Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE CENTERS FOR MEDICARE & MEDICAID SERVICES COULD IMPROVE PERFORMANCE MEASURES ASSOCIATED WITH THE FRAUD PREVENTION SYSTEM

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A-01-15-00509

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: September 2017
Report No. A-01-15-00509

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

The Centers for Medicare & Medicaid Services Could Improve Performance Measures Associated With the Fraud Prevention System

Why OIG Did This Review

The Fraud Prevention System (FPS), which was developed to meet a requirement in the Small Business Jobs Act of 2010, uses models that predict suspicious behavior to identify and prevent the payment of improper Medicare claims. We conducted required audit work to certify the actual and projected savings and the return on investment related to the use of FPS. When performing that work, we became aware that the Department of Health and Human Services might not have the capability to trace the savings from administrative actions back to the specific FPS model that generated the savings. Without this capability, the Department is not able to accurately evaluate an individual FPS model's performance. Therefore, the Department may be limited in how it assesses the effectiveness of its predictive analytics technologies.

Our objective was to evaluate Centers for Medicare & Medicaid Services' (CMS's) process for refining and enhancing FPS models.

How OIG Did This Review

We reviewed savings data for the second and third implementation years. We met with CMS and discussed the governance process and current performance measures. We evaluated the current performance measures to determine whether the Department effectively used the performance results to refine and enhance the models. We also discussed CMS's plan to upgrade to a new version of FPS.

What OIG Found

We found that CMS's process for refining and enhancing FPS models needs improvement. Specifically, CMS could not track savings from administrative actions back to the individual FPS models that initiated the investigation because, according to CMS, that capability was not built into the FPS. In addition, CMS did not make use of all pertinent performance results because CMS did not (1) ensure that contractors' adjusted savings reported to CMS reflected amounts certified by the Office of Inspector General and (2) evaluate FPS model performance on the basis of the amounts actually expected to be prevented or recovered. As a result, the FPS is not as effective in preventing fraud, waste, and abuse in Medicare as it could be.

What OIG Recommends and the Centers for Medicare & Medicaid Services Comments

We recommend that CMS make better use of its performance results to refine and enhance the predictive analytics technologies of the FPS models by ensuring that (1) the redesigned FPS is effective in allowing CMS to track savings from administrative actions back to individual FPS models, (2) contractors adjust savings reported to CMS to reflect only FPS-related savings amounts, and (3) evaluations of FPS model performance consider not only the identified savings but also the adjusted savings.

CMS concurred with our recommendations and outlined steps for implementing those recommendations.

The full report can be found at https://oig.hhs.gov/oas/reports/region1/11500509.asp.

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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 (fraud-detection models) to identify improper Medicare Fee-for-Service claims that providers submit and to prevent the payment of such claims. To fulfill this requirement, the Department designated the Centers for Medicare & Medicaid Services (CMS) to develop and implement the Fraud Prevention System (FPS). Through using fraud-detection models and prepayment edits, the FPS is intended to identify and prevent fraud, waste, and abuse in the Medicare Fee-for-Service program nationwide.

The Act also required the Department's Office of Inspector General (OIG) to certify the actual and projected savings with respect to improper payments prevented and recovered. In addition, we certified the return on investment (ROI) related to the Department's use of the FPS for each of its first 3 implementation years.[1] OIG certified the FPS savings and ROI under the Act when OIG issued the third-year report.[2] However, when performing that work, we became aware that the Department might not have the capability to trace the savings from administrative actions back to the specific FPS model[3] that generated the savings. Without this capability, the Department is not able to accurately evaluate an individual FPS model's performance. Therefore, the Department may be limited in how it assesses the effectiveness of its predictive analytics technologies. We performed this audit to follow up on some of our concerns from our previous audits.

OBJECTIVE

Our objective was to evaluate CMS's process for refining and enhancing FPS models.

[1] 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 through December 31, 2014.

[2] The report for the third implementation year, *The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings* (A-01-14-00503), June 2015, is available online at https://oig.hhs.gov/oas/reports/region1/11400503.asp. A list of all of our previous FPS-related work is included as Appendix A. In the report for the third implementation year, 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.

[3] FPS models are based on a set of assumptions or rules used to identify suspicious behavior.

BACKGROUND

CMS's Fraud Prevention System

To fulfill the Act's requirement to use predictive analytics technologies, CMS established the FPS on June 30, 2011. CMS uses system contractors to help develop and maintain the FPS and its models. CMS identifies both questionable billing patterns and aberrancies using the FPS and provides this information through Alert Summary Reports (referred to as "FPS leads" in this report) to Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) for investigation.[4] The ZPICs and PSCs are divided into seven different zones based on their geographic location. Their primary purpose is to investigate instances of suspected fraud, waste, and abuse in the Medicare program.

CMS's Process for Modifying the Fraud Prevention System

CMS established an FPS governance process in the first implementation year to provide oversight, management, and control over the selection and development of new models, the enhancement of existing models, and the implementation of system changes. This governance process enables CMS to create or adapt fraud-detection models to address identified vulnerabilities, such as those identified in prior OIG reports and investigations. CMS evaluates the resulting models for impact and effectiveness and decides which models to continue, adjust, or retire.

CMS also uses monthly FPS data to assess the performance of its FPS models. CMS uses this information, along with feedback from the ZPICs and PSCs, to validate a model's ability to identify providers with known risks. At annual meetings, CMS also solicits information from the ZPICs and PSCs about the performance of the FPS models to help determine whether CMS should continue, adjust, or retire any of the FPS models.

Fraud Prevention System Model Types

CMS designed the FPS to accommodate a variety of model types[5] to address multiple kinds of fraud schemes. As of December 31, 2015, there were 89 models in the FPS: 30 rule-based models that use rules to filter fraudulent claims and behaviors, 46 anomaly-detection models that use thresholds to identify potentially fraudulent behavior, 9 predictive models based on past known fraud cases, and 4 social-network analysis models that identify links among potentially fraudulent subjects. For the first 3 implementation years, CMS retired 26 models mainly because of feedback from the ZPICs and PSCs.

[4] As of December 12, 2016, Unified Program Integrity Contractor replaced all the ZPICs and PSCs.

[5] CMS described each FPS model type in detail on page 6 of the *Report to Congress Fraud Prevention System Third Implementation Year* issued in July 2015.

System Contractor Roles in the Fraud Prevention System

CMS contracts with several types of FPS system contractors. The Development Contractor designed, built, and implemented the FPS. They also create, test, and refine new predictive models and other sophisticated data analytics and incorporate models from other sources into the FPS. The Modeling Contractor creates, tests, and refines new models and other sophisticated analytics that complement existing FPS models. The ZPICs and PSCs use an FPS lead to conduct and support a suspected fraud, waste, or abuse investigation.

An FPS lead is one of several sources that the ZPICs and PSCs use to conduct an investigation. Because multiple sources (e.g., ZPICs and PSCs own internal data analysis, OIG referrals, and hot line tips) could contribute during an investigation that leads to an administrative action,[6] it is not always possible to quantify each source's contribution to an individual administrative action. In addition to conducting investigations, the ZPICs and PSCs provide input on FPS model effectiveness and potential modifications through CMS's Models and Edits workshops, by providing subject matter experts nationwide, and by ensuring the information needed to develop recommendations for investigation is available.

During the third implementation year, the ZPICs and PSCs submitted administrative actions and the related savings to CMS for review to determine whether the administrative actions were attributable to the FPS. If CMS determined the administrative actions were not attributable to the FPS, then CMS directed the ZPICs and PSCs to reclassify the related savings accordingly. This was to ensure that the ZPICs and PSCs only classify savings as FPS savings if the administrative actions resulted from the FPS leads.

Technical Direction Letter

On June 17, 2014, CMS issued a Technical Direction Letter (TDL) instructing ZPICs and PSCs on how to document that an FPS lead contributed to an investigation and the resulting administrative action.

Before taking an administrative action, the ZPICs and PSCs must rule that a FPS lead is one of the following: Suspect New, Suspect Existing, or Not Suspect:

- Suspect New—When the ZPIC or PSC receives an FPS lead before an investigation is opened, the ZPIC or PSC opens an investigation and classifies it as Suspect New.

- Suspect Existing—When a ZPIC or PSC receives an FPS lead that the ZPIC or PSC already has an open investigation, the ZPIC or PSC classifies it as Suspect Existing.

- Not Suspect—When the ZPIC or PSC closes the FPS lead without an investigation.

[6] An investigation can result in the following administrative actions: payment suspension, overpayment recoveries, law enforcement referrals, prepayment edits, autodenial, or autorejection edits, and provider revocation.

According to the TDL, the ZPICs and PSCs should attribute to the FPS 100 percent of the savings from an administrative action resulting from any Suspect New and Suspect Existing investigations that corroborated, augmented, or expedited the investigation. The TDL also states that the ZPICs and PSCs must classify an investigation as FPS regardless of whether the investigation is related to the FPS models that identified the provider. Specifically, an investigation can be classified as FPS-related even if the FPS lead does not contribute to the investigation.

Fraud Prevention System Identified Versus Adjusted Savings

CMS reports two types of savings that result from the administrative actions: identified and adjusted savings. Identified savings are the actual and projected savings that the FPS identified that might not be prevented or recovered.[7] Adjusted savings are the amounts of the FPS identified actual and projected savings that reasonably can be expected to be prevented or recovered.

According to CMS,[8] historical data indicates that only a portion of identified improper payments are prevented or recovered.[9] In response to our recommendation in the first-year certification report, CMS began using adjustment factors in its second and third implementation years to help determine the amount of identified savings attributable to the FPS that would actually be prevented or collected. As stated in our third-year report, we believe these adjusted savings amounts represent a more accurate estimate than the identified savings amounts of improper payments CMS has already recovered or is likely to recover or avoid in the future. Nevertheless, CMS stated in response to our second and third implementation years reports that it will continue to make decisions on expanding the FPS based primarily on the identified savings.

HOW WE CONDUCTED THIS REVIEW

We reviewed savings data for the second and third implementation years. We met with CMS and discussed the governance process and the current FPS performance measures that CMS and its contractors have in place. We evaluated the current performance measures, including the ZPICs' feedback and PSCs' feedback on FPS model performance, to determine whether CMS

[7] CMS defined "actual savings" as dollars prevented or recovered and returned to the Medicare Trust Funds during the implementation year due to actions taken on FPS leads during that year. "Projected savings" are dollars from actions taken on FPS leads during the implementation year, but they are not expected to be returned to the Medicare Trust Funds or anticipated to be prevented until a subsequent period.

[8] CMS introduced the adjusted savings on page 3 of the *Report to Congress Fraud Prevention System Second Implementation Year* issued in June 2014.

[9] An example of an improper payment prevented is an autorejection (i.e., a claim is rejected without being paid). Historical data showed that some providers resubmitted the rejected claims, which were eventually paid.

could effectively use the performance results to refine and enhance the FPS models. We also discussed CMS's plan to upgrade to a new version of the FPS.

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

We found that CMS's process for refining and enhancing FPS models needs improvement. Specifically, CMS could not track savings from administrative actions back to the individual FPS models that initiated the investigation because, according to CMS, that capability was not built into the FPS. In addition, CMS did not make use of all pertinent performance results because CMS did not (1) ensure that ZPICs' adjusted savings and PSCs' adjusted savings reported to CMS reflected amounts certified by the OIG and (2) evaluate FPS model performance on the basis of the amounts actually expected to be prevented or recovered (i.e., adjusted savings). As a result, the FPS is not as effective in preventing fraud, waste, and abuse in Medicare as it could be.

CMS COULD NOT TRACK ADMINISTRATIVE ACTIONS TO INDIVIDUAL FPS MODELS

CMS could not track the savings from administrative actions back to the individual FPS model that initiated the investigation because that capability was not built into the FPS. Therefore, CMS is unable to determine the amount of savings generated for each FPS model. Calculating the savings from the administrative actions that resulted from specific FPS models is an essential step in determining how effectively a FPS model is performing. Without that essential information, CMS does not have complete data to make the most effective determinations about which FPS models should be continued, adjusted, or retired. Because it could not use savings data to assess individual FPS model performance, CMS focused on the number of FPS leads that the ZPICs and PSCs ruled as suspect versus not suspect.[10] CMS calculated the percentage of FPS leads that were ruled as suspect to assess whether it should refine or retire a FPS model. Because not all FPS leads ruled as suspect resulted in an administrative action, this percentage based on suspect FPS leads alone is not the most accurate indicator of a FPS model's effectiveness to identify improper payments.

[10] "Suspect" FPS leads include suspect new and suspect existing rulings, which result in an investigation. "Not suspect" FPS leads do not warrant an investigation.

CMS DID NOT MAKE USE OF ALL PERTINENT PERFORMANCE RESULTS AND USED OVERSTATED SAVINGS DATA TO ASSESS FPS MODELS

CMS Did Not Ensure That Savings Reported to CMS Only Reflected FPS-Related Savings

CMS did not ensure that the ZPICs and PSCs reported savings reflected only FPS-related savings amounts for the first 3 implementation years. It is important to ensure that only FPS-related savings data are used to provide a more accurate measure in assessing FPS model performance. CMS relies on the ZPICs and PSCs to provide savings data that are classified as FPS. In our second and third implementation year reports, we were unable to certify more than $220 million in savings that the ZPICs and PSCs had identified as attributable to the FPS. CMS provides education and training to the ZPICs and PSCs to help them determine when identified savings should be attributable to the FPS. However, the ZPICs and PSCs included these uncertified savings in the respective years when providing feedback to CMS regarding the effectiveness of the FPS models. CMS uses the savings data as an indication of how well the FPS models are doing. The Table shows the uncertified savings from the second and third implementation year. The ZPICs and PSCs attributed some administrative actions to the FPS when there was no contribution from the FPS leads.[11]

Table: Savings Included in the Contractors' FPS Model Assessment (Dollars in millions)

	Reported Savings[12]	Uncertified Savings[13]	Certified Savings[14]
Second Implementation Year	$299	$89	$211
Third Implementation Year	586	132	454
Total	**$885**	**$221**	**$665**

[11] 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 attributed the $981,000 savings for this administrative action to the FPS.

[12] Savings that CMS provided to us for certification.

[13] Savings that we did not certify because the FPS led did not contribute to the administrative action.

[14] Savings that resulted from administrative actions that the FPS initiated or the FPS lead contributed to the existing investigation.

According to CMS officials, CMS directed the ZPICs and PSCs to reclassify from FPS to non-FPS those savings we did not certify as attributable to FPS. However, some of the ZPICs and PSCs told us that CMS had not directed them to reclassify uncertified savings. Therefore, the ZPICs and PSCs provided CMS overstated savings data to assess the FPS model performance.[15]

CMS Did Not Evaluate FPS Model Performance Using the Amounts Actually Expected To Be Prevented or Recovered

CMS did not use the amounts actually expected to be prevented or recovered (i.e., adjusted savings) to evaluate FPS model performance. CMS used only identified savings to assess FPS model performance. The difference between the identified and adjusted savings represents the estimated amount of the identified savings that would likely not be collected or prevented from being paid.

However, the use of both adjusted savings and identified savings would make CMS's assessment of the performance results more effective and may lead to additional improvements to refine and enhance the FPS models. Adjusted savings could be compared to identified savings to identify FPS models that need improvement. For example, if adjusted savings are low when compared to identified savings, it may be a sign that the FPS model is identifying the provider too late.

According to the collection contractors, recoveries from aberrant providers[16] are often very low because providers do not have sufficient assets to allow for full collections of overpayments. Therefore, the longer it takes to identify an aberrant provider, the more overpayments have likely been paid to that provider and the less likely it is to receive a full collection of overpayments. This is particularly true for fraudulent providers whose intention is to defraud the Medicare program and hide the fraudulent payments they receive.

FRAUD PREVENTION SYSTEM REDESIGN

As part of its process to redesign the FPS, CMS officials are addressing several limitations. CMS's goal is to transition to a new system that would be more capable of obtaining useful information about FPS model performance and decrease the administrative time and cost that the ZPICs and PSCs spend during their investigations. Specifically, CMS expects the new version of the FPS to be able to track an administrative action back to the FPS model that generated the FPS lead. This would better quantify the contribution the FPS lead made to the administrative action.

[15] In April 2016, CMS issued a revised TDL to the ZPICs and PSCs to clarify the attribution of FPS savings.
[16] Providers that demonstrate significant improper billing patterns.

RECOMMENDATIONS

Although we acknowledge CMS's efforts to improve the FPS, we recommend that CMS make better use of its performance results to refine and enhance the predictive analytics technologies of the FPS models by ensuring that:

- the redesigned FPS is effective in allowing CMS to track savings from administrative actions back to individual FPS models,

- ZPICs and PSCs adjust savings reported to CMS to reflect only FPS-related savings amounts, and

- evaluations of FPS model performance consider not only the identified savings but also the adjusted savings.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described its plans for implementing our recommendations. CMS's comments are included in their entirety as Appendix C.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings	A-01-14-00503	June 2015
The Fraud Prevention System Identified Millions in Medicare Savings, but the Department Could Strengthen Savings Data by Improving Its Procedures	A-01-13-00510	June 2014
The Department of Health and Human Services Has Implemented Predictive Analytics Technologies but Can Improve Reporting on Related Savings and Return on Investment	A-17-12-53000	December 2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the CMS's use of predictive analytics technologies for the first 3 implementation years. We reviewed savings data for the second and third implementation years. We met and discussed with CMS and the FPS system contractors the governance process and the current FPS performance measures in place. We evaluated the current performance measures, such as the ZPICs and PSCs' feedback on FPS model performance, to determine whether CMS could effectively use the performance results to refine and enhance the FPS models. We also discussed CMS's plan to upgrade to a new version of the FPS.

We conducted fieldwork at the offices of the FPS system contractors and CMS's offices in Baltimore, Maryland. We also contacted the ZPICs and PSCs in the seven zones. We conducted our fieldwork from December 2015 through May 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed the Act to gain an understanding of the Department's responsibilities on performance measures,
- reviewed savings data for the second and third implementation years,
- interviewed the FPS development and modeling contractors to gain an understanding of their role with FPS models and performance measures related to FPS models,
- contacted the ZPICs and PSCs in the seven zones to gain an understanding of their involvement with the FPS models and performance measures related to FPS models,
- met and discussed with CMS officials the governance process, current FPS model performance measures, and future plans to upgrade the FPS,
- reviewed and evaluated supporting documentation to determine the effectiveness of current FPS model performance measures, and
- discussed the results of our audit 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUL 28 2017

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Could Improve Performance Measures Associated With the Fraud Prevention System (A-01-15-00509)

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 has run predictive algorithms and other sophisticated analytics nationwide against all Medicare Fee-for-Service claims in order to identify, prevent, and stop potentially fraudulent claims. For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare Fee-for-Service claims on a continuous, national basis. CMS uses the Fraud Prevention System to target investigative resources to suspect claims and providers 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 Fraud Prevention System 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.

Using a methodology certified by OIG, CMS found that the Fraud Prevention System helped identify or prevent $654.8 million in inappropriate payments during calendar year 2015 through actions taken due to the system or through investigations expedited, augmented, or corroborated by the system. These identified savings were about 44 percent higher than the identified savings from the previous year, with a nearly $11.5 to $1 return on investment. The Fraud Prevention System helped identify or prevent over $1.4 billion in inappropriate payments through December 31, 2015.

In an effort to enhance CMS' 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 model development time and performance measurement; and expands CMS' program integrity capabilities addressing the full spectrum of fraud, waste, and abuse. Fraud Prevention System 2.0 is designed to provide CMS with the capability of

tracking an administrative action back to the models that generated the lead and attribute savings accordingly. Fraud Prevention System 2.0 also provides better real-time insight into the performance of models and edits; allows more of CMS' program integrity stakeholders to use Fraud Prevention System data; and helps CMS more effectively target provider education efforts.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Ensure that the redesigned Fraud Prevention System is effective in allowing CMS to track savings from administrative actions back to individual Fraud Prevention System models.

CMS Response

CMS concurs with OIG's recommendation. In March 2017, CMS launched Fraud Prevention System 2.0, which is designed to provide CMS with the capability of tracking an administrative action back to the models that generated the lead and attribute savings accordingly.

OIG Recommendation

Ensure that Zone Program Integrity Contractors and Program Safeguard Contractors adjust savings reported to CMS to only reflect Fraud Prevention System-related savings amounts.

CMS Response

CMS concurs with OIG's recommendation. CMS issued a Technical Direction Letter in April 2016 clarifying Fraud Prevention System attribution, and the incidence of Zone Program Integrity Contractor and Unified Program Integrity Contractor-submitted savings that should not be attributable to the Fraud Prevention System dropped dramatically. CMS also has an internal quality assurance process to identify and exclude Zone Program Integrity Contractor and Unified Program Integrity Contractor-submitted administrative actions that are not Fraud Prevention System-attributable from savings. CMS will further refine its process to feed Fraud Prevention System attribution information back to the Zone Program Integrity Contractors and Unified Program Integrity Contractors.

OIG Recommendation

Ensure that evaluations of Fraud Prevention System model performance consider not only the identified savings but also the adjusted savings.

CMS Response

CMS concurs with OIG's recommendation. CMS considers identified savings to be an important metric when evaluating a model's performance. With Fraud Prevention System 2.0, CMS will also use adjusted savings to internally evaluate models. The combination of identified and actual savings will allow CMS to evaluate how well various administrative actions perform in terms of prevention and recovery.

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