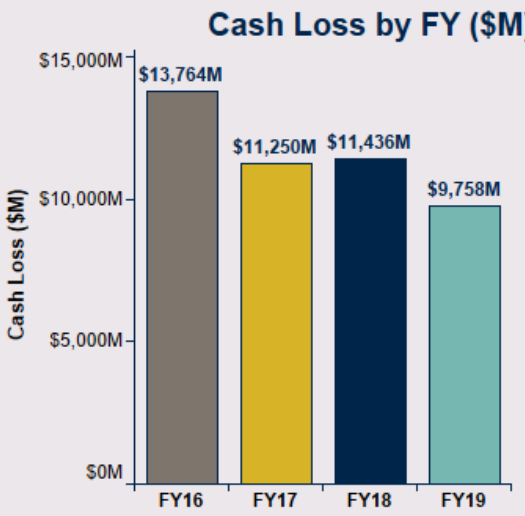
Goal: Getting Payments Right

Program or Activity	Reporting Period
Medicare Fee For Service	Q4 2020

Change from Previous FY ($M) -$1,678M

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.



Key Milestones		Status	ECD
1	Develop mitigation strategies to get the payment right the first time	Completed	Nov-18
2	Evaluate the ROI of the mitigation strategy	On-Track	Nov-20
3	Determine which strategies have the best ROI to prevent cash loss	On-Track	Nov-20
4	Implement new mitigation strategies to prevent cash loss	On-Track	Nov-20
5	Analyze results of implementing new strategies	On-Track	Nov-20

Quarterly Progress Goals			Status	Notes	ECD
1	Q4 2020	Prior Authorization Model for Repetitive Scheduled Non-emergent Ambulance Transport	On-Track	In FY 2020, HHS continued a prior authorization model for repetitive scheduled non-emergent ambulance transport. HHS announced that it will expand the model nationwide in December 2020, as all expansion criteria has been met.	Dec-20
2	Q4 2020	Prior Authorization for Certain DMEPOS Items	On-Track	In FY 2020, HHS provisionally affirmed over 53,130 DMEPOS items through the prior authorization process. HHS expanded requirements for prior authorization for five Pressure Reducing Support Surface codes and six Lower Limb Prosthetic codes.	Dec-20

Recent Accomplishments		Date
1	HHS finalized regulation (CMS-1717-FC) establishing a nationwide prior authorization process and requirements for certain hospital outpatient services. This process serves as a method for controlling unnecessary increases in the volume of services.	Jul-20
2	In FY 2020, MACs reviewed approximately 1,124 Hospital Outpatient providers, 92 Inpatient Rehabilitation Facility providers, 22 Skilled Nursing Facility providers, and 582 Home Health Agency providers under the Targeted Probe and Educate program.	Sep-20
3	HHS finalized (CMS-1729-F) the removal of the post-admission physician evaluation, required within 24 hours of patient admission to the IRF by the physician. This became effective for all IRF discharges beginning on or after October 1, 2020.	Oct-20

Amt($)	Root Cause	Root Cause Description	Mitigation Strategy	Anticipated Impact of Mitigation
$5,396M	Medical necessity	Medical Necessity errors resulted in overpayments of $5,395.69 million.	Continue to provide expanded provider education through Medicare FFS Recovery Audit Contractors and Targeted Probe & Educate Program. Inform providers of the results of Supplemental Medical Review Contractor's post-payment reviews.	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.
$4,362M	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 $4,361.92 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.

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