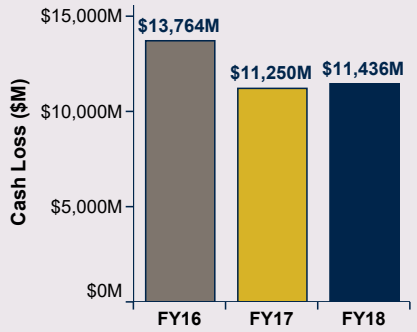
Goal: Getting Payments Right

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.

Change from Previous FY ($M)	$186M	↑

Cash Loss by FY ($M)



Key Milestones		Status	ECD
1	Finalize cash loss estimation methodology	Completed	Nov-18
2	Identify cash loss amount for FY 2018	Completed	Nov-18
3	Identify true root causes of cash loss	Completed	Nov-18
4	Develop mitigation strategies to get the payment right the first time	Completed	Nov-18
5	Evaluate the ROI of the mitigation strategy	On-Track	Nov-19
6	Determine which strategies have the best ROI to prevent cash loss	On-Track	Nov-19

Quarterly Progress Goals			Status	Notes	ECD
1	Q4 2018	HHS will continue to educate IRF providers through the Targeted Probe & Educate (TPE) process in order to reduce the error rate.	On-Track	HHS plans to use the Medicare Learning Network (MLN) among other options to achieve this goal.	Dec-19
2	Q4 2018	In 2019, HHS will continue to approve IRF issues for Recovery Audit Contractor (RAC) review, as appropriate.	On-Track	None	Dec-19

Recent Accomplishments		Date
1	In September 2018, HHS approved the Medicare FFS Recovery Audit Contractor's request to review IRF claims. Refer to the "Medicare Fee For Service Recovery Audit Program's Approved RAC Topics" page on CMS.gov, specifically issue number “0073”.	Sep-18
2	Medicare Administrative Contractors implemented the Targeted Probe & Educate medical review strategy in FY18; conducted up to 3 rounds of hospital outpatient claims reviews, 20-40 claims per round, and educated providers at the end of each round.	Sep-18
3	National Correct Coding Initiative Edits saved the Medicare program $505.30 million in the first three quarters of FY 2018.	Sep-18

FY18 Amt($)	Root Cause	Root Cause Description	Mitigation Strategy	Anticipated Impact of Mitigation
$6,740M	Medical necessity	Medical Necessity errors resulted in overpayments of $6,739.63 million. The Inpatient Rehabilitation Facility (IRF) services billed were not medically necessary in accordance with CMS requirements.	Reduce medical necessity errors using Prospective Payment System data to inform future Inpatient Rehabilitation Facility rulemaking and provide expanded education through Medicare Learning Network articles and Medicare FFS Recovery Audit Contractors.	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 2 years, and implementing new/revised policies may also result in a slight increase in rates.
$4,696M	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 (i.e., participating lender, health care provider, or any other organization administering Federal dollars) resulted in overpayments of $4,695.96 million.	Reduce administrative or process errors made by other party through systems edits, provider & supplier screening, 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 2 years, and implementing new/revised policies may also result in a slight increase in rates.