Medicare Fee-for-Service

Department of Health and Human Services

Medicare Fee-for-Service (FFS) is a program that provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible citizens. Part A is provided to persons 65 and over who qualify for Social Security benefits and pays for hospital, skilled nursing facility, home health, and hospice care. Part B is optional coverage that pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by Part A. Medicare processes over one billion FFS claims per year.

Agency Accountable Official: **Ellen Murray**, Assistant Secretary for Financial Resources

Program Accountable Official: **Shantanu Agrawal, M.D.**, Deputy Administrator and Director for the Center for Program Integrity, Centers for Medicare & Medicaid Services

Measures

- Annual Error Rate
- Chiropractic Services Rate
- Inpatient Hospital Short Stays Rate
- Power Wheelchair Rate
- Pressure Reducing Support Surfaces Rate

Current

$358.3B	$43.3B	12.1%
Total Payments (Outlays)	Improper Payments	Improper Payment Rate

2016

11.5%

Improper Payment Rate Target

All amounts are in billions of dollars

Projections | Historical

Tabular View

Program Comments

The Department of Health and Human Services (HHS) is committed to reducing the incidence of improper payments made by the Medicare FFS program. In order to reduce these improper payments, it is essential to accurately account for where, how, and why these improper payments occur. Beginning in Fiscal Year (FY) 2012, in consultation with the Office of Management and Budget (OMB), HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. HHS continued this methodology in FY 2015. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B. HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Additional information regarding the adjustment factor can be found on pages 166-167 of HHS's FY 2012 AFR (available at www.hhs.gov/afr). Application of the adjustment factor decreased the overall improper payment rate by 0.4 percentage points to 12.1 percent, or $43.3 billion in projected improper payments. As a result, HHS believes that this adjustment results in a more accurate reflection of improper payment estimates in the Medicare FFS program. The FY 2015 Medicare FFS improper payment rate decreased from 12.7 percent in FY 2014 to 12.1 percent in FY 2015, meeting and exceeding the FY 2015 improper payment rate target of 12.5 percent. This decrease was driven by a reduction in improper payments for inpatient hospital and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims. The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation errors for home health claims were the major contributing factors to the FY 2015 improper payment rate. The improper payment rate for home health claims increased from 51.4 percent in FY 2014 to 59.0 percent in FY 2015. In order to reduce improper payments and protect the Medicare Trust Funds, HHS finalized changes to the face-to-face encounter documentation requirements for episodes beginning on or after January 1, 2015. HHS anticipates that these changes, which simplify home health documentation requirements, will: improve provider compliance; ease provider administrative burden; and protect the integrity of the Medicare program. Insufficient documentation errors were also the primary cause of improper payments for Skilled Nursing Facility (SNF) claims. The improper payment rate for SNF claims increased from 6.9 percent in FY 2014 to 11.0 percent in FY 2015. **Read More...**

Report Fraud, Waste & Abuse for Medicare Fee-for-Service »