Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) Medicare Advantage (Part C)	Q1 2024

FY 2023 Overpayment Amount ($M)* **$14,649**

*Estimate based a sampling time frame starting 1/2021 and ending 12/2021

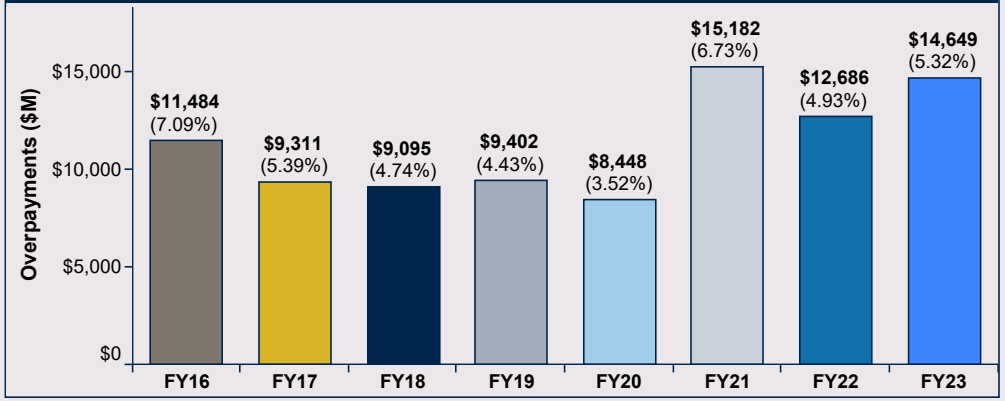
Health and Human Services

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 continues performing quality assurance checks of medical record review results for Risk Adjustment Data Validation Audit for payment years 2011 - 2015 in preparation for releasing audit reports and initiating overpayment recovery later in 2024. In addition, next quarter CMS expects to finalize a regulation that will provide clarifications to the Risk Adjustment Data Validation Audit appeals process. CMS also 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 report identified fraud schemes and trends based on information reported by plan sponsors which allows plans to prevent, detect, and correct improper payments.	Oct-23
2	Continued performing quality assurance checks of medical record review results for Risk Adjustment Data Validation Audit for payment years 2011 - 2015 in preparation for releasing audit reports and initiating overpayment recovery later in 2024.	Dec-23

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

Reporting Period
Q1 2024

	Goals towards Reducing Overpayments	Status	ECD
1	Analyze public comments submitted in response to CMS's recent proposed rule regarding clarifications to the Medicare Advantage Risk Adjustment Data Validation Audit appeals process.	On-Track	Mar-24
2	Complete quality assurance checks of medical review results for the Risk Adjustment Data Validation Audit for payment years 2011-2015. Quality assurance checks are necessary before an official audit report can be finalized and overpayments can start being collected.	On-Track	Mar-24

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Activity**	Worked on quality assurance checks of medical record review data for Risk Adjustment Data Validation Audit reports for payment years 2011-2015. The audits are used to identify overpayments and initiate recovery activities.	Published a final rule (CMS-4185-F2) on January 30, 2023, finalizing important policies that will allow CMS to extrapolate Risk Adjustment Data Validation Audit findings beginning with Payment Year 2018.

No

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$14,649M	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.	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.