Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) Medicare Advantage (Part C)	Q3 2023

FY 2022 Overpayment Amount ($M)* **$12,686**

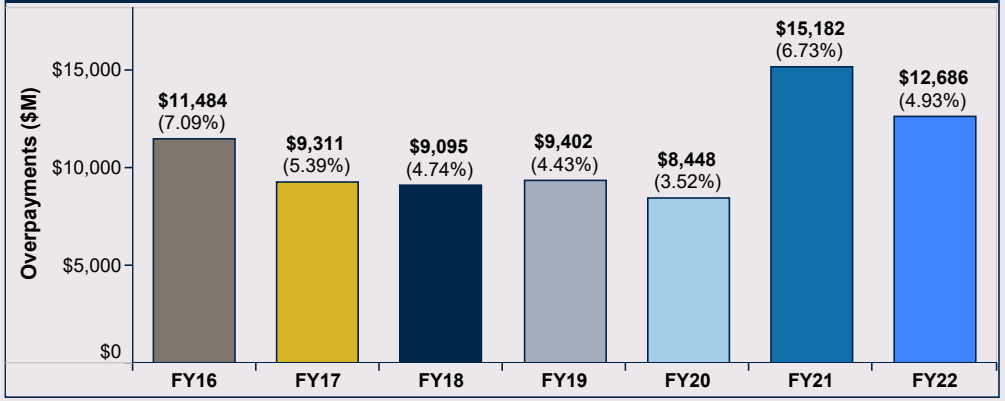
*Estimate based a sampling time frame starting 1/2020 and ending 12/2020

HHS
Centers for Medicare & Medicaid Services (CMS) Medicare Advantage (Part C)

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

Under the Medicare Advantage Program, also known as Medicare Part C, beneficiaries can opt to receive their Medicare benefits through a private health plan. Approximately half of all Medicare beneficiaries are enrolled in Medicare Advantage plans. The primary causes of overpayments are medical record discrepancies and insufficient documentation. Medicare Advantage Organizations are responsible for collecting and maintaining the documentation necessary to validate the data used in payment determinations. Medical records are not submitted to the agency at the time of making payment 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

CMS continued Medicare Advantage risk adjustment data validation (RADV) audits which examine whether the diagnoses submitted for payment are documented in medical records. In Quarter 3, CMS completed the medical record review phase for the Payment Year 2015 RADV audits. Using the data gathered during the medical record review phase, CMS will initiate the payment error calculation phase for the Payment Year 2015 RADV in Quarter 4.

	Accomplishments in Reducing Overpayment	Date
1	Conducted a fraud, waste, and abuse training with plan sponsors that focused on Part C fraud schemes and trends. Through education, plan sponsors can take the necessary steps to prevent, detect, and correct improper payments resulting from potential fraud, waste, and abuse.	Mar-23
2	The Program Integrity Portal identifies fraud schemes and trends based on information reported by plan sponsors. The portal helps plan sponsors monitor potential fraud, waste, and abuse; allowing plans to prevent, detect, and correct improper payments.	Apr-23
3	Reviewed 100 percent of medical records submitted by Medicare Advantage Organizations as part of Risk Adjustment Data Validation Audit for Payment Year 2015.	Jun-23

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Reporting Period
Q3 2023

	Goals towards Reducing Overpayments	Status	ECD
1	Complete quality assurance checks of medical review results for the Risk Adjustment Data Validation Audit for payment year 2011. Quality assurance checks are necessary before an official audit report is finalized and overpayments can start being collected.	On-Track	Sep-23
2	Complete quality assurance checks of medical review results for the Risk Adjustment Data Validation Audit for payment year 2012. Quality assurance checks are necessary before an official audit report is finalized and overpayments can start being collected.	On-Track	Sep-23

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Activity**	Finalize Risk Adjustment Data Validation audits for payment years 2011-2015. The audits are used to identify overpayments and recoveries can begin once the audits are finalized.	Published a Federal Register Notice (CMS-4185-F2) on February 1, 2023, finalizing important policies to improve program integrity and payment accuracy. The policies enacted cover the processes by which audits are conducted and recoveries of overpayments are made.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$12,686M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicare Advantage (Part C) overpayments are medical record discrepancies and insufficient documentation that does not prove that the beneficiaries have the diagnoses which were submitted by the Medicare Advantage Organization for increased payment.	Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Provide expanded education on improper payment requirements, the medical review process, and detailed submission instructions to reduce administrative or process errors made by Medicare Advantage Organizations which leads to overpayments.
			Change Process – altering or updating a process or policy to prevent or correct error.	Improve policy and guidance based on on statutory requirements to reduce administrative or process errors made by Medicare Advantage Organizations which leads to overpayments.
			Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	Conduct Risk Adjustment Data Validation audits, which examine medical records to see if the diagnoses submitted for payment are accurate, to reduce administrative or process errors made by Medicare Advantage Organizations which leads to overpayments.