Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Children's Health Insurance Program (CHIP)

Reporting Period
Q3 2023

FY 2022 Overpayment Amount ($M)* **$4,303**

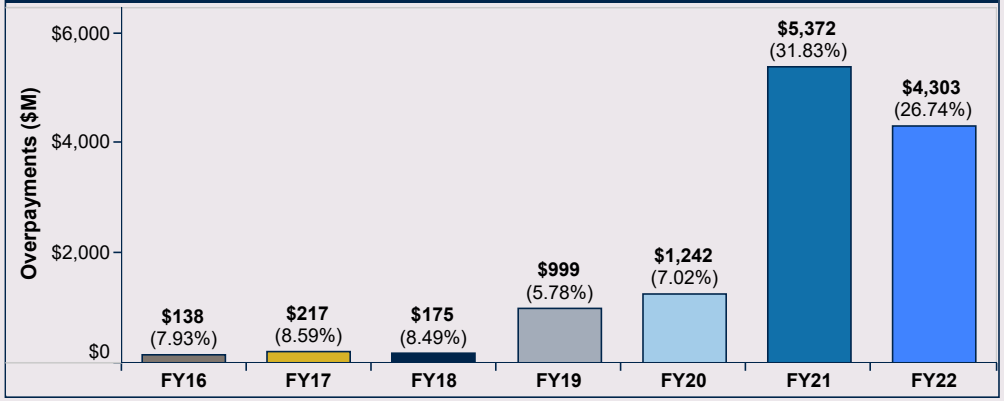
*Estimate based a sampling time frame starting 7/2020 and ending 6/2021

HHS
Centers for Medicare & Medicaid Services (CMS) Children's Health Insurance Program (CHIP)

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

The Children's Health Insurance Program (CHIP) is a joint federal/state program, administered by the states, that provides health insurance for qualifying children. Overpayments occur because: providers are not properly screened by the state or not enrolled; the National Provider Identifier is not on the claim; a beneficiary is enrolled when ineligible or 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. Barriers to prevention include: high state employee turnover, lack of state employee training, and insufficient eligibility edits.

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 3, 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 CHIP. In Quarter 4, 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 provide technical assistance and guidance to each of the 17 states within a cycle to ensure their corrective action plans addressed the source of identified errors. Created a 13 state workgroup to facilitate the exchange of promising practices.	Apr-23
2	Monitored Medicaid-only providers in 6 states and offered 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.	Jun-23
3	The Medicaid Integrity Institute provided education to states and territories covering: provider auditing fundamentals; certified coder bootcamp; fraud schemes; coding non-coders; Do Not Pay-Bene/Provider Pay Integrity; provider enrollment and terminations; and managed care.	Jun-23

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	Goals towards Reducing Overpayments	Status	ECD
1	Monitor Corrective Action Plan submissions and follow 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	Dec-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	Dec-23

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	CHIP claims are not included within the scope of Medicaid recovery audit reviews. However, States are not precluded from reviewing CHIP claims to identify overpayments or underpayments.	Medicaid Recovery Audit Contractors operate at the direction of the states. States have the discretion to determine what areas of the Medicaid programs to target based on vulnerabilities identified in their respective states.
2	**Recovery Activity**	Current statutory authority only allows overpayments to be recovered through the Payment Error Rate Measurement program. The only funds that can be recovered are from the sampled claims that contractors identified as improper payments resulting in overpayments.	States must return the federal share of overpayments identified by the Payment Error Rate Measurement program. States must return the federal share on claims with overpayments within one year from the date the recovery contractor submits the Final Errors for Recovery report.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$4,303M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of CHIP overpayments are insufficient state documentation (mostly related to eligibility redetermination/verification and provider screening/revalidation/National Provider Identifier) and states claiming beneficiaries under CHIP instead of Medicaid.	Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	Conduct site visits for provider screening & enrollment to ensure payments are not made to providers who are improperly enrolled.
			Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Provide state Medicaid provider enrollment tools, technical assistance, and training to ensure payments are not made to providers who are improperly enrolled.
			Change Process – altering or updating a process or policy to prevent or correct error.	Work with states to develop state-specific corrective action plans to reduce overpayments made in error for CHIP claims.