Goal: Getting Payments Right

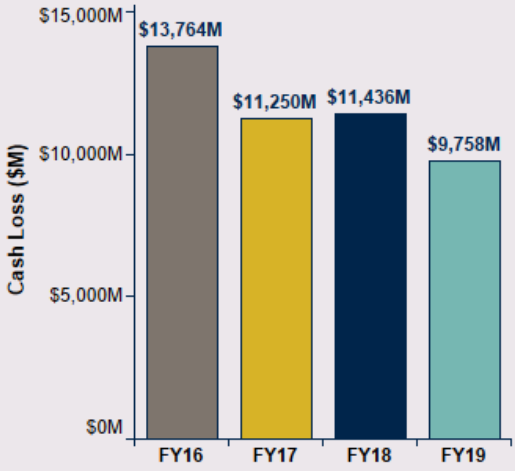
Program or Activity	Reporting Period
Medicare Fee For Service	Q1 2020

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.

Cash Loss by FY ($M)



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	Q1 2020	In 2020, HHS will continue to approve IRF and Hospital Outpatient issues for Recovery Audit Contractor (RAC) review, as appropriate. In 2020, HHS will also begin to prior authorize a limited number of outpatient serv..	On-Track		Nov-20
2	Q1 2020	In 2020, HHS will continue to educate IRF and Hospital Outpatient providers through the Targeted Probe & Educate (TPE) process in order to reduce the improper payment rate.	On-Track		Nov-20

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
3	In FY2019, Medicare Administrative Contractors (MACs) reviewed approximately 600 IRFs providers under the TPE program. In FY2019, MACs reviewed approximately 1,400 Hospital Outpatient providers under the TPE program.	Oct-19

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.