

CMS Report to Congress on the First Year Implementation Medicare's Fraud Prevention System

OVERVIEW

On Friday, December 14, 2012, CMS released a report to Congress that was required to be released by October 1, 2012, as required by the Small Jobs Business Act of 2010.¹ According to CMS, the FPS “generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations” and the agency “stopped, prevented, or identified an estimated \$115.4 million in payments.”² CMS estimates the FPS achieved “a positive return on investment (ROI), saving an estimated \$3 for every \$1 spent in the first year.”³

The report is very heavily weighted toward the *process* CMS used to establish FPS, the current operations of the FPS, and CMS's plans for the future of the program. Accordingly, this summary does not exhaustively recount process milestones to date. Rather, since Congress, stakeholders, and the public are interested in the *results* the system is producing and will want to ensure CMS is making changes to the FPS system in a transparent and responsive manner, this summary reviews CMS's methodology, assumptions, and calculations. Therefore, this is a summary of some of the report's key claims and facts.

HHS OIG: CMS “DID NOT FULLY COMPLY WITH THE REQUIREMENTS” FOR REPORTING

The law requires the HHS Office of Inspector General (OIG) to certify the actual and projected improper payments recovered and avoided and the return on investment related to the Department's use of predictive analytics technologies in the Medicare fee-for-service program—for the first three years of implementation. HHS OIG must also recommend whether the Department should continue, expand, or modify its use of predictive analytics technologies.

HHS OIG found that CMS “did not fully comply with the requirements for reporting actual and projected improper payments recovered and avoided in the Medicare fee-for-service program and its return on investment related to its use of predictive analytics technologies....[CMS] did not report some of the amounts required and had inconsistencies in its data; in addition, its methodology for calculating other reported amounts included some invalid assumptions that may have affected the accuracy of those amounts.”⁴ As a result, the OIG said they “could not determine whether the savings-related information that the Department [CMS/HHS] reported was accurate.”⁵

¹ <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>

² Prologue and Executive Summary

³ Executive Summary

⁴ HHS OIG report, A-17-12-53000, September 2012 (“HHS OIG report”)

⁵ HHS OIG report

HHS OIG FINDS METHODOLOGICAL PROBLEMS WITH CMS' "ACTUAL SAVINGS"

Actual Savings Are \$31 M, Not \$115 M, While Actual Recoveries Remain Unknown

CMS says the agency “saved an estimated \$115.4 million in payments, comprising \$31.8 million in estimated actual savings and \$83.6 million in estimated projected savings.”⁶ They explain: actual savings as “those dollars avoided (never paid) or recovered and returned to the Medicare Trust Funds during the first implementation year due to actions taken on FPS leads during that year.”⁷ However, CMS notes that they are “currently unable to report actual *recoveries* specific to FPS leads.”⁸

CMS processes 4.5 million claims per day worth more than \$1 billion. For illustrative purposes, assume the first year’s \$31.8 million in estimated actual savings is completely accurate and legitimate. That would still mean that in its first year, the FPS only achieved savings worth a few hours of a normal work day of Medicare bills.

CMS Does Not Know What Improper Payments Were Avoided Due to FPS

HHS OIG found that CMS “could not present actual savings with respect to improper payments recovered. The Department acknowledged in the first implementation report that it did not report this information because it does not require contractors to track recoveries by source (i.e., the entity that identified the improper payment). Departmental officials advised us that this problem, related to the attribution of the sources, affects other CMS recoveries...”⁹

Methodological Flaw In Estimated Savings Due to Revoking Provider Billing Privileges, OIG Warns “May Not Be Valid,” Says “Could Not Determine” If Accurate

HHS OIG said they “could not determine whether the \$7.3 million reported as actual costs avoided by revoking provider billing privileges was accurate because the Department's methodology assumes one of the claims submitted by the provider was a legitimate claim that would have been paid if the beneficiary had received the services from another provider.” CMS did not provide support for this assumption, and OIG noted they “found evidence that it may not be valid.”¹⁰

Estimated Savings Due To Changes in Provider Behavior Based on Ineffective Edit, Actual Savings Likely “Overstated”

HHS OIG said they “could not determine whether the \$6.7 million reported as actual costs avoided from changes in provider behaviors was accurate” since HHS’s “methodology is based on an edit added to the MACs' Medicare fee-for-service claims processing system.” HHS OIG explained they “examined the payments to one provider affected by this edit after it was implemented and found that the provider received payment for some services that this edit was designed to deny.” They explained their concern is that CMS’s “methodology assumes that

⁶ Page 23

⁷ Page 24

⁸ Page 27

⁹ HHS OIG report, Page 4

¹⁰ HHS OIG report, Page 6

100 percent of the claims denied by the edit were improper. If any of these payments were proper, the \$6.7 million reported as actual costs avoided by this edit would be overstated.”¹¹

OIG “Could Not Determine” if Savings From Edits and Payment Suspensions Was Accurate, But Number Reflects Some Adjustments Made in Response to Errors OIG Found

HHS OIG said they “could not determine whether the \$17.8 million reported as actual costs avoided through edits and payment suspensions was accurate. The supporting information maintained by [CMS] was not consistent with the supporting information provided and certified by the [program integrity contractors]. The \$17.8 million that CMS reported “reflects adjustments it made in response to those errors that [OIG] identified during [their] review.”

HHS OIG: NO DATA OR HISTORICAL EXPERIENCE SUPPORT “PROJECTED SAVINGS”

OIG said they “could not determine whether the \$68.2 million in projected savings from law enforcement referrals was an accurate projection of savings. This amount represents the total value of claims identified during the investigation of leads. The Department's methodology assumes that 100 percent of the amount referred to law enforcement will be recovered. The Department did not provide any support for this assumption, such as historical data. The methodology does not reasonably account for known variables that may impede the 100 percent recovery of the amount referred.”

HHS OIG: RETURN-ON-INVESTMENT “NOT ACCURATE,” AND “DID NOT INCLUDE ALL COSTS”

OIG said CMS “reported an estimated return on investment of \$3.30 for every dollar spent on the FPS in its first implementation year,” but found “this figure was not accurate because it was calculated by dividing the total of both actual and projected savings that were reported by a summary of the costs used to implement the FPS during its first year, and, as previously discussed, there were inconsistencies and unverified assumptions in the methodology used to accumulate the actual and projected savings.” HHS OIG also found that CMS “did not include all costs associated with the FPS in its calculation...the cost of the contract for preparing the first implementation report and the first-year indirect costs (e.g., office space, furnishings, and equipment) that should have been allocated among the various fraud-fighting programs, including the FPS.”¹²

DESPITE SCATHING OIG REPORT, CMS INSISTS ESTIMATED SAVINGS ARE “CONSERVATIVE”?

Despite HHS OIG’s, CMS rather oddly claims that “CMS believes [the agency’s cost avoidance estimates] are a conservative representation of the significant value that has already been realized.”¹³

¹¹ HHS OIG report, Page 6

¹² HHS OIG report, Page 7

¹³ Prologue