Payment Integrity Scorecard

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

Reporting Period
Q1 2024

FY 2023 Overpayment Amount ($M)* **$2,122**

*Estimate based a sampling time frame starting 7/2021 and ending 6/2022

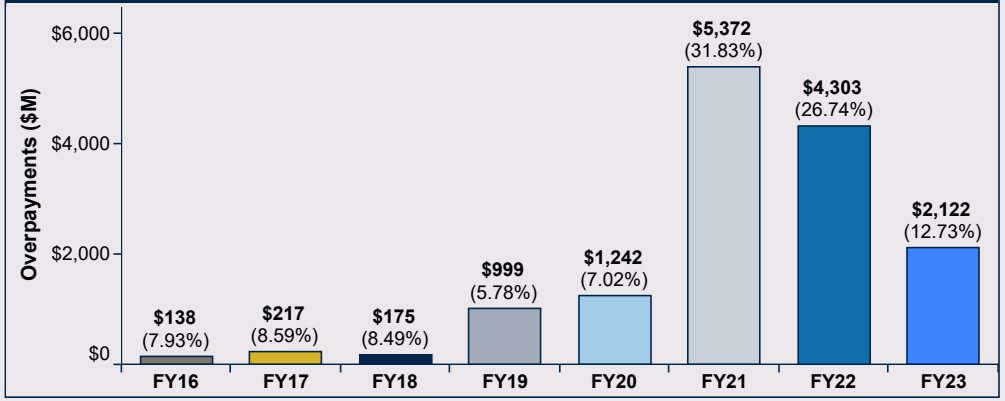
Health and Human Services

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) provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program. Overpayments occur due largely to eligibility and data processing errors, including missing documentation to support eligibility determinations, provider enrollment/National Provider Identifier (NPI) requirements, and medical necessity. Similar to Medicaid, known barriers include lack of sufficient training/utilization of all available resources and on-going updates to applicable systems.

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 1 of FY 2024, CMS continued providing education to states through the Medicaid Integrity Institute (MII). CMS also continued to offer the data compare service to states, which allows them to rely on Medicare screening for dually enrolled providers. CMS also continued to provide technical assistance and guidance to each of the 17 states within the applicable review year Payment Error Rate Measurement (PERM) cycle to ensure their corrective action plans addressed the source of identified errors. This also includes the use of Technical Advisory Groups (TAGs) focused on certain areas of risk, including provider enrollment, data analytics, and eligibility. Specifically, a new TAG focused on county-level eligibility determinations commenced in 2023. Three meetings of this TAG have been held to date. CMS also issued updated sub-regulatory guidance to all states via the Medicaid Provider Enrollment Compendium (MPEC). In Quarter 2 of FY 2024, CMS will continue to issue quarterly updates via the MPEC, monitor Corrective Action Plan submissions and 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 Payment Error Rate Measurement (PERM) cycle to ensure their corrective action plans addressed the source of identified errors, including the use of TAGs focused on certain areas of risk.	Oct-23
2	Issued updated sub-regulatory guidance to all states via the MPEC, published on December 29, 2023. This guidance addressed a variety of provider enrollment related topics, including ordering/referring (ORP) NPI requirements for school based services.	Dec-23
3	The MII 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.	Dec-23

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	Goals towards Reducing Overpayments	Status	ECD
1	Continue to issue quarterly updates via the MPEC to provide enhanced sub-regulatory guidance to states to reduce overpayments stemming from data processing errors for failing to comply with ORP NPI requirements on claims. This also includes increased collaboration with the Center for Medicaid and CHIP Services (CMCS) on corresponding guidance.	On-Track	Mar-24
2	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	Mar-24

	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 certain 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 certain overpayments identified by the Payment Error Rate Measurement program 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
$2,122M	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/NPI) and states claiming beneficiaries under CHIP instead of Medicaid.	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.

The Medicaid Eligibility and Quality Program continues to work with states over 3 cycles (17 states per cycle) through pilot reviews that are conducted in between Payment Error Rate Measurement cycles to identify Incorrect eligibility decisions in Medicaid and CHIP such as redeterminations, negative case actions and payment reviews to identify and collect overpayments that occur through improper eligibility determinations.