Payment Integrity Scorecard

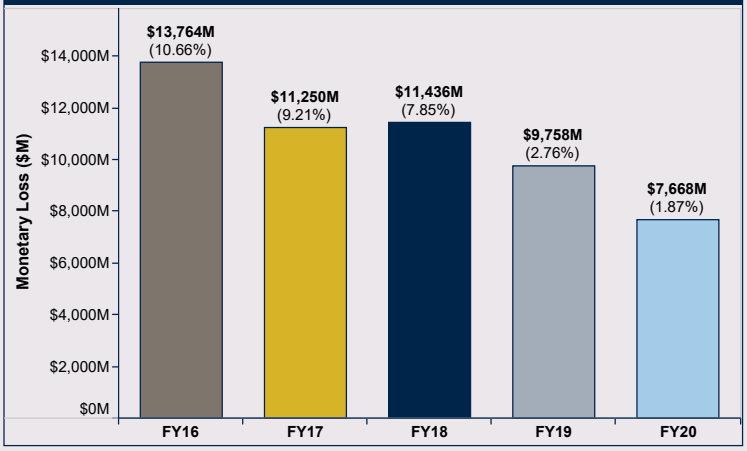
Program or Activity	Reporting Period
Medicare Fee For Service	Q2 2021

Change from Previous FY ($M) **-$2,090M**

HHS
Medicare Fee For Service

Brief Program Description:
Medicare Fee-for-Service (FFS) is a federal health insurance program that provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible citizens.

Monetary Loss ($M)
(Overpayment as Percentage of Total Outlays)



Key Milestones		Status	ECD
1	Develop mitigation strategies to get the payment right the first time	Completed	Nov-19
2	Evaluate the ROI of the mitigation strategy	On-Track	Dec-21
3	Determine which strategies have the best ROI to prevent cash loss	On-Track	Dec-21
4	Implement new mitigation strategies to prevent cash loss	On-Track	Dec-21
5	Analyze results of implementing new strategies	On-Track	Dec-21
6	Achieved compliance with PIIA	On-Track	Dec-22
7	Identified any data needs for mitigation	On-Track	Dec-22

Goals towards Reducing Monetary Loss			Status	ECD
1	Q2 2021	Prior Authorization for Certain DMEPOS Items	On-Track	Dec-21
2	Q2 2021	Prior Authorization Model for Repetitive Scheduled Non-emergent Ambulance Transport	On-Track	Dec-21

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	Recovery Activity	HHS and its review contractors (Medicare Administrative Contractors and Recovery Audit Contractors) complete post payment review and Targeted Probe and Educate (MACs) based on improper payment rate findings.	HHS and the Recovery Audit Contractors review inpatient claims for medical necessity and coding purposes.
2	Recovery Activity	HHS assigns review projects to the Supplemental Medical Review Contractor (SMRC) based on improper payment rate findings. The SMRC is reviewing several projects in FY 21 based on FY 20 improper payment rate findings and OIG report recommendations.	HHS began the Review Choice Demonstration for Home Health Services in the states of North Carolina and Florida on a voluntary basis. The demonstration is currently required in the states of Illinois, Ohio, and Texas.
3	Recovery Activity	HHS believes in a comprehensive approach to prevent overpayments through proactive measures. National prior authorization programs are considered part of the overall recovery strategy, reducing or eliminating the need for recovery activities.	HHS completed a medical review project specifically reviewing inpatient claims with a COVID-19 diagnosis that received the 20% increase in payment. Claims not meeting the requirements will be denied and monies recouped.

Accomplishments in Reducing Monetary Loss		Date
1	HHS continued implementing processes to begin the prior authorization of 2 additional services (cervical fusion with disc removal and implanted spinal neurostimulators) and requirements for certain hospital outpatient services in July 2021.	Mar-21
2	HHS continued Recovery Audit Contractor review and Medicare Administrative Contractor post payment review of claims based on data analysis and the CERT findings.	Mar-21
3	HHS continued to use the Supplemental Medical Review Contractor (SMRC) to complete special studies and projects in relation to the Public Health Emergency, recent Office of Inspector General reports, and CERT findings.	Mar-21

Amt($)	Root Cause of Monetary Loss	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$4,162M	Medical necessity	Medical Necessity resulted in overpayments of $4,162.09 million.	Continue to provide expanded provider education through Medicare FFS Recovery Audit Contractors and Targeted Probe & Educate Program. Inform providers of the results of Supplemental Medical Review Contractor's post-payment reviews.	HHS takes a holistic approach to develop corrective actions from various perspectives. Impact on the improper payment rate may not be realized for up to two years.
$3,506M	Administrative or process errors made by: others (participating lender, health care provider, or other organization administering Federal dollars)	Administrative or Process Errors Made by: Other Party resulted in overpayments of $3,506.00 million.	Reduce administrative or process errors through systems edits, provider & supplier screening, participation in the Healthcare Fraud Prevention Partnership (HFPP), integrated medical review approaches, improved policy, and expanded provider education.	HHS takes a holistic approach to develop corrective actions from various perspectives. Impact on the improper payment rate may not be realized for up to two years.

Monetary Loss - Monetary loss to the Government includes amounts that should not have been paid and in theory should/could be recovered.