Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) Medicare Advantage (Part C)	Q4 2023

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

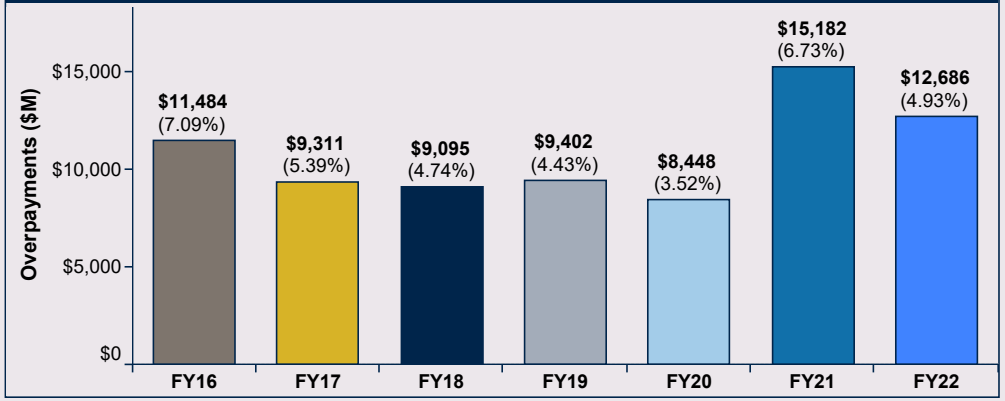
*Estimate based a sampling time frame starting 1/2020 and ending 12/2020

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 prepared quality assurance checks on medical record review results for Risk Adjustment Data Validation Audit in payment years 2011 and 2012 to prepare for official audit reports and complete overpayment recovery. In Quarter 1, CMS will complete quality assurance checks on medical review results for the Risk Adjustment Data Validation Audit in payment years 2013 and 2014. CMS provides training to plan sponsors through Medicare Part C Fraud, Waste, and Abuse webinars covering the latest schemes, trends, data analysis, and investigations.

	Accomplishments in Reducing Overpayment	Date
1	The Fraud, Waste, and Abuse Quarterly Plan identifies fraud schemes and trends based on information reported by plan sponsors which allows plans to prevent, detect, and correct improper payments.	Jul-23
2	Prepared quality assurance checks on medical record review results for Risk Adjustment Data Validation Audit in payment years 2011 and 2012 to prepare for official audit reports and complete overpayment recovery.	Sep-23

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Reporting Period
Q4 2023

	Goals towards Reducing Overpayments	Status	ECD
1	Complete quality assurance checks on medical review results for the Risk Adjustment Data Validation Audit in payment year 2013. Quality assurance checks are necessary before an official audit report is finalized and overpayments can start being collected.	On-Track	Dec-23
2	Complete quality assurance checks on medical review results for the Risk Adjustment Data Validation Audit in payment year 2014. Quality assurance checks are necessary before an official audit report is finalized and overpayments can start being collected.	On-Track	Dec-23

	Recovery Method	Brief Description of Plans to Recover Overpayments	No	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 final rule (CMS-4185-F2) on January 30, 2023, finalizing important policies that will allow CMS to exrapolate Risk Adjustment Data Validation audit findings beginning with Payment Year 2018.

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 lead 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 lead to overpayments.
			Change Process – altering or updating a process or policy to prevent or correct error.	Improve policy and guidance to reduce administrative or process errors made by Medicare Advantage Organizations which lead to overpayments.