Payment Integrity Scorecard

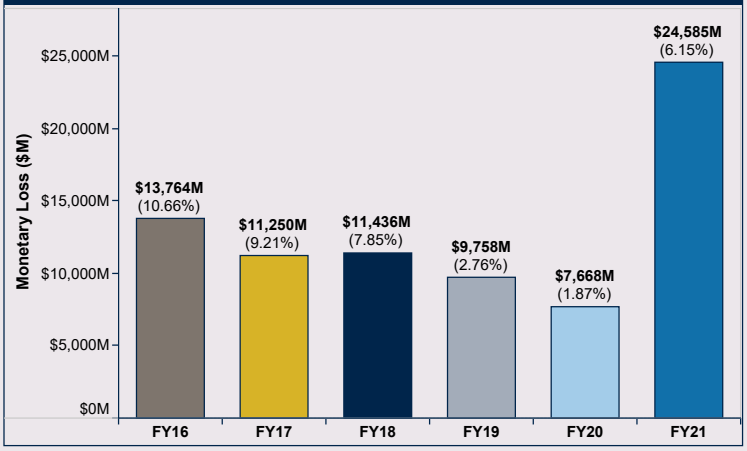
Program or Activity	Reporting Period
CMS Medicare Fee-for-Service (FFS)	Q2 2022

HHS
CMS Medicare Fee-for-Service (FFS)

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.

Change from Previous FY ($M)	$16,917M

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-22
3	Determine which strategies have the best ROI to prevent cash loss	On-Track	Dec-22
4	Implement new mitigation strategies to prevent cash loss	On-Track	Dec-22
5	Analyze results of implementing new strategies	On-Track	Dec-22
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 2022	HHS is developing several corrective actions to reduce the improper payment rate for hospice.	On-Track	Jun-22
2	Q2 2022	Review Choice Demonstration for Inpatient Rehabilitation Services	On-Track	Sep-22

	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 continues to task the Supplemental Medical Review Contractor (SMRC) with medical reviews based on recommendations from Office of the Inspector General (OIG) reports.
3	Recovery Activity	HHS uses 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 continues to use the Targeted Probe and Educate medical review process to review and correct improper payments and educate providers to prevent future errors.

Accomplishments in Reducing Monetary Loss		Date
1	HHS added 5 items to the DMEPOS required prior authorization list. These items were orthoses that were part of larger fraud initiatives in the past.	Apr-22
2	HHS added 7 items to the DMEPOS required face-to-face list. Prior to this addition, only statutorily required items were on the list. HHS added 7 items that have been involved in larger fraud initiatives in the past.	Apr-22
3	HHS created and posted an infographic for provider use on ordering diabetic test strips. Diabetic test strips have had a high improper payment rate in the past.	Apr-22

Amt($)	Root Cause of Monetary Loss	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$24,585M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicare Fee-for-Service improper payments continue to be insufficient documentation and medical necessity errors for hospital outpatient, skilled nursing facility, home health, and hospice claims.	Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	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.