

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE CENTERS FOR MEDICARE
& MEDICAID SERVICES COULD
IMPROVE ITS PROCESSES FOR
EVALUATING AND REPORTING
PAYMENT RECOVERY SAVINGS
ASSOCIATED WITH THE FRAUD
PREVENTION SYSTEM**

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



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: October 2019

Report No. A-01-15-00510

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

We made a commitment in our previous Fraud Prevention System (FPS) work to assess why the FPS's reported amounts that were reasonably expected to be prevented or recovered (adjusted savings) were such a small percentage of the FPS's identified savings, particularly for overpayment determinations and law enforcement referrals. These payment recovery administrative actions have the most significant FPS adjustment factors (used to calculate adjusted savings from the identified savings) and account for a large share of the reported differences.

Our objectives were to determine (1) why the FPS's adjusted savings for overpayment determinations and law enforcement referrals were approximately 10 percent of the identified savings for its second and third implementation years and (2) whether the manner in which CMS reported FPS savings after the third implementation year provides stakeholders with sufficient information to assess the value of the FPS accurately.

How OIG Did This Review

We obtained an understanding of the identified savings valuation process for FPS overpayment determinations and law enforcement referrals. We obtained an understanding of the various challenges associated with recovering FPS overpayments. We also reviewed the savings and return on investment (ROI) figures that CMS reported for the FPS after the third implementation year.

The Centers for Medicare & Medicaid Services Could Improve Its Processes for Evaluating and Reporting Payment Recovery Savings Associated With the Fraud Prevention System

What OIG Found

The FPS's adjusted savings for overpayment determinations and law enforcement referrals were approximately 10 percent of the identified savings for its second and third implementation years because (1) the Medicare administrative contractors' (MACs') opportunities to collect FPS-identified overpayments were often limited by both the time it took to get referrals from the Program Integrity Contractors and by unique challenges in attempting to recover overpayments from providers and (2) CMS has not established a standard process for the Program Integrity Contractors to estimate the value of law enforcement referrals.

CMS's reported FPS savings and ROIs after the third implementation year gave stakeholders an incomplete picture of the FPS's value because CMS has continued to rely primarily on identified savings for its reporting. After the third implementation year (from January 1, 2015, through September 30, 2016), almost two-thirds of the FPS's total identified savings reported by CMS have come from FPS payment recovery administrative actions. Historically, the overwhelming majority of the identified savings from payment recovery administrative actions have not been recovered. Reporting adjusted savings and the corresponding adjusted ROI in addition to identified savings would provide a more complete picture of the value of the FPS.

What OIG Recommends and CMS Comments

We recommend that CMS (1) continue to work with the Program Integrity Contractors and the MACs to develop strategies that improve timely coordination to give the MACs a better opportunity to recover overpayments, (2) establish a uniform methodology for the Program Integrity Contractors to use when reporting estimates for the value of law enforcement referrals, and (3) update the FPS's law enforcement referral adjustment factor.

In written comments on our draft report, CMS concurred with our recommendations and described the steps that it has taken or planned to take to implement our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Small Business Jobs Act of 2010 (the Act) required the Department of Health and Human Services (the Department) to use predictive modeling and other analytics technologies (predictive analytics technologies) to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.¹ The Department designated the Centers for Medicare & Medicaid Services (CMS) to develop and implement the Fraud Prevention System (FPS) to fulfill the requirements of the Act. As also required by the Act, the Department's Office of Inspector General (OIG) certified and reported on the FPS's savings and its return on investment (ROI) for the FPS's second and third implementation years.²

OIG certified the ROIs of the FPS for the second and third implementation years based on adjusted savings, which represent the estimated improper payment amounts that reasonably can be expected to be prevented or recovered. However, CMS did not present FPS adjusted savings within reports that included information on FPS performance after the third implementation year. Instead, CMS reported only identified savings in those reports and used these amounts to calculate the ROI for the FPS.³ Identified savings represent the total dollar amount of potential fraud, waste, and abuse identified from FPS administrative actions, including amounts that might not be prevented or recovered.

Investigative activity associated with the FPS can result in administrative actions that either prevent future losses (payment prevention) or recover improper payments (payment recovery). Payment prevention administrative actions include payment suspensions, prepayment edits,

¹ Title XVIII of the Social Security Act established the Medicare program, which provides health insurance for people aged 65 or older, people with disabilities, and people with end stage renal disease. The Medicare fee-for-service program covers Medicare Parts A and B. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage for of hospital outpatient services. CMS administers the Medicare program.

² See Appendix B for references to this earlier work as well as other reports we have issued related to the FPS. For the FPS's first implementation year, covering July 1, 2011, to June 30, 2012, we could not determine whether the savings-related information that CMS reported was accurate for improper payments prevented or recovered. Consequently, we could not verify whether the FPS's first implementation year ROI was accurate. The FPS's second implementation year covered October 1, 2012, to September 30, 2013, and the third implementation year covered January 1, 2014, to December 31, 2014. Thus, there are gaps between these implementation years.

³ For the FPS's second and third implementation year, CMS reported both identified and adjusted savings. CMS reported ROIs of \$5.2 and \$9.7 for every dollar spent on the FPS for its second and third implementation years, respectively, based on identified savings. However, we certified ROIs of \$1.3 and \$2.8 for every dollar spent on the FPS for its second and third implementation years, based on adjusted savings.

autodenial or autorejection edits, and provider revocations.⁴ Payment recovery administrative actions include overpayment determinations⁵ and law enforcement referrals.⁶ Unlike the payment prevention administrative actions, payment recovery administrative actions involve identifying and recovering improper Medicare payments after they have been made to providers rather than preventing improper payment before they are made.

OIG made a commitment in its second-year report to assess why the FPS's adjusted savings were such a small percentage of the identified savings, particularly for the administrative actions that resulted from overpayment determinations and law enforcement referrals. These payment recovery administrative actions have the most significant adjustment factors⁷ and, consequently, are responsible for a large share of the difference between the FPS's identified savings and adjusted savings.⁸ We performed this audit as a followup to our previous audit.

OBJECTIVES

Our objectives were to determine (1) why the FPS's adjusted savings for overpayment determinations and law enforcement referrals were approximately 10 percent of the identified savings for its second and third implementation years and (2) whether the manner in which CMS reported FPS savings after the third implementation year provides stakeholders with sufficient information to assess the value of the FPS accurately.

⁴ A provider revocation involves the removal of a provider's Medicare billing privileges. This prevents payments for claims submitted by these providers.

⁵ These are Medicare payments that providers received in excess of amounts due and payable under statute and regulations.

⁶ This is suspected fraud that is referred to law enforcement agencies for potential prosecution. In accordance with CMS's *Medicare Program Integrity Manual* (Pub. 100-08), chapter 4, § 4.18.1, investigation contractors are required to refer cases of potential fraud to the OIG's Office of Investigations (OI). Potential fraud includes documented allegations that a provider has engaged in a pattern of improper billing, submitted improper claims with suspected knowledge of their falsity, or submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. Payments may be recovered as part of the resolution of these cases.

⁷ According to CMS, historical data indicate that only a portion of identified improper payments are recovered. CMS developed FPS adjustment factors to estimate the amount of identified recoverable savings attributable to the FPS that will be collected or avoided from administrative actions.

⁸ Only \$39.2 million, or approximately 10 percent, of the \$385.9 million in FPS-identified savings for overpayment determinations and law enforcement referrals for the FPS's second and third implementation years, according to OIG's past analysis, reasonably were expected to be recovered and returned to the Medicare Trust Funds or the Treasury.

BACKGROUND

CMS's Fraud Prevention System

To fulfill the Act's requirement to use predictive analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program, CMS established the FPS on June 30, 2011. The FPS is intended to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program. Preventing improper payments through more timely identification of suspicious activity is part of CMS's strategy to shift beyond a payment recovery approach to program integrity. Examples include denying improper payments before they are made through prepayment edits or revoking a providers' billing privileges, when necessary, to avoid potential future improper payments from being made. CMS identifies both aberrancies⁹ and questionable billing patterns using the FPS and provides this information through Alert Summary Reports (also referred to as "FPS leads") to Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) for investigation.¹⁰ In this report, we use the term "Contractors" for both ZPICs and PSCs.

The Contractors' primary purpose is to investigate¹¹ instances of suspected fraud, waste, and abuse in Medicare. An FPS lead is one of several sources that the Contractors may use to conduct an investigation that can result in a payment prevention or payment recovery administrative action. Once an FPS administrative action of any type is complete, the Contractors are required to report the corresponding savings amounts to CMS for tracking purposes.¹² CMS then validates the data on these savings to confirm that the amounts are attributable to the FPS. Any savings amounts that pass CMS's validation are included as FPS identified savings, and savings amounts that do not pass the CMS's validation are excluded from FPS savings.¹³

⁹ Billing activity that deviates from the norm.

¹⁰ CMS has transitioned contracts under the ZPICs and PSCs over to newly formed Unified Program Integrity Contractors (UPICs). The UPICs are intended to consolidate the Medicare and Medicaid program integrity functions within five defined geographic areas (UPIC jurisdictions) covering the Nation.

¹¹ The Contractors identify the need for administrative actions through the early development of investigations into suspected fraud, waste, and abuse. During this development, Contractors that identify potential fraud that warrants further investigation that could lead to civil or criminal prosecution will refer the applicable cases to OIG for its consideration.

¹² The Contractors previously used the CMS Analysis, Reporting, and Tracking System (CMS ARTS) to report savings amounts and other information to CMS. The UPICs now enter this information into CMS's centralized Unified Case Management (UCM) System.

¹³ We could not certify some of the additional identified savings amounts that CMS initially validated for the FPS's second and third implementation years because the documentation we reviewed did not support that the information in the FPS lead was new or that it contributed to achieving the administrative action.

Medicare Administrative Contractors' Role With the Fraud Prevention System

Medicare administrative contractors (MACs) perform several Medicare program functions, including one of the FPS administrative actions: the recovery of overpayment determinations referred to them by Contractors. MACs process each overpayment determination in the order it is received, regardless of its source, by establishing an accounts receivable for collection. MACs begin their recovery activities by sending an initial demand letter¹⁴ to the affected provider on the same date the accounts receivable is created. Once MACs send the demand letter, they are required to follow a timeline for collection.¹⁵ However, the MACs may ultimately classify uncollected overpayment determination amounts as either eligible delinquent debt for referral to the Department of Treasury or debt that is ineligible for recoupment.

Initial OIG Certification Report

In our certification review of the FPS first implementation year, we could not determine whether the actual and projected savings-related information that CMS reported was accurate for improper payments prevented or recovered. Consequently, we could not verify whether the FPS's first implementation year ROI was accurate. As a result, we recommended that CMS require contractors to track recoveries that result from FPS leads, coordinate with law enforcement officials to enhance reporting of investigative and prosecutorial outcomes in cases predicated on referrals from the FPS, and revise the methodology used to calculate projected savings with respect to the improper payments that were prevented. In response, CMS generally concurred with our recommendations¹⁶ and then developed adjustment factors for each of its administrative actions, including overpayment determinations and law enforcement referrals.

Overpayment Determination and Law Enforcement Referral Adjustment Factors

CMS used the adjustment factors in its second and third implementation years to determine the adjusted savings, which is the portion of identified improper payment amounts attributable

¹⁴ An initial MAC demand letter offers notification to providers explaining the nature of a Medicare overpayment determination (CMS, Medicare Financial Management Manual (Pub. 100-06), chapter 4, §§ 20 and 20.2). This notification includes information about how the overpayment was determined, the amount identified, options to work out a repayment plan, and a statement that interest will begin to accrue if the overpayment is not repaid in full within 30 days.

¹⁵ MACs' collection timeline is outlined in CMS's Medicare Financial Management Manual (Pub. 100-06), chapter 4, § 10.1.

¹⁶ See Appendix B for reference to the OIG's FPS first implementation year review (A-17-12-53000).

to the FPS that CMS could reasonably expect to prevent or recover.¹⁷ The adjustment factor for overpayment determinations was approximately 16 percent, while the adjustment factor for law enforcement referrals was approximately 6 percent.¹⁸ Only \$39.2 million, or approximately 10 percent, of the combined \$385.9 million in FPS-identified amounts for overpayment determinations and law enforcement referrals for the FPS's second and third implementation years were expected to be recovered and returned to the Medicare Trust Funds or the Treasury (Appendix C, Table 1).

Overpayment Determination and Law Enforcement Referral Valuation

Contractors follow the practices outlined in CMS's *Medicare Program Integrity Manual* to calculate overpayment amounts for referral to the MACs for collection. Depending on the type of provider issue (or issues) under review, Contractors may calculate an exact overpayment, or they may sample claims and develop a statistical estimate of overpayments. Contractors have greater flexibility when determining the value of identified savings for law enforcement referrals and they make these determinations on a case-by-case basis.

Fraud Prevention System Reporting After the Third Implementation Year

CMS reported FPS-identified savings of \$654.8 million for its fourth implementation year within a brief summary paper, covering January 1, 2015, to December 31, 2015.¹⁹ CMS did not report adjusted savings for 2015 and stated that it planned to report only identified savings for the FPS in future reports. After the FPS's fourth implementation year, CMS began reporting the FPS-identified savings and ROI on a fiscal year (FY) basis and included this information in its annual report to Congress on its integrity programs. CMS reported \$604.7 million in FPS-identified savings for its FY 2015 annual report to Congress,²⁰ covering October 1, 2014, to September 30, 2015, which spans the FPS's third and fourth implementation years. CMS reported \$527.1

¹⁷ CMS introduced the concept of adjusted savings on page 1 of the *Report to Congress Fraud Prevention System Second Implementation Year*, issued in June 2014.

¹⁸ CMS originally determined a range of overpayment determination adjustment rates for the FPS's second and third implementation years. From these, we calculated weighted average adjustment factors by dividing the adjusted savings amounts by the identified savings amount, as depicted in Appendix C, Table 1. These calculations resulted in overpayment determination adjustment factors of 16 percent and 15 percent for the FPS's second and third implementation years, respectively. We used the more conservative 16-percent adjustment factor for reporting purposes. CMS separately determined its 6-percent law enforcement referral adjustment factor, which remained the same for both the FPS's second and third implementation years.

¹⁹ CMS, *Fraud Prevention System Return on Investment Fourth Implementation Year*, is available online at <https://www.cms.gov/About-CMS/Components/CPI/Downloads/Fraud-Prevention-System-Return-on-Investment-Fourth-Implementation-Year-2015.pdf>. Accessed on March 28, 2017.

²⁰ CMS, *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015*, is available online at <https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf>. Accessed on November 1, 2017.

million in FPS-identified savings for its FY 2016 annual report to Congress,²¹ covering October 1, 2015, to September 30, 2016, which also includes part of the FPS's fourth implementation year.

During FY 2016, CMS developed its next generation of the FPS (FPS 2.0), which according to CMS modernizes the system and user interface; improves model development time and performance measurement; and expands CMS's program integrity capabilities addressing the full spectrum of fraud, waste, and abuse. The FPS 2.0 became operational in FY 2017.²²

HOW WE CONDUCTED THIS REVIEW

To achieve our objectives, we discussed the continued use of FPS adjustment factors with CMS officials. We also reviewed documentation that supported CMS's calculation of savings for the FPS's second and third implementation years, to which CMS applied adjustment factors to identified savings to determine adjusted savings. We contacted each of the Contractors to discuss and review their processes for valuing overpayment determinations and law enforcement referrals. We also contacted each of the MACs to discuss their collections processes to gain a better understanding of the various challenges that they encounter when attempting to recover overpayments. Additionally, we reviewed FPS savings data that CMS used in its reports to Congress after the FPS's third implementation year up through the end of FY 2016 (the most recent FPS savings information available from CMS, as of January 31, 2019).

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 A contains details of our scope and methodology.

FINDINGS

We determined that the FPS's adjusted savings for overpayment determinations and law enforcement referrals were approximately 10 percent of the identified savings for its second and third implementation years because (1) the MACs' opportunities to collect FPS-identified overpayments were often limited by the time it took to get referrals from the Contractors and by unique challenges in attempting to recover overpayments from providers and (2) CMS has not established a standard process for the Contractors to estimate the value of law enforcement referrals.

²¹ CMS, *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2016*, is available online at <https://www.cms.gov/About-CMS/Components/CPI/Downloads/2016-Medicare-Medicaid-PI-Report-to-Congress.pdf>. Accessed on August 2, 2018.

²² As of January 31, 2019, CMS had not publicly issued its *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2017*.

CMS's reported FPS savings and ROIs after the third implementation year provided stakeholders with an incomplete picture of the FPS's value because CMS has continued to rely primarily on identified savings for its reporting. Identified savings may be effective in assessing the value of FPS payment prevention administrative actions (e.g., payment suspensions and edits) because the differences between identified savings and adjusted savings are not as significant as they are for FPS payment recovery administrative actions. After the third implementation year (from January 1, 2015, through September 30, 2016), almost two-thirds of the FPS's total identified savings reported by CMS have come from FPS payment recovery administrative actions. Historically, the overwhelming majority of the identified savings from payment recovery administrative actions have not been recovered. Reporting adjusted savings and the corresponding adjusted ROI in addition to identified savings would provide a more complete picture of the value of the FPS.

In addition, CMS did not update the FPS's adjustment factors that it previously used to adjust the identified savings for overpayment determinations and law enforcement referrals. When CMS first established these payment recovery adjustment factors for the FPS's second and third implementation years, it used reasonably supported calculations based on historical data that were available at the time. CMS could update these adjustment factors in the future using more targeted and current payment recovery data and thus report its FPS adjusted savings with greater precision. CMS has nonetheless continued to calculate the FPS's ROI based on identified savings only. This overstates the FPS's ROI because it does not consider the low adjusted savings amounts associated with the payment recovery administrative actions.

REASONS FOR LOW ADJUSTED SAVINGS FROM OVERPAYMENT DETERMINATIONS AND LAW ENFORCEMENT REFERRALS

Medicare Administrative Contractors Could Not Always Collect Fraud Prevention System Identified Overpayments

The MACs' opportunities to collect FPS-identified overpayments were often limited by the time it took to get referrals from the Contractors and by unique challenges in attempting to recover overpayments from providers. According to the MACs, they experience challenges when attempting to recover overpayment determinations from providers who (1) have stopped billing Medicare, (2) have limited financial resources, (3) have ended their enrollment in Medicare, (4) have terminated their businesses altogether, or (5) cannot be found. MACs indicated that despite these challenges, in some cases they would have had a better chance to recover additional amounts if Contractors had referred the overpayment determinations sooner. Improved coordination between the Contractors and the MACs would give the MACs a better opportunity to recover more overpayments. Nevertheless, the uncollected portion of identified improper payments from providers often cannot be recovered, resulting in delinquent debts that CMS either writes off or refers to the Department of Treasury, as is illustrated in the following example:

For the FPS third implementation year, CMS identified approximately \$1.8 million in identified savings for an overpayment determination that a Contractor initially referred to one of the MACs in November 2014 for collection. However, according to the MAC, the provider was no longer receiving Medicare payments in December, and despite sending multiple demand letters, the MAC was unable to recover any of the \$1.8 million in overpayments. Ultimately, the MAC referred the delinquent debt balance to the Department of Treasury. However, CMS included the entire \$1.8 million overpayment as FPS identified savings in its third implementation year report.

In addition to the challenges described above, a provider also has the right to appeal an overpayment determination, which can further delay any MAC recoupment efforts. If the provider succeeds in its appeal, the overpayment determination amount may be partially or fully overturned, as is illustrated in the following example:

For the FPS third implementation year, CMS identified an overpayment of approximately \$5.5 million that was referred to one of the MAC's in October 2014 for collection. However, according to the MAC, after appealing the overpayment, the provider received a partially favorable decision in August 2016 that reduced the initial overpayment amount by \$3.8 million. Under agreement with the provider, the MAC established a plan to collect the remaining \$1.7 million through scheduled repayments over several years. However, CMS included the entire \$5.5 million overpayment as FPS identified savings in its third implementation year report.

The MACs' recovery challenges and providers' rights to appeal help explain why only \$26.6 million in adjusted savings were expected to be recovered out of the \$170.4 million in identified savings from overpayment determinations for the FPS's second and third implementation years.

CMS Had Not Established a Standard Process for Contractors To Estimate the Value of Law Enforcement Referrals

CMS had not established a standard process for Contractors to estimate the value of law enforcement referrals. Contractors had great flexibility when determining the value of savings from law enforcement referrals, which could have led to differences in the way law enforcement administrative actions were valued. For instance, Contractors could have determined the value of a law enforcement referral by using exact overpayment calculations or statistical sampling estimates. Alternatively, Contractors could have determined the value of a law enforcement referral by including all the payments associated with suspicious billing activities over a period of time. Consequently, some identified savings amounts for law enforcement referrals were overstated, as is illustrated in the following example:

One law enforcement referral included evaluation and management services that a provider billed over approximately 3 years. The Contractor determined that approximately \$970,000 in total payments were made for these evaluation and management services during this timeframe. Based on a previous but limited review of this provider, the Contractor found a 65 percent denial rate for evaluation and management services. To expedite the law enforcement referral, the Contractor applied this 65 percent rate to the \$970,000 for an estimate of approximately \$630,000 in potential improper payments, which became the identified savings amount. However, law enforcement later declined the referral and returned it the Contractor for reassessment. At that point, the Contractor further developed and recalculated the law enforcement referral into overpayment determinations valued at about \$4,000, representing about 1 percent of the original identified savings amount. CMS included the entire \$630,000 law enforcement referral as FPS identified savings in its third implementation year report.

In addition to the lack of a standard valuation process, the nature of fraud also contributes to the significant adjustment factor for law enforcement referrals. While criminal and civil enforcement efforts lead to billions of dollars recovered and returned to the Medicare Trust Funds and other government agencies each year,²³ there are challenges in recouping fraudulent proceeds from some providers. For example, some of the most egregious cases of fraud involve criminals who set up illegitimate businesses, false storefronts, and illegal offshore accounts to defraud Medicare. This type of deception complicates law enforcement's efforts to track down suspects who are able to obtain and conceal Medicare dollars. Additionally, building a criminal or civil fraud case requires a higher standard of evidence than required in administrative proceedings so claims identified as potential fraud at the time of referral do not always lead to sufficient evidence to pursue all or part of the identified loss in criminal or civil court. In these cases, CMS can follow through with administrative recovery efforts when criminal or civil proceedings aren't appropriate.

Overall, the flexibility Contractors have when valuing law enforcement referrals, along with the inherent challenges associated with recovering improper payments from fraudulent providers, helps to explain why only \$12.7 million in adjusted savings were expected to be recovered out of the \$215.5 million in identified savings from law enforcement referrals for the FPS's second and third implementation years.

²³ According to the Health Care Fraud and Abuse Control Program (HCFAC) reports for FYs 2015 and 2016, approximately \$2.4 billion and \$3.3 billion, respectively, were recovered through law enforcement and audit payment recovery efforts and deposited with the Medicare Trust Funds and Treasury, transferred to other federal agencies administering health care programs, or paid to private persons during the fiscal years. The annual HCFAC reports for FYs 2015 and 2016 are available online at <https://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf> and <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>.

CMS'S REPORTED FRAUD PREVENTION SYSTEM SAVINGS AND RETURN ON INVESTMENTS AFTER THE THIRD IMPLEMENTATION YEAR PROVIDED STAKEHOLDERS WITH AN INCOMPLETE PICTURE OF THE FRAUD PREVENTION SYSTEM'S VALUE

CMS's reported FPS savings and ROIs after the third implementation year provided stakeholders with an incomplete picture of the FPS's value because CMS has continued to rely primarily on identified savings for its reporting. Identified savings may be effective in assessing the value of FPS payment prevention administrative actions (e.g., payment suspensions and edits) because the differences between identified savings and adjusted savings are not as significant as they are for FPS payment recovery administrative actions. However, identified savings are not a reliable substitute for savings from payment recovery administrative actions. After the third implementation year (from January 1, 2015, through September 30, 2016), almost two-thirds of the FPS's total identified savings came from FPS payment recovery administrative actions. The following highlights the consistently high percentages of payment recovery savings reported by CMS from the FPS's second implementation year through FY 2016:

For the FPS's second and third implementation years, the proportion of FPS identified savings from payment recovery administrative actions were 52 percent and 61 percent, respectively (Appendix C, Table 2).²⁴

For FY 2015 and FY 2016, the proportion of FPS-identified savings from payment recovery administrative actions was 53 percent and 76 percent, respectively (Appendix C, Table 3).

Historically, the overwhelming majority of the identified savings from payment recovery administrative actions have not been recovered. Therefore, recoveries as determined by adjusted savings are a more accurate measure of the value of these administrative actions than identified savings.

In addition, CMS did not update the FPS's adjustment factors that it previously used to adjust the identified savings for overpayment determinations and law enforcement referrals. When CMS first established these adjustment factors for the FPS's second and third implementation years, it used reasonably supported calculations based on historical data that were available at the time. CMS could update these adjustment factors in the future using more targeted and

²⁴ For the FPS's fourth implementation year alone, FPS-identified savings from payment recovery administrative actions accounted for about 65 percent of the total identified savings that were reported. However, because OIG certification was not required beyond the third implementation year, we did not certify any of the fourth-year savings amounts reported by CMS. CMS no longer reports FPS metrics on an implementation- or calendar-year basis. In addition, CMS's more recent FY 2015 and FY 2016 reports to Congress include the FPS's fourth implementation year savings metrics.

current payment recovery data and thus report its FPS adjusted savings with greater precision.²⁵

CMS has nonetheless continued to calculate the FPS's ROI based on identified savings only. This overstates the FPS's ROI because it does not consider the low adjusted savings amounts associated with these payment recovery administrative actions. An illustration, using past examples, follows:

CMS reported ROIs for the FPS's second and third implementation years of \$5.2 and \$9.7 for every dollar spent, based upon identified savings. However, we certified ROIs for the FPS of \$1.3 and \$2.8 for every dollar spent, based on adjusted savings that CMS reported for these respective years.

CMS reported its FY 2015 and FY 2016 ROIs for the FPS of \$11 and \$6.3²⁶ for every dollar spent, based on identified savings. ROIs based on adjusted savings, which would be considerably lower, are a more conservative valuation of the FPS.

RECOMMENDATIONS

Although we acknowledge the Centers for Medicare & Medicaid Services' continued efforts to improve the FPS, we recommend that CMS:

- continue to work with the Contractors and the MACs to develop strategies that improve timely coordination to give the MACs a better opportunity to recover overpayments,
- establish a uniform methodology for the Contractors to use when reporting estimates for the value of law enforcement referrals, and
- update the FPS's law enforcement referral adjustment factor.

CMS COMMENTS

Our draft report included five recommendations to CMS. In written comments on our draft report, CMS concurred with all five of our recommendations and described the steps that it has taken or planned to take to implement our recommendations. CMS also requested that we

²⁵ CMS currently has the ability to run recovery reports on overpayment determinations, including those attributable to the FPS. This type of targeted FPS information was unavailable when CMS first established its FPS adjustment factors. In addition, OIG tracks the number of law enforcement referrals it receives, the number of cases it opens, and the dollar amount of expected recoveries from Contractor-initiated administrative actions. Accordingly, CMS could update the FPS's payment recovery adjustment factors using more recent figures from these types of data sources.

²⁶ CMS noted that the costs associated with the development of FPS 2.0 were included in its FY 2016 calculation for the FPS's ROI. The FPS 2.0 became operational in FY 2017, so there were no savings associated with it in FY 2016.

remove three of the five recommendations from our report that it believes have been implemented. CMS's comments on these three recommendations are summarized below.

Regarding our recommendation for CMS to “continue to work with the Contractors and the MACs to develop strategies that improve timely coordination to give the MACs a better opportunity to recover overpayments,” CMS explained that it holds regular meetings with the Contractors to review and discuss select cases, to promote consistency in appropriate overpayment recovery efforts, and to allow CMS to address challenges hindering the identification of overpayments. CMS also stated that OIG did not identify specific challenges that prevent Contractors from referring overpayment determinations sooner.

Regarding our recommendation for CMS to “update the FPS's overpayment determination adjustment factors,” CMS stated that it updated the FPS's overpayment adjustment factors in 2017.

Regarding our recommendation for CMS to “resume reporting FPS adjusted savings, along with the corresponding ROI,” CMS explained that starting with its *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2017* (FY 2017 Report to Congress), CMS reports adjusted or actual Medicare and Medicaid savings at the administrative-action level by the entities or activities that directly produce the administrative action. CMS stated that it reports adjusted savings related to FPS-generated leads within the total adjusted administrative-actions-level savings from Contractors and adjusted savings from FPS edits. CMS stated that it also reports the overall Medicare program integrity ROI, and savings related to the FPS are part of this ROI measure.

CMS's comments, excluding technical comments that we addressed in the report as appropriate, are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We commend CMS for the actions it has already taken and acknowledge the additional steps that CMS is in the process of taking to implement our recommendations. Our response to CMS's comments regarding three recommendations it requested that we remove is provided below.

We did not remove our recommendation for CMS to “continue to work with the Contractors and the MACs to develop strategies that improve timely coordination to give the MACs a better opportunity to recover overpayments.” As we state in our report, improved coordination between the Contractors and the MACs would give the MACs a better opportunity to recover more overpayments. Although this review did not focus on specific challenges that prevent Contractors from referring overpayments sooner, our report highlighted key challenges that the MACs encounter when attempting to recover the referred overpayments. We recognize that CMS meets with its Contractors on a continual basis to strengthen its FPS initiative. We believe CMS should also meet with its MACs on a continual basis to develop overpayment referral and

recovery strategies. We continue to believe that this area needs to be further strengthened, as is supported by the low percentage of recoveries, to provide the MACs a better opportunity to recover overpayments.

We removed our recommendation for CMS to “update the FPS’s overpayment determination adjustment factors.” After receiving our draft report, CMS sent us documentation to support this corrective action. We reviewed CMS’s additional supporting documentation and verified that it has implemented this recommendation.

We removed our recommendation for CMS to “resume reporting FPS adjusted savings, along with the corresponding ROI.” We stated in our draft report that, as of January 31, 2019, CMS had not publicly issued its *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2017* (FY 2017 Report to Congress). After the March 29, 2019, issuance of CMS’s FY 2017 Report to Congress, CMS has begun reporting adjusted savings related to FPS-generated leads within the total adjusted administrative-actions-level savings from Contractors and adjusted savings from FPS edits. These savings are also included as part of the overall program integrity ROI reported by CMS. After receiving our draft report, CMS sent us additional documentation to support the corrective actions it said it has already taken. We reviewed the documentation and verified that CMS has implemented this recommendation. However, we note that CMS did not include a dedicated FPS section within its FY 2017 Report to Congress, as it did within its FY 2015 and FY 2016 Reports to Congress. Additionally, with the exception of FPS edits, CMS’s reported adjusted savings from FPS administrative actions are not separately broken out in its FY 2017 Report to Congress, thus limiting stakeholders’ ability to directly evaluate the FPS using publicly available information. Accordingly, CMS’s maintaining documentation to support adjusted savings amounts for each of the FPS administrative actions, in addition to FPS costs used for calculating the corresponding ROI, would be necessary if stakeholders inquire about FPS specific outcomes and metrics.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered CMS's use of overpayment determination and law enforcement referral adjustment factors for their predictive analytics technologies during the FPS's second and third implementation years. Additionally, our audit assessed CMS's continued reporting of FPS savings from these payment recovery administrative actions after the third implementation year up through the end of FY 2016 (the most recent FPS savings information available from CMS as of January 31, 2019).

We discussed our review with CMS officials and reviewed supporting documentation that CMS used to calculate savings for the FPS's second and third implementation years. We discussed with the Contractors their processes for valuing overpayment determinations and law enforcement referrals. We also discussed with the MACs their collections processes and challenges when attempting to recover overpayments. Additionally, we reviewed FPS savings data that CMS used in its reports to Congress after the FPS's third implementation year up through the end of FY 2016.

We conducted our fieldwork from November 2015 through August 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed the Act to gain an understanding of the Department's responsibilities regarding predictive analytics technologies;
- reviewed other applicable Federal laws, regulations, and guidance;
- discussed our review and the continued use of FPS adjustment factors with CMS officials;
- reviewed supporting documentation that CMS used to calculate identified and adjusted savings for the FPS's second and third implementation years;
- contacted each of the Contractors to learn more about their processes for valuing identified overpayment determination and law enforcement referrals;
- obtained an understanding of the Contractors' processes for valuing overpayment determinations and law enforcement referrals;

- contacted each of the MACs to learn more about their ongoing collections processes for provider referrals;
- obtained an understanding of the challenges MACs encounter when trying to recover overpayments from provider referrals;
- reviewed data that CMS used to support its reported FPS savings metrics for the fourth implementation year, FY 2015, and FY 2016; and
- discussed the results of our review with CMS 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 upon our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>The Centers for Medicare & Medicaid Services Could Improve Performance Measures Associated With the Fraud Prevention System</i>	A-01-15-00509	September 2017
<i>The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings</i>	A-01-14-00503	June 2015
<i>The Fraud Prevention System Identified Millions in Medicare Savings, but the Department Could Strengthen Savings Data by Improving Its Procedures</i>	A-01-13-00510	June 2014
<i>The Department of Health and Human Services Has Implemented Predictive Analytics Technologies but Can Improve Its Reporting on Related Savings and Return on Investment</i>	A-17-12-53000	September 2012

APPENDIX C: FRAUD PREVENTION SYSTEM REPORTED IDENTIFIED SAVINGS

Table 1: Fraud Prevention System’s Second and Third Implementation Year Certified Savings for Overpayment Determinations and Law Enforcement Referrals					
Administrative Action	FPS Year	Identified Savings (\$ millions)	Adjustment Factor	Reduction Amount (\$ millions)	Adjusted Savings (\$ millions)
Overpayment Determinations	Second	\$35.6	16%	\$29.9	\$5.8
	Third	134.8	15%	114	20.8
Law Enforcement Referrals	Second	73.2	6%	68.9	4.3
	Third	142.3	6%	133.9	8.4
Totals	Second & Third	\$385.9	10%*	\$346.7	\$39.2

Source: We obtained the FPS second and third implementation year savings-related data from our OIG certification reports (Appendix B). The FPS’s second implementation year covered October 1, 2012, to September 30, 2013, and the third implementation year covered January 1, 2014, to December 31, 2014. The amounts may not add up exactly due to rounding. Percentages are also rounded.

*Represents the approximate combined average recovery rate from payment recovery administrative actions for the FPS’s second and third implementation years.

Table 2: Fraud Prevention System’s Payment Prevention and Payment Recovery Identified Savings for the Second, Third, and Fourth Implementation Years				
Identified Savings	FPS Second Year (\$ millions)	FPS Third Year (\$ millions)	Total Second and Third Years (\$ millions)	FPS Fourth Year (\$ millions)*
Payment Prevention†	\$101.9	\$176.9	\$278.8	\$229.2
Payment Recovery‡	108.8	277.1	385.9	425.6
Total Identified Savings	\$210.7	\$454	\$664.7	\$654.8
Payment Recovery Percent of Total Identified Savings	52%	61%	58%	65%

Sources: We obtained the FPS second and third implementation year savings-related data from our OIG certification reports (Appendix B). We obtained the FPS fourth implementation year savings data from CMS’s *Fraud Prevention System Return on Investment Fourth Implementation Year* report, referenced in “Background.” The amounts may not add up exactly due to rounding. Percentages are also rounded.

* We did not conduct a certification review of the savings-related information that CMS reported for the FPS’s fourth implementation year that covered January 1, 2015, to December 31, 2015 (which spans the FY 2015 and FY 2016 timeframes represented in Table 3).

† Payment prevention includes identified savings from prepayment edits, autodenial edits, FPS (autorejection) edits, payment suspensions, and provider revocations.

‡ Payment recovery includes identified savings from overpayment determinations and law enforcement referrals.

Additional Note: For our certification review of FPS’s first implementation year, we could not determine whether the savings-related information that CMS reported was accurate.

Table 3: Fraud Prevention System's Payment Prevention and Payment Recovery Identified Savings for Fiscal Years 2015 and 2016			
Identified Savings	Fiscal Year 2015 (\$ millions)	Fiscal Year 2016 (\$ millions)	Total Fiscal Years 2015 and 2016 (\$ millions)
Payment Prevention*	\$286.8	\$127.8	\$414.6
Payment Recovery†	318	399.3	717.2
Total Identified Savings	\$604.7	\$527.1	\$1,131.8
Payment Recovery Percent of Total Identified Savings	53%	76%	63%

Source: We obtained the FPS's FYs 2015 and 2016 identified savings-related data from CMS. FY 2015 covered October 1, 2014, to September 30, 2015; FY 2016 covered October 1, 2015, to September 30, 2016. The amounts may not add up exactly due to rounding. Percentages are also rounded.

* Payment prevention includes identified savings from prepayment edits, autodenial edits, FPS (autorejection) edits, payment suspensions, and provider revocations.

† Payment recovery includes identified savings from overpayment determinations and law enforcement referrals.

Additional Notes: FY 2015 covers overlapping FPS identified savings metrics from part of the third implementation year (October 1, 2014, to December 31, 2014) and from part of the fourth implementation year (January 1, 2015, to September 30, 2015). FY 2016 covers overlapping FPS identified savings metrics from part of the fourth implementation year (October 1, 2015, to December 31, 2015) and from part of calendar year 2016 (January 1, 2016, to September 30, 2016).

With the exception of the FPS identified savings covering part of the FPS's third implementation year, we did not conduct any certification of the FPS identified savings amounts presented in this table for FYs 2015 and 2016.

CMS no longer reports FPS metrics on an implementation- or calendar-year basis.

APPENDIX D: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: August 13, 2019

TO: Joanne Chiedi
Acting Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: The Centers for Medicare & Medicaid Services Could Improve its Processes for Evaluating and Reporting Payment Recovery Savings Associated with the Fraud Prevention System (A-01-15-00510)

A handwritten signature in blue ink that reads "Seema Verma".

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to program integrity efforts in Medicare.

Since June 30, 2011, the Fraud Prevention System (FPS) has run predictive algorithms and other sophisticated analytics on a continuous basis against nationwide Medicare Fee-for-Service claims in order to identify, prevent, and stop potentially fraudulent claims. CMS uses the FPS to target investigative resources to suspect claims, providers, and suppliers and swiftly impose administrative action when warranted. When predictive models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation.

The FPS helps CMS reduce the administrative and compliance burdens on legitimate providers and suppliers, target fraudulent providers and suppliers, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care. As mandated by the Small Business Jobs Act (SBJA), CMS submitted to Congress annual reports on the implementation of the FPS through its first three years (FY 2012-FY 2014).¹ These reports demonstrated the FPS's efficacy in producing quality leads that result in administrative action savings and return on investment (ROI). The OIG certified CMS's calculation of adjusted savings and ROI related to the second and third years of FPS implementation, thereby supporting the value of the FPS and justifying its continuation beyond the formal evaluative period specified in the SBJA.

CMS has built a complex program integrity ecosystem with interconnected data systems in order to comprehensively address fraud, waste, and abuse across the Medicare and Medicaid programs. To promote clear understanding of the complex program integrity landscape, CMS has standardized the way it reports Medicare program integrity savings and ROI to Congress and the public. Starting with the Fiscal Year 2017 Report to Congress on the Medicare and Medicaid Integrity Programs, CMS reports adjusted or actual Medicare and Medicaid savings at the

¹ Sec. 4241 (e) of the Small Business Jobs Act (PL 111-240)

administrative-action level by the entities or activities that directly produced the administrative actions. CMS considers this the most objective and non-duplicative way to categorize and present savings because administrative actions are discrete, measureable events, and CMS can ensure unique attribution of administrative action savings to particular entities (e.g., program integrity contractors) or activities (e.g., medically unlikely editing). CMS reports adjusted savings related to FPS-generated leads within the total adjusted, administrative-action-level savings from Unified Program Integrity Contractors (UPICs) and adjusted savings from FPS edits. CMS also reports the overall Medicare program integrity ROI. As one of CMS's many program integrity support systems, savings related to the FPS are part of this ROI measure.

In an effort to enhance CMS's ability to prevent and reduce improper payments, in March 2017, CMS launched an updated version of the Fraud Prevention System (FPS 2.0) that modernizes the system and user interface; improves predictive model development time and performance measurement; and expands CMS' program integrity capabilities addressing the full spectrum of fraud, waste, and abuse. FPS 2.0 provides better real-time insight into the performance of models and edits; allows more of CMS' program integrity stakeholders to use FPS data; and helps CMS more effectively target provider education efforts.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Continue to work with the Contractors and the MACs to develop strategies that improve timely coordination to give the MACs a better opportunity to recover overpayments.

CMS Response

CMS concurs with OIG's recommendation. CMS meets with the Unified Program Integrity Contractors no less than once a month and selects samples of contractors' cases for review and discussion. These meetings promote consistency in appropriate overpayment recovery efforts and allow CMS to address challenges hindering the identification of overpayments. OIG did not identify specific challenges that prevent Unified Program Integrity Contractors from referring overpayment determinations sooner. Therefore, we believe that this recommendation has been implemented and request that it be removed from OIG's report.

OIG Recommendation

Establish a uniform methodology for the Contractors to use when reporting estimates for the value of law enforcement referrals.

CMS Response

CMS concurs with OIG's recommendation. CMS is working to establish a methodology for Unified Program Integrity Contractors to use when reporting estimates for the value of law enforcement referrals.

OIG Recommendation

Update the FPS's overpayment determination adjustment factors.

CMS Response

CMS concurs with OIG's recommendation. CMS updated the FPS's overpayment adjustment factor in 2017. We believe that this recommendation has been implemented and request that it be removed from OIG's report.

OIG Recommendation

Update the FPS's law enforcement referral adjustment factor.

CMS Response

CMS concurs with OIG's recommendation. In order to update the law enforcement referral adjustment factor, CMS needed OIG to provide data related to the outcomes of its investigations. OIG recently transferred the necessary data to CMS, and CMS is working on updating the law enforcement adjustment factor.

OIG Recommendation

Resume reporting FPS adjusted savings, along with a corresponding ROI.

CMS Response

CMS concurs with OIG's recommendation. As mentioned above, CMS reports adjusted savings related to FPS-generated leads within the total adjusted, administrative-action-level savings from UPICs and adjusted savings from FPS edits. CMS also reports the overall Medicare program integrity ROI, and savings related to the FPS are part of this ROI measure. We believe that this recommendation has been implemented and request that it be removed from OIG's report.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.