Payment Integrity Scorecard

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

Reporting Period
Q3 2026

FY 2025 Overpayment Amount ($M)* **$27,870**

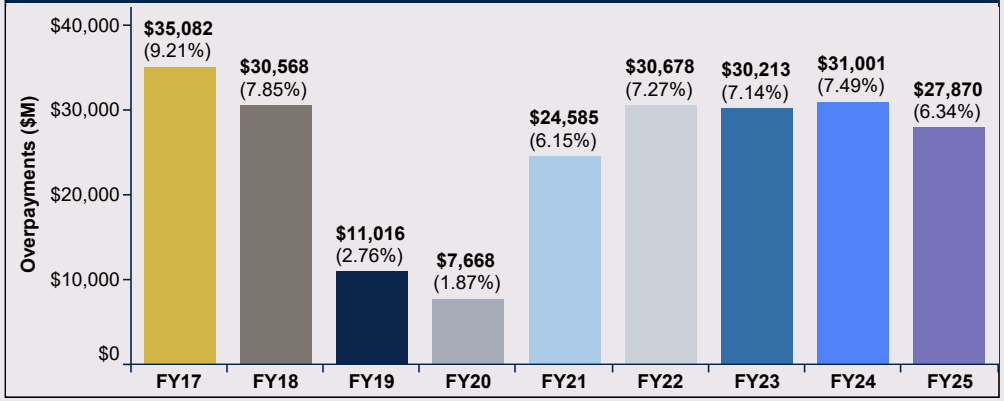
*Estimate based a sampling time frame starting 7/2023 and ending 6/2024

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

The Centers for Medicare & Medicaid Services (CMS) released the annual hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER) report which was highly requested by the Industry. CMS paused the report release in 2023 and completed a new procurement and redesigned the entire PEPPER program. In FY 2026, CMS plans to release all of the PEPPERs with the hospice PEPPER being the most requested. CMS also expanded the Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD) into California. Lastly, CMS began reviews for new suppliers and certain high vulnerability items/services under the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

	Accomplishments in Reducing Overpayment	Date
1	Released the hospice PEPPER which is an individualized report which compares providers to their peers and can be used by providers to conduct their own risk assessment. This report which was highly requested from the hospice industry since CMS paused the program in 2023.	Jun-26
2	Successfully expanded the Inpatient Rehabilitation Facility Review Choice Demonstration into California to increase the identification of potentially fraudulent or improper claims.	May-26
3	Strategically worked with the DME Medicare Administrative Contractors to complete 100% medical review for claims submitted by new suppliers and for select items/services such as surgical dressings. These reviews help identify improper payments and help educate suppliers.	Apr-26

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	Goals towards Reducing Overpayments	Status	ECD
1	Expand the hospice notification pilot to additional states. Through this pilot, notification letters are sent to beneficiaries newly enrolled in hospice to ensure the hospice election was accurate and not fraudulent.	On-Track	Dec-26
2	Identify future items for inclusion to the Master List for Required Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.	On-Track	Aug-26

	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 FY2025 findings and the Office of the 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
$27,870M	Overpayments 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.