Payment Integrity Scorecard

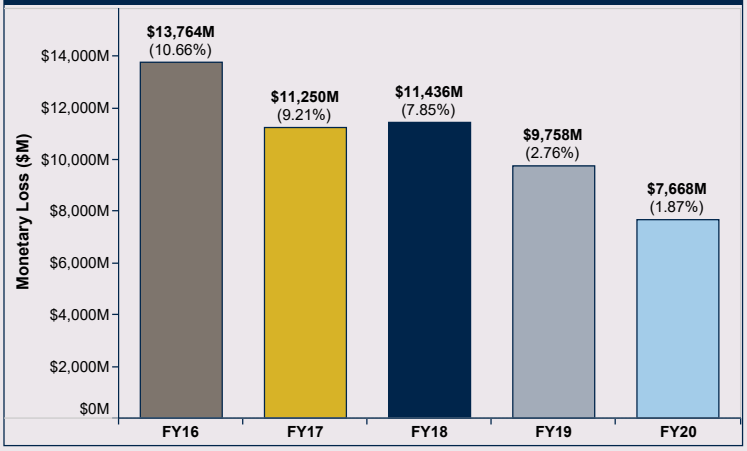
Program or Activity	Reporting Period
Medicare Fee For Service	Q4 2021

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	Q4 2021	Review Choice Demonstration for Home Health Services	Completed	Sep-21
2	Q4 2021	Supplemental Medical Review Contractor (SMRC) Post-Payment Medical Review Activity	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 announced the Review Choice Demonstration for Home Health Services will be required in the states of North Carolina and Florida as of 09/01/21. 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 identified a process for Recovery Audit Contractors and Medicare Administrative Contractors to resume full medical review activities which had been paused and limited because of the Public Health Emergency.

Accomplishments in Reducing Monetary Loss		Date
1	HHS continued Recovery Audit Contractor review and Medicare Administrative Contractor post payment review of claims based on data analysis and the CERT findings.	Jul-21
2	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.	Jul-21
3	HHS implemented 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.	Jul-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.	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.
$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.