Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)

Reporting Period
Q3 2023

FY 2022 Overpayment Amount ($M)* **$30,678**

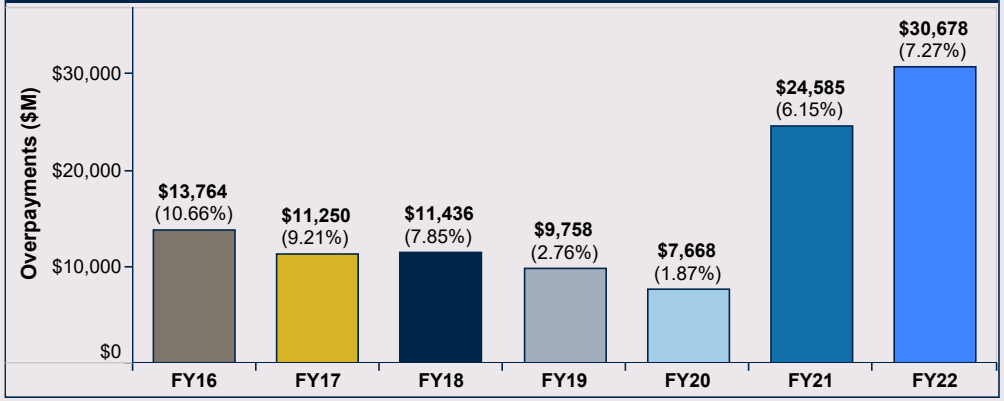
*Estimate based a sampling time frame starting 7/2020 and ending 6/2021

HHS
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)

Brief Program Description & summary of overpayment causes and barriers to prevention:

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. The primary causes of overpayments continue to be insufficient documentation and medical necessity errors for skilled nursing facilities, hospital outpatient, hospice, and home health claims. A known barrier to preventing improper payments is that providers' and suppliers' compliance with requirements is outside of the agency's control.

Historical Payment Rate and Amount ($M)
(Overpayment as Percentage of Total Outlays)



Discussion of Actions Taken in the Preceding Quarter and Actions Planned in the Following Quarter to Prevent Overpayments

In Quarter 3, CMS announced the start date (August 21, 2023) for the Review Choice Demonstration for Inpatient Rehabilitation Services (IRF) in Alabama. This demonstration will test the use of prior authorization in an IRF setting and its impact on the identification of possible fraud, waste, and abuse, which includes improper payments. CMS review contractors began reviews after the Public Health Emergency without any waivers in place, allowing for reviews of all claim types, as appropriate. Recovery Audit Contractors continued to review inpatient claims for medical necessity and coding purposes. The Supplemental Medical Review Contractor was also assigned medical reviews based on recommendations from the Office of the Inspector General. In Quarter 4, CMS anticipates additional corrective actions will be implemented to reduce the improper payment rate for hospice.

	Accomplishments in Reducing Overpayment	Date
1	Implemented a Probe and Educate program for Skilled Nursing Facilities (SNFs). This program includes a review of all SNFs that bill Medicare FFS and will provide education, as necessary, to help lower the SNF improper payment rate.	Apr-23
2	Announced the start date of August 21, 2023 for the Review Choice Demonstration for Inpatient Rehabilitation Facilities (IRF) in Alabama. Began education of IRF providers in Alabama and continued working with the Medicare Administrative Contractor to ensure a smooth rollout.	May-23
3	Awarded a contract for Education and Outreach. The contract helps CMS with the creation of educational materials and provides conference facilitation. For example, this contractor helps CMS host conferences to help providers understand coverage/payment requirements.	Jun-23

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	Goals towards Reducing Overpayments	Status	ECD
1	Implement a process to complete targeted probe and education reviews for new hospice providers to ensure they understand how to apply hospice eligibility requirements correctly. Education will be provided, as necessary, and data shared with provider enrollment. This will help reduce improper payments and identify possibly fraudulent providers so that necessary revocation actions can be explored. This is beginning in 4 states that have seen significant increases in hospice enrollment.	On-Track	Aug-23
2	Begin a Supplemental Medical Review Contractor study on hospice claims after the first 90 day election period. This study will review the beneficiary stay during the second election period to determine adherence to the eligibility requirements as well as all other coverage/payment requirements. This small study will help CMS determine if this earlier review would be beneficial to other review contractors on a larger scale.	On-Track	Mar-24

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	Medicare Administrative Contractors and Recovery Audit Contractors will complete post payment review and Targeted Probe and Educate based on improper payment findings.	Medicare Administrative Contractors and Recovery Audit Contractors review claims, identify and collect improper payments, and provide education to providers.
2	**Recovery Activity**	Assign review projects to the Supplemental Medical Review Contractor based on improper payment findings. The contractor will complete reviews to identify improper payments for collection based on FY 22 findings and the Office of Inspector General report recommendations.	Assigned the Supplemental Medical Review Contractor with medical reviews based on recommendations form the Office of the Inspector General. Claims are reviewed to identify improper payments for collection.
3	**Recovery Activity**	Use 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.	Used the Targeted Probe and Educate medical review process to review and correct overpayments and educate providers to prevent future errors.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$30,678M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicare Fee-for-Service overpayments continue to be insufficient documentation and medical necessity errors for hospital outpatient, skilled nursing facility, home health, and hospice claims.	Change Process – altering or updating a process or policy to prevent or correct error.	CMS prevents overpayments through prior authorization programs. Under prior authorization, the provider submits a prior authorization request to CMS and receives the decision regarding whether CMS will pay for a service before any services are rendered.
			Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	The Supplemental Medical Review Contractor performed medical reviews of hospice, skilled nursing facility, inpatient rehabilitation facility, and durable medical equipment claims to identify improper payments for collection.
			Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Training and education will reduce errors made when billing claims and documenting medical records. System edits, integrated medical review approaches, improved policy, and expanded provider education are used to identify and provide necessary training.