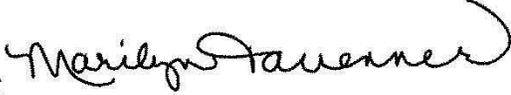
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 21 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner 
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "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-09-11-02016)

Thank you for the opportunity to review and provide comments on the Office of Inspector General's (OIG) report entitled, "The Department of Health and Human Services Has Implemented Predictive Analytics Technologies But Can Improve Its Reporting on Related Savings and Return On Investment." As required by the Small Business Jobs Act of 2010 (Act), the Centers for Medicare & Medicaid Services (CMS) developed the Fraud Prevention System (FPS) in order to implement predictive analytics technologies to identify and prevent the payment of improper claims in the Medicare fee-for-service program.

The CMS appreciates OIG's finding that "continuing to use the FPS will strengthen the Department's efforts to combat fraud, waste, and abuse in the Medicare fee-for-service program" and agrees with its recommendation that the FPS continue. In the first year of the FPS, CMS implemented predictive analytic technology on a nationwide basis in less time than statutorily-required without adversely impacting providers, suppliers, or beneficiaries. CMS and its contractors have developed complex analytic models that the OIG points out have led to "valuable data that [CMS fraud contractors] have used in ongoing investigations and to initiate investigations that have identified potential recoveries and costs that could be avoided."

In its first year, the FPS generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations, and triggered thousands of provider and beneficiary interviews to verify legitimate items and services were provided to beneficiaries. Such data have also helped the Office of Inspector General, Office of Investigations (OIG/OI) and the Federal Bureau of Investigations (FBI) in developing stronger cases against fraudulent providers and suppliers.

However, we recognize that there remain challenges in evaluating the FPS and over the next year we will continue to enhance our ability to estimate savings with respect to both improper payments recovered and improper payments avoided. Because of the inherent difficulties with estimating savings from fraud prevention, we fully appreciate that this creates a significant

OIG Note: The report number has since been updated.

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challenge for an outside entity such as OIG to validate and certify actual and projected savings from the FPS as the statute requires. We note that this is the first time predictive analytic technology has been used by the government on such a large scale for the purpose of identifying health care fraud, and it is the first time both CMS and OIG have been required by law to calculate actual and projected savings for a specific fraud prevention tool such as the FPS.

The CMS believes that we have developed the appropriate measures needed to estimate savings with respect to both improper payments recovered and improper payments avoided. We appreciate OIG's recommendations to revise the methodology used to calculate actual and projected savings and are committed to working with OIG to ensure that its recommendations are appropriately incorporated into our next FPS report.

Our response to each of OIG's recommendations follows.

OIG Recommendation 1

Require contractors to track recoveries that result from FPS leads.

CMS Response

The CMS concurs with OIG's recommendation. While the agency tracks the amount of overpayments collected overall, there are inherent systemic challenges associated with the tracking of overpayment recovery by the source responsible for identifying the overpayment, e.g., FPS lead. CMS is evaluating corrective actions to track overpayment recoveries made by the Medicare Administrative Contractors (MACs) by the source of the overpayment determination. Once this corrective action is in place, overpayment recoveries can be accurately measured based on each identifying source, including FPS leads.

OIG Recommendation 2

Work with law enforcement to obtain the data necessary to estimate the proportion of claims associated with referrals to law enforcement that will be recovered.

CMS Response

The CMS concurs with OIG's recommendation. CMS is committed to working with law enforcement officials in an effort to develop accurate estimates of recoveries associated with referrals to law enforcement.

OIG Recommendation 3

Revise the methodology used to calculate projected savings with respect to improper payments avoided to recognize that: (1) some of the services associated with prior-year claims submitted by a revoked provider may be legitimate; and (2) claims denied based on edits may ultimately be paid.

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CMS Response

The CMS generally concurs with OIG's recommendation to refine the methodology for estimating cost avoidance. CMS will evaluate applying a corrective factor that would systematically account for legitimate services and claims overturned on appeal.

OIG Recommendation 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 that maintained by the Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs).

CMS Response

The CMS concurs with OIG's recommendation. CMS recognizes that there are some inconsistencies between the information submitted through the FPS by the ZPICs and PSCs and the actual business records maintained by these contractors due to challenges in how data are collected and reported. CMS will be making changes to ensure consistency and accuracy of information reported by the contractors. As part of that effort, CMS is developing options for new data collection and reporting requirements that would minimize or eliminate deficiencies currently observed in the manual reporting.

OIG Recommendation 5

Include all costs associated with the FPS, including reporting costs, indirect costs, and projected costs, in its return on investment calculation.

CMS Response

The CMS concurs with OIG's recommendation and will consider taking into account such costs in its return on investment calculation in future years.