

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE FRAUD PREVENTION SYSTEM
INCREASED RECOVERY AND
PREVENTION OF IMPROPER MEDICARE
PAYMENTS, BUT UPDATED
PROCEDURES WOULD IMPROVE
REPORTED SAVINGS**

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June 2015
A-01-14-00503

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

In the third implementation year of the Fraud Prevention System (FPS), we certify \$133,200,896 of adjusted savings (return on investment of \$2.84) and \$453,976,078 in unadjusted savings. This represents an increase from the prior year, but updated procedures would improve reported savings.

WHY WE DID THIS REVIEW

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. The Act also requires the Department's Office of Inspector General (OIG) to certify the actual and projected savings with respect to (1) improper payments returned to (recovered) and prevented from leaving the Medicare Trust Funds (avoided) and (2) 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). The Act requires that the Secretary of Health and Human Services submit to Congress and make publicly available a report that includes this information. In addition, the Act requires OIG to determine whether the Department should continue, expand, or modify its predictive analytics technologies. This report fulfills OIG's responsibilities for the third 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, the Department's Centers for Medicare & Medicaid Services (CMS), through its Center for Program Integrity, established the FPS on June 30, 2011, to identify and prevent fraud, waste, and abuse in the Medicare Fee-for-Service program nationwide. Using the FPS, the Department identifies both questionable billing patterns and aberrancies and provides this information through Alert Summary Reports (referred to as "leads" in this report) to Zone Program Integrity and Program Safeguard Contractors (contractors) for investigation.

The Department reports two types of FPS savings: "adjusted savings" and "identified or unadjusted savings." Adjusted savings are the amounts of the FPS identified actual and projected savings that, according to OIG's analyses, reasonably can be expected to be recovered or avoided. Identified or unadjusted savings are the actual and projected savings that the FPS identified that, according to OIG's analyses, may not be recovered or avoided.

In our report to Congress for the second implementation year (October 1, 2012 to September 30, 2013), we noted that the Department complied with requirements of the Act to report actual and projected savings with respect to improper payments recovered and avoided and actual and projected savings relative to the return on investment. We recommended that the Department (1) provide contractors with written instructions on how to determine when actual and projected savings from an administrative action should be attributable to the FPS and (2) require contractors to maintain documentation to support how an FPS lead contributes to an administrative action. The Department took steps intended to address our recommendations.

WHAT WE FOUND

In the third implementation year of the FPS in calendar year (CY) 2014, 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 \$133,200,896 of adjusted actual and projected savings to the Medicare Fee-for-Service program. Of the certified amount, \$85,755,356 resulted from administrative actions that the FPS initiated, and \$47,445,540 resulted from administrative actions for which the FPS lead contributed to the existing investigation. We also certify a return on investment of \$2.84 for every dollar spent on the FPS. In addition, we certify the \$453,976,078 in unadjusted savings that the FPS identified. The Department's contractors identified additional savings that we did not certify because the FPS lead did not contribute to the administrative action.

The Department's use of the FPS enhances and should continue to enhance its efforts to prevent fraud, waste, and abuse in the Medicare Fee-for-Service program. In CY 2014, the Department's use of the FPS generated a positive return on investment, and the Department continues to provide oversight, management, and control of selecting and developing new models, enhancing existing models, and implementing system changes to improve the FPS. The Act required the Department to analyze and report on the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and the Children's Health Insurance Program (CHIP). The Department conducted an evaluation and determined that it is not cost-effective and feasible, at this time, to systematically expand the FPS to Medicaid and CHIP in all States. Although the Department has made significant progress to address the challenges of measuring actual and projected savings, the Department's written directives to its contractors were not sufficient to ensure that the contractors could identify and report the most accurate estimate of FPS savings.

WHAT WE RECOMMEND

To help identify and better report FPS savings, we recommend that the Department provide its contractors with improved written instructions on how to attribute the FPS savings accurately and better document the contribution of the FPS leads toward achieving administrative actions.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

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

CMS stated that it “will continue to make decisions on expanding the FPS based primarily on the identified savings” because (1) “the concept of adjusted savings is important as it relates to this financial audit,” (2) recovering money is contingent on numerous other processes and limitations, and (3) there are other hard-to-quantify benefits of the FPS activity.

OUR RESPONSE

We appreciate that CMS is committed to providing additional guidance to its contractors that will clarify the steps needed to attribute savings to FPS. 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 recovered or avoided. Therefore, decisions on expanding the FPS should be based primarily on adjusted savings.

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INTRODUCTION

WHY WE DID THIS REVIEW

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.¹ The Act also requires the Department's Office of Inspector General (OIG) to certify the actual and projected savings with respect to (1) improper payments returned to (recovered) and prevented from leaving the Medicare Trust Funds (avoided) and (2) 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 OIG's responsibilities for the third 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 identify and prevent payment for improper Medicare Fee-for-Service claims that providers submit for reimbursement and to estimate the amount of such payments recovered and avoided.³ Congress appropriated \$100 million for the Department to carry out the requirements of the Act.⁴ The Department reported \$75 million in costs for the first and second implementation years (July 1, 2011 to June

¹ P.L. No. 111-240 § 4241.

² The Act § 4241(c) 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 was January 1, 2014, to December 31, 2014. Thus, there are gaps between the implementation years.

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).

30, 2012, and, October 1, 2012 to September 30, 2013, respectively) and \$46.9 million in costs for the third implementation year in calendar year (CY) 2014.⁵

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. We refer to ZPICs and PSCs collectively as contractors here forward).

The FPS lead is one of several sources that the contractors use to conduct an investigation. Some of these sources include the contractor's data analysis and beneficiary complaints. The FPS lead may initiate an investigation or contribute to an ongoing investigation, which could result in an administrative action. Because there are often several sources that lead to an action, it is not generally feasible to quantify each source's contribution to the achieved action. The contractors use the same processes for conducting an investigation regardless of the source, including data analysis, interviews, and site visits. 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, and the remaining amounts are paid to the provider.
- **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**—instructions in the software that suspend all or part of submitted claims. Contractors review the claims before determining whether to make payments.
- **Autodenial or autorejection edits**—instructions in the software that automatically deny all or part of the submitted claims without making any payments to providers.

⁵ In addition to the costs incurred during the implementation years, the Department also incurred an additional \$21.9 million in costs for the months between implementation years.

- **Provider revocation**—revocation of a provider’s Medicare billing privileges. This prevents revoked providers from being paid for any billing for claims.

As a result of these administrative actions, the Department reports two types of savings: “adjusted savings” and “identified or unadjusted savings.” Adjusted savings are the amounts of the FPS identified actual and projected savings that, according to OIG’s analyses, reasonably can be expected to be recovered or avoided. Identified or unadjusted savings are the actual and projected savings that the FPS identified that, according to OIG’s analyses, may not be recovered or avoided.

Fraud Prevention System Adjusted Savings

According to the Department, historical data indicate that only a portion of identified improper payments are recovered or avoided. The Department applies adjustment factors to identified savings to determine the amount attributable to the FPS that the Department expects will be collected or avoided. Therefore, the adjusted savings amount represents a more accurate estimate of the identified savings related to improper payments that the Department has already recovered or is likely to recover, or avoid in the future.

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 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 Second Implementation Year of the Fraud Prevention System

In our report to Congress for the second implementation year,⁸ we noted that the Department complied with requirements of the Act to report actual and projected savings with respect to

⁶ The report for the first implementation year is *Report to Congress: Fraud Prevention System First Implementation Year*, September 2012, is available online at <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>. The report for the second implementation year is *Report to Congress: Fraud Prevention System Second Implementation Year*, June 2014, is available online at <http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf>.

⁷ The Act § 4241(e).

⁸ The first implementation year 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-17-12-53000), September 2012, is available online at <http://oig.hhs.gov/oas/reports/region1/171253000.pdf>. The second implementation year report, *The Fraud Prevention System Identified Millions in Identified Savings, but the*

The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings (A-01-14-00503)

improper payments recovered and avoided and actual and projected savings relative to the return on investment. We certified that the Department's use of the FPS resulted in \$54.2 million of actual and projected savings and a return on investment of \$1.34 for every dollar spent on the FPS. We also certified \$210.7 million in unadjusted savings that the FPS identified. We recommended that the Department (1) provide contractors with written instructions on how to determine when savings from an administrative action should be attributable to the FPS and (2) require contractors to maintain documentation to support how an FPS lead contributes to an administrative action. The Department took steps to address our recommendations. On June 17, 2014, the Department issued a Technical Direction Letter (TDL) to the contractors modifying its methodology for determining FPS attribution and requiring contractors to maintain supporting documentation. Appendix A includes more detail on our recommendations and the Department's actions to address them.

Technical Direction Letter to the Contractors

The TDL that CMS issued on June 17, 2014, instructed contractors on how to document that an FPS lead contributed to an investigation and the resulting administrative action. According to the TDL, the contractors should attribute to the FPS any savings from an administrative action resulting from FPS-initiated or ongoing contractor investigations. The TDL states that if an FPS lead is identified before the contractors take an administrative action, and the information in the FPS lead corroborated, augmented, and/or expedited the investigation, then the contractors are required to describe how the information in the FPS lead corroborated, augmented, and/or expedited the investigation. The TDL also states that for any administrative action that the contractors designate as "initiated" by an FPS lead, the contractors do not need to provide additional information to attribute savings to FPS.

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 and has continued this process through year three. This governance process enables the Department to use fraud detection models to address identified vulnerabilities, such as those identified in OIG reports and investigations. The Department evaluates the resulting models for impact and effectiveness and uses the results to decide which models to continue or retire.

HOW WE CONDUCTED THIS REVIEW

To satisfy the Act's certification requirement, we conducted a performance audit to certify (1) the Department's reported actual and projected savings to the Medicare Fee-for-Service program and (2) the Department's return on investment, which is based on the improper payments recovered and avoided through FPS. We define the term "certification" to mean a

Department Could Strengthen Savings Data by Improving Its Procedures, (A-01-13-00510), June 2014, is available online at <http://oig.hhs.gov/oas/reports/region1/11300510.pdf>.

The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings (A-01-14-00503)

determination that the Department's (1) reported FPS adjusted actual and projected savings, (2) return on investment, and (3) identified actual and projected savings were reasonably estimated.

We reviewed the identified savings and cost data that the Department provided to us for the period January 1 through December 31, 2014. We did not rely solely on the methodology the contractors followed in the Department's TDL to evaluate whether the savings amount that the Department attributed to the FPS was reasonable. Rather, we reviewed and discussed the supporting documentation with contractor and CMS personnel and analyzed supporting documentation related to selected administrative actions to determine whether the FPS contributed to achieving the administrative action in accordance with our recommendations in our year-two report.

To calculate the adjusted savings amount, we applied the Department's various adjustment factors to the identified savings from administrative actions. We also confirmed that the adjustment factors used to estimate savings were consistent with the prior year. In addition, we reviewed the reported costs used by the Department to calculate return on investment. We did not verify that the Department provided us with complete savings and cost data. Finally, we reviewed the contractors' process for developing investigations from their various sources, including the FPS.

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 also reviewed the Department's draft study to determine the cost-effectiveness and feasibility of expanding the FPS to Medicaid and the Children's Health Insurance Program (CHIP).

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.

FINDINGS

In the third 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 \$133,200,896 of adjusted actual and projected savings to the Medicare Fee-for-Service program. Of the certified amount, \$85,755,356 resulted from

administrative actions that the FPS initiated,⁹ and \$47,445,540 resulted from administrative actions for which the FPS lead contributed to the existing investigation. We also certify a return on investment¹⁰ of \$2.84 for every dollar spent on the FPS. In addition, we certify the \$453,976,078 in unadjusted savings that the FPS identified. The Department's contractors identified additional savings we did not certify because the FPS lead did not contribute to the administrative action.

The Department's use of the FPS should continue to 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 develop and refine its fraud detection models through its governance process. The Department conducted an evaluation of the cost-effectiveness and feasibility of applying predictive analytics technology to Medicaid and CHIP and determined that it is not cost-effective and feasible, at this time, to systematically expand the FPS to the Medicaid and CHIP programs in all States. Although the Department has made significant progress to address the challenges of measuring actual and projected savings, the Department's written directives to its contractors were not sufficient to ensure that the contractors could identify and report the most accurate estimate of 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 \$133,200,896 of adjusted actual and projected savings to the Medicare Fee-for-Service program. Of the certified amount, \$85,755,356 resulted from administrative actions that the FPS initiated, and \$47,445,540 resulted from administrative actions for which the FPS lead provided information that contributed to an existing investigation.¹¹ The \$133,200,896 certified amount corresponds to \$453,976,078 of certified unadjusted savings that the FPS identified before we applied the various adjustment factors, including supportable documentation and whether an FPS lead directly contributed to an administrative action to estimate the FPS savings more accurately (Appendix C). The table below contains the unadjusted and adjusted savings we have certified.

⁹ "FPS initiated" includes (1) administrative actions that the FPS originally identified and (2) existing investigations that the FPS made a contribution to that directly resulted in achieving an administrative action.

¹⁰ The Department determined 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 third implementation year, the Department calculated the return on investment by dividing the total \$133.2 million of actual and projected savings by the \$46.9 million of costs.

¹¹ For example, during one investigation the FPS identified two potentially aberrant providers in addition to the original providers other sources identified. The related administrative action resulted in \$16 million in unadjusted savings. The savings from this action cannot be allocated to the respective sources, meaning the \$16 million in unadjusted savings was not attributable solely to the FPS. However, because the FPS lead augmented the existing investigation, the \$16 million of unadjusted savings are included as certified FPS savings.

Table 1: Certified Unadjusted and Adjusted Savings

	Unadjusted Savings	Adjustment Factor	Adjusted Savings
FPS initiated	\$320,333,723	27%	\$85,755,356
FPS contributed	133,642,355	36%	47,445,540
Total Certified Savings	\$453,976,078	29%	\$133,200,896

Of the certified adjusted actual and projected savings, we found that:

- \$29.2 million of projected improper payments were estimated to be recovered from law enforcement referrals and overpayment recoveries;
- \$28.8 million of actual improper payments were estimated to be avoided through prepayment edits, autodenial or autorejection edits, and payment suspensions; and
- \$75.2 million of projected improper payments were estimated to be avoided by revoking provider billing privileges.

The Department’s contractors identified additional savings we did not certify because the FPS lead did not contribute to the administrative action. The TDL instructed the contractors to describe in the notes how the information in the FPS corroborated, augmented, and/or expedited the investigation. However, the TDL did not require the contractors to identify the contribution beyond those terms. As a result, for some cases the contractors attributed administrative actions to the FPS when there was no contribution from the FPS leads.¹² The Department agreed that the contractors should not have attributed these savings to the FPS.

We certify that the Department’s use of its predictive analytics technologies resulted in a return on investment of \$2.84 for every dollar spent on the FPS. The Department reported \$46.9 million in total costs for three categories: (1) \$23 million for FPS system contractor costs, (2) \$2.3 million for Department staff costs, and (3) \$21.6 million for contractor costs.

With regard to the requirement for the Department to report on its return on investment compared to other strategies or technologies, in the third implementation year, the Department did not compare the FPS to any other similar technologies. The Department stated in its year-three report that programs with similar technology are difficult to identify, but as similar programs mature it will compare the success of the FPS with other technologies the Federal Government uses.

¹² For example, one contractor opened an investigation on the basis of its own internal proactive data analysis that resulted in an administrative action without any information from the FPS. While the administrative action was in process, a contractor analyst identified an FPS lead for the subject provider and included it in the documentation for the investigation. The contractor reported the \$981,000 savings for this administrative action as FPS.

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.¹³

The Department’s use of the FPS enhances and should continue to 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. In accordance with requirements in the Act,¹⁴ the Department conducted an evaluation of the cost-effectiveness and feasibility of applying predictive analytics technology to Medicaid and CHIP in all 50 States and Puerto Rico. The Department determined that it is not cost-effective and feasible, at this time, to systematically expand predictive analytics to all States because of policy differences among programs, program structure, information technology readiness, staff resources, data availability, and cost. Despite the challenges of systematically applying predictive analytics nationally to Medicaid and CHIP claims, there is opportunity to support expansion in the coming years. In FPS’s third 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 written directives to its contractors were not sufficient to ensure that the contractors could identify and report the most accurate estimate of FPS savings.

RECOMMENDATION

To help identify and better report FPS savings, we recommend that the Department provide its contractors with improved written instructions on how to attribute the FPS savings accurately and better document the contribution of the FPS leads toward achieving administrative actions.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

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

CMS stated that it “will continue to make decisions on expanding the FPS based primarily on the identified savings” because (1) “the concept of adjusted savings is important as it relates to this financial audit,” (2) recovering money is contingent on numerous other processes and limitations, and (3) there are other hard-to-quantify benefits of the FPS activity.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate that CMS is committed to providing additional guidance to its contractors that will clarify the steps needed to attribute savings to FPS. The “concept of adjusted savings” is important not only as it relates to a financial audit, but more significantly as a measure of the

¹³ The Act § 4241(e)(1)(B)(iii).

¹⁴ The Act § 4241(f)(2).

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 recovered or avoided. Therefore, decisions on expanding the FPS should be based primarily on adjusted savings.

**APPENDIX A: OFFICE OF INSPECTOR GENERAL RECOMMENDATIONS AND
DEPARTMENT ACTIONS IN RESPONSE TO THE SECOND-YEAR
IMPLEMENTATION REPORT**

**Table 2: OIG Recommendations and Department Actions
for the Second Implementation Year of FPS**

No.	OIG Recommendation	Department Action	Status
1	Provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS.	Issued a Technical Direction Letter to the contractors modifying its methodology for determining FPS attribution.	Implemented
2	Require contractors to maintain documentation to support how the FPS lead contributes to an administrative action.	Issued a Technical Direction Letter to the contractors requiring contractors to maintain documentation.	Implemented

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the Department's use of predictive analytics technologies during the third implementation year of the FPS (January 1, 2014, through December 31, 2014). We reviewed the unadjusted savings and cost data provided by the Department for that period. On November 26, 2014, the Department provided us with data on the administrative actions taken during the first 9 months of the implementation year. On February 13, 2015, the Department provided us with data on the administrative actions taken during the last 3 months of the implementation year. For the third implementation year, the Department provided us with data that included a total of \$586 million in unadjusted savings reported by contractors. In addition, on April 30, 2015, the Department provided us with the final total reported FPS cost data totaling \$46.9 million.

To evaluate whether the savings amount that the Department attributed to the FPS was reasonable, we reviewed and discussed the supporting documentation with contractor and CMS personnel and analyzed supporting documentation related to selected administrative actions. This enabled us to determine the contribution of the FPS to achievement of the administrative action. We did not rely on the methodology the Department's contractors followed from the TDL for determining attribution of the administrative actions to FPS. We made our determination on the basis of our assessment of the contribution of FPS's new information to the administrative action.

We applied the Department's various adjustment factors to the unadjusted savings from administrative actions to reasonably estimate the FPS adjusted savings that are expected to be recovered or avoided. 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 \$46.9 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 whether the Department provided us with complete savings and cost data. Finally, we reviewed the contractors' process for developing an investigation from various sources, including the FPS.

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 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 based on the improper payments recovered and avoided. We define the term "certification" to mean a determination that the Department's (1) reported adjusted actual and projected savings, (2) its return on investment that resulted from a contribution to the investigation from the FPS, and (3) its identified actual and projected savings were reasonably estimated. However, in addition to the adjusted savings that are expected to be recovered or avoided, identified savings

also include improper payments that may not be recovered or avoided. 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 three contractors, in Hingham, Massachusetts; Miramar, Florida; and Dallas, Texas. We conducted our fieldwork from October 2014 through April 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed the Act to gain an understanding of the Department's responsibilities and our responsibilities for the third implementation year;
- met with Department officials to learn about the Department's implementation of the FPS;
- reviewed supporting documentation to determine whether the Department's methodologies for calculating actual and projected 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 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;
- interviewed Department officials to understand their views and plans for comparing FPS return on investment to other strategies or technologies;
- reviewed the Department’s report to Congress for the third 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
JANUARY THROUGH DECEMBER 31, 2014**

Table 3: Certified Fraud Prevention System Savings by Administrative Action

Administrative Action	Unadjusted Savings	Adjustment Factor	Reduction Amount	Certified FPS Savings¹⁵
Payment suspensions	\$9,823,378	96%	\$363,456	\$9,459,913
Law enforcement referrals	142,284,619	6%	133,918,283	8,366,336
Autorejection edits	6,026,121	67%	2,013,715	4,012,407
Overpayment recoveries	134,800,088	15%	114,000,166	20,799,922
Prepayment edits	24,036,937	59%	9,822,982	14,213,955
Autodenial edits	1,450,664	78%	313,717	1,136,947
Provider revocations	135,554,270	55%	60,342,854	75,211,416
Totals	\$453,976,078	29%	\$320,775,182	\$133,200,896

The Department calculated individual adjustment factors for payment suspensions and law enforcement referrals. The Department also calculated a range of adjustment factors for autorejection edits, overpayment recoveries, prepayment edits, autodenial edits, and provider revocations. For those administrative actions with a range of adjustment factors, we used a weighted average adjustment factor (a reduction amount divided by the unadjusted savings) as shown in the Adjustment Factor column of Table 3. 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. A critical success factor will be to update the adjustment factors, as appropriate, based upon evolving historical data and other relevant information to ensure appropriate estimates are provided.

¹⁵ Our application of the Department's various adjustment factors reduced the unadjusted savings by \$320,775,182, or 71 percent. Differences in the Certified FPS Savings column are due to rounding.



APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY 15 2015

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt 
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings (A-01-14-00503)*

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-mentioned OIG draft report. The Fraud Prevention System (FPS) meets the requirements of the Small Business Jobs Act of 2010 (SBJA) to apply predictive analytics technology to Medicare fee-for-service claims on a prepayment basis. The CMS is in the fourth year of implementing and expanding the technology to prevent and detect fraud, waste, and abuse.

The CMS appreciates OIG's finding that the "Department's use of the FPS should continue to enhance its 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. **Over the first three years of implementation, FPS identified or prevented \$820 million in inappropriate payments.** In the third implementation year, which aligned with calendar year (CY) 2014, the identified savings, certified by OIG, associated with these prevention and detection actions due to FPS was \$454.0 million, more than 80% higher than the amount identified during the second year of the program and almost quadruple the amount identified during the first year.

The CMS will continue to make decisions on expanding the FPS based primarily on the identified savings. The concept of *adjusted savings* is important as it relates to this financial audit; however, 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.

The SBJA added a new requirement for the third implementation year report. The SBJA required CMS to analyze and report on the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP, effect, if any, the application of

predictive analytic technologies to claims under Medicare and CHIP would have on states; and recommendations regarding the extent to which technical assistance may be necessary to expand the application of predictive analytics technologies to claims under Medicaid and CHIP and the type of such assistance.

After extensive analysis and discussion with states, CMS has determined that it is not cost-effective and feasible to systematically expand predictive analytics technology to Medicaid as defined in the SBJA. However, there are opportunities to transfer techniques learned through our experience with the implementation of FPS and assist states with identifying program integrity risks using predictive analytics technologies in protecting their Medicaid programs from fraud, waste, and abuse.

Our response to the OIG recommendation follows.

OIG Recommendation

To help identify and better report FPS savings, we recommend that the Department provide its contractors with revised written instructions on how to attribute the FPS savings accurately and better document the contribution of the FPS leads towards achieving administrative actions.

CMS Response

The CMS concurs with the OIG recommendation and will issue guidance to clarify the Technical Direction Letter (TDL) issued to contractors in June 2014 regarding FPS attribution. The guidance will clarify when contractors should attribute savings to the FPS. The guidance will direct contractors to distinguish those savings initiated by the FPS separately from those savings where FPS contributed to an existing investigation.