Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Medicaid

Reporting Period
Q2 2023

FY 2022 Overpayment Amount ($M)* **$80,204**

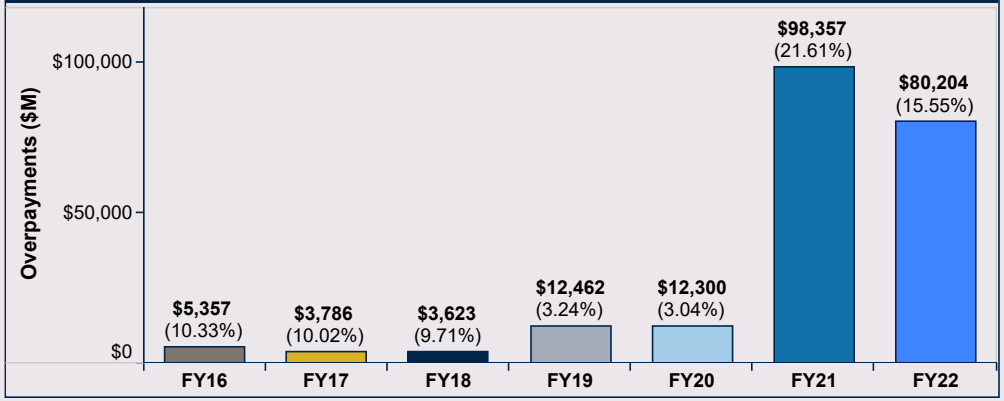
*Estimate based a sampling time frame starting 7/2020 and ending 6/2021

HHS
Centers for Medicare & Medicaid Services (CMS) Medicaid

Brief Program Description & summary of overpayment causes and barriers to prevention:

Medicaid is a joint federal/state program, administered by HHS in partnership with the states, which provides health insurance to qualifying low-income individuals and long-term care services to seniors and disabled individuals. Overpayments occur because: providers are not properly screened by the state; providers are not properly rescreened at revalidation; providers are not enrolled; the National Provider Identifier (NPI) is not on the claim; a beneficiary is enrolled when ineligible; a beneficiary is determined to be eligible for the incorrect eligibility category; beneficiary redeterminations are not conducted in a timely manner; sufficient documentation is not provided to support eligibility determinations.

Historical Payment Rate and Amount ($M)
(Overpayment as Percentage of Total Outlays)



Discussion of Actions Taken in the Preceding Quarter and Actions Planned in the Following Quarter to Prevent Overpayments

In Quarter 2, CMS continued conducting audits of beneficiary eligibility determinations in high-risk states. Unified Program Integrity Contractors also continued to conduct audits and investigations to reduce fraud, waste, and abuse in Medicaid. In Quarter 3, CMS plans to roll out Medicaid-only provider screening to states. Additionally, CMS will continue to monitor Corrective Action Plan submissions, and will follow up with all states on their progress in implementing effective corrective actions.

	Accomplishments in Reducing Overpayment	Date
1	Continued to monitor Medicaid-only providers in 6 states and offer a data compare service that allows states to remove dually enrolled providers from the revalidation workload. 38 states have participated in the data compare service.	Oct-22
2	The Medicaid Integrity Institute provided education that addressed: Program Integrity risk assessments; Program Integrity review process; opioid fraud, waste, and abuse data; and Medicaid provider enrollment and terminations.	Dec-22
3	Worked with states to ensure corrective action plans addressed the source of errors. Conducted an all state call on December 7th, 2022 to address common cause of errors related to Medicaid enrollment.	Dec-22

Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Medicaid

Reporting Period
Q2 2023

	Goals towards Reducing Overpayments	Status	ECD
1	Monitor Corrective Action Plan submissions and follows up with all states on their progress in implementing effective corrective actions. Gather lessons learned to inform areas to evaluate for future guidance and education.	On-Track	Jun-23
2	Offer Medicaid-only provider screening to states. Centralizing this process will improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of overpayments measured.	On-Track	Jun-23

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	States are generally required to establish State Medicaid Recovery Audit Programs to identify and recover overpayments, to the extent possible.	States are generally required to establish State Medicaid Recovery Audit Programs to identify and recover overpayments, to the extent possible.
2	**Recovery Activity**	Continue conducting audits of beneficiary eligibility determinations in high-risk states based on a risk assessment that reviewed states with higher eligibility improper payment rates and eligibility errors based on GAO or OIG reports.	Continued audits in Connecticut, Kansas, Missouri, and Pennsylvania.
3	**Recovery Audit**	Unified Program Integrity Contractors conduct audits and investigations to reduce fraud, waste, and abuse in Medicare and Medicaid.	The most common provider type audits and investigations initiated were hospitals, clinics, pharmacies and pharmacists, hospices, Durable Medical Equipment suppliers, and labs. Managed care network providers made up over 50 percent of those audits and investigations.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$80,204M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicaid improper payments are insufficient documentation from states (mostly related to eligibility redetermination/verification and medical services) and lack of provider enrollment screening and revalidations determinations.	Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Assist states with upgrading provider enrollment system; provide state Medicaid provider enrollment tools, technical assistance, and training to improve medical documentation; and conduct site visits for provider screening & enrollment.