Goal: Getting Payments Right

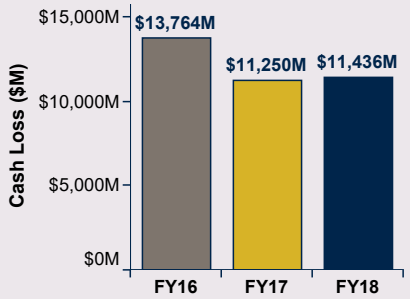
Program or Activity	Reporting Period
Medicare Fee For Service	Q4 2019

Change from Previous FY ($M) | **$186M** | ↑

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.

Cash Loss by FY ($M)



Key Milestones		Status	ECD
1	Finalize estimated cash loss estimation methodology	Completed	Nov-18
2	Identify estimated 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 2019	In 2019, 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 2019	In 2019, HHS will continue to approve IRF issues for Recovery Audit Contractor (RAC) review, as appropriate.	On-Track	N/A	Dec-19

Recent Accomplishments		Date
1	HHS extended the Medicare Prior Authorization model for Repetitive, Scheduled Non-Emergent Ambulance Transport through December 1, 2020. This model requires prior authorization in nine states and the District of Columbia.	Sep-19
2	HHS released 10 Comparative Billing Reports to top Part B providers to review their billing patterns, determine appropriateness, & provide education & observed a decline in allowed charges for emergency department services/established office visits.	Sep-19

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 HHS 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 two 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 through systems edits, provider & supplier screening, participation in the 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 two years, and implementing new/revised policies may also result in a slight increase in rates.

Cash Loss - Cash loss to the Government includes amounts that should not have been paid and in theory should/could be recovered.