Goal: Getting Payments Right

HHS
Medicare Part C

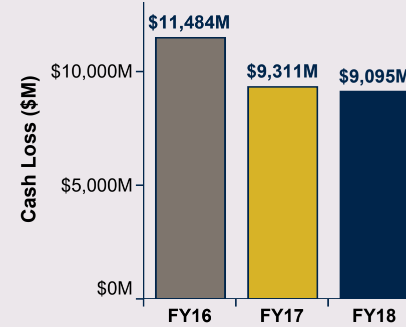
Brief Program Description:
Under the Medicare Advantage (MA) Program, also known as Medicare Part C, beneficiaries can opt to receive their Medicare benefits through a private health plan. Currently, more than 19 million beneficiaries are enrolled in Medicare Advantage plans.

	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

Change from Previous FY ($M)

-$216M

Cash Loss by FY ($M)



	Quarterly Progress Goals		Status	Notes	ECD
1	Q4 2018	HHS will host an industry-wide training in January 2019 to provide an overview of the RADV program for representatives of MAOs, Programs of All-Inclusive Care for the Elderly, Cost Plans, Demonstration Projects, and Third Party Submitters.	On-Track	None	Jan-19
2	Q4 2018	HHS will release data underlying a FFS Adjustor Study in FY19.	On-Track	None	Dec-19

	Recent Accomplishments	Date
1	In July 2018, HHS conducted a large in-person fraud, waste, and abuse training conference for MA plans on program integrity initiatives, investigations, data analyses, and potential fraud schemes.	Jul-18
2	According to law enforcement notifications received during the first 3 quarters of FY 2018, National Benefit Integrity Medicare Drug Integrity Contractor's (NBI MEDIC) referrals to law enforcement resulted in recoveries of $2.51 million for Part C.	Sep-18
3	In FY 2018, MAOs reported and returned approximately $64.93 million in self-reported overpayments.	Sep-18

FY18 Amt($)	Root Cause	Root Cause Description	Mitigation Strategy	Anticipated Impact of Mitigation
$9,095M	Insufficient documentation to determine	Insufficient Documentation to Determine resulted in overpayments of $9,094.97 million.	Reduce insufficient documentation to determine errors through contract-level Risk Adjustment Data Validation (RADV) audits, improved policy based on statutory requirements, and expanded education to Medicare Advantage Organizations (MAOs).	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.