Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Medicaid

Reporting Period
Q2 2024

FY 2023 Overpayment Amount ($M)* **$48,820**

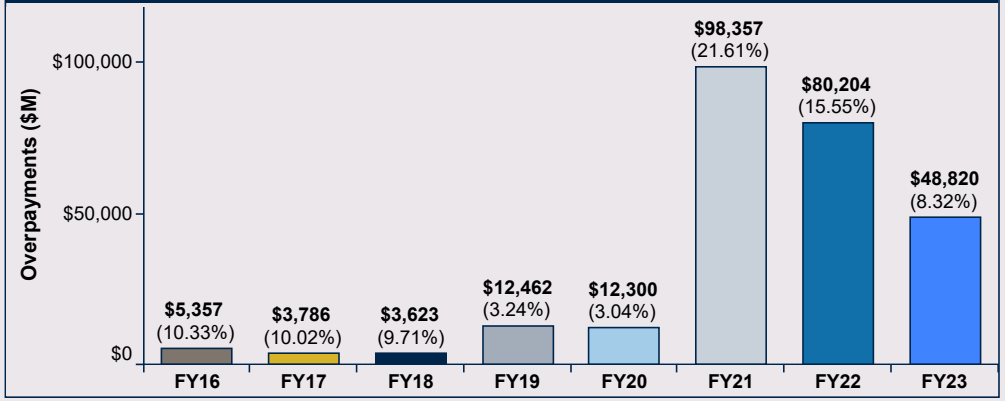
*Estimate based a sampling time frame starting 7/2021 and ending 6/2022

Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS) Medicaid

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

Medicaid is a joint federal/state program, administered by HHS, that provides health insurance to eligible low-income individuals and long-term care services to seniors and disabled individuals. 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 2 of FY 2024, CMS continued providing education to states through the Medicaid Integrity Institute. 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 utilizes monthly Technical Advisory Group calls to offer an open forum to address area specific questions from states, including provider enrollment and fraud, waste, and abuse. CMS also issued updated sub-regulatory guidance to all states via the Medicaid Provider Enrollment Compendium, published on April 15, 2024. During Quarter 3 of FY 2024, CMS will continue to monitor Corrective Action Plan submissions and follow up with all states on their progress in implementing effective corrective actions, and will continue to issue quarterly updates via the Medicaid Provider Enrollment Compendium to provide enhanced sub-regulatory guidance to states.

	Accomplishments in Reducing Overpayment	Date
1	Provided technical assistance and guidance to the 17 states within a Payment Error Rate Measurement cycle to ensure their corrective action plans addressed the source of identified errors. Utilized Technical Advisory Groups to target specific risk areas.	Mar-24
2	Issued updated sub-regulatory guidance to all states via the Medicaid Provider Enrollment Compendium, published on April 15, 2024 to address limiting the publication of for-cause terminations in the data exchange system to 10 years.	Apr-24
3	The Medicaid Integrity Institute provided education to states and territories covering: Medicaid managed care; evaluation & management coding, professional and hospital outpatient services coding; and an annual call with our territory partners.	Apr-24

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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	May-24
2	Engage in individualized communication with each state and territory to assess current compliance efforts with all applicable provider enrollment and screening requirements to triage and prioritize CMS in-person visits to provide further guidance and assistance.	On-Track	Jun-24

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	Medicaid Recovery Audit Contractors identify and correct improper Medicaid payments through the collection of overpayments and reimbursement of underpayments made on claims for health care services provided to Medicaid beneficiaries.	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 certain 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.
3	**Recovery Audit**	Unified Program Integrity Contractors conduct post-payment investigations and audits of Medicaid providers and managed care plans throughout the country and report identified overpayments to the states for recovery.	States are responsible for sending demand letters to the appropriate providers or plans, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their states administrative process.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$48,820M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	Providers not screened using risk-based criteria prior to the claim payment date; ORP Type 1 NPI missing on the claim; insufficient documentation to verify eligibility or non-compliance with redetermination requirements; providers failure to respond to records requests.	Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	Assist states with best practices and messaging with their provider community to ensure proper record retention and response to audits to verify compliance.
			Training teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Provide state Medicaid provider enrollment best practices, technical assistance, and training to ensure eligibility criteria is met.
			Automation - automatically controlled operation, process, or system.	Assist states with upgrading provider enrollment systems to ensure the applicable edits are available to ensure improper payments are not made for claims that do not meet requirements, such as the Ordering/Referring Provider National Provider Identifier.

The Medicaid Eligibility Quality Control Program continues to work with states over 3 cycles (17 states in cycles 1 and 2. 18 states in cycle 3 with the addition of the commonwealth of Puerto Rico) 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. Over the past several months CMS has worked to deploy a system called the Medicaid & CHIP Program Integrity Reporting Portal which will improve states tracking and implementation of corrective action plans to improve program integrity through the Medicaid Eligibility Quality Control process.