

Payment Integrity Scorecard

Program or Activity

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

Reporting Period

Q3 2024

FY 2023 Overpayment Amount (\$M)*

\$14,649

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



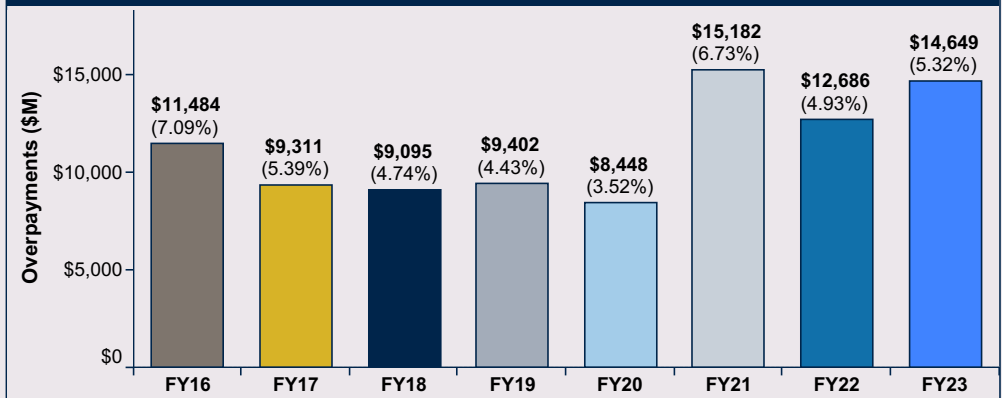
Department of Health and Human Services

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

Last quarter, CMS performed quality assurance checks of medical record review results for Risk Adjustment Data Validation audits for payment years 2011 through 2015 in preparation for releasing audit reports and initiating overpayment recovery later in 2024. These quality assurance checks will continue through the current quarter. CMS also finalized a regulation in April 2024 that provided clarifications to the Risk Adjustment Data Validation audit appeals process. In Q3, CMS also provided training to plan sponsors through Medicare Part C Fraud, Waste, and Abuse webinars covering the latest schemes, trends, data analysis, and investigations. CMS also plans to issue notice to Medicare Advantage Organizations that were selected for the next Risk Adjustment Data Validation audit. In Q4, CMS will complete quality assurance checks of medical review results for the Risk Adjustment Data Validation audits for payment years 2011 through 2015.

Accomplishments in Reducing Overpayment

		Date
1	Finalized a regulation in April 2024 that provided clarifications to the Risk Adjustment Data Validation audit appeals process.	Apr-24
2	The Fraud, Waste, and Abuse Quarterly Plan reports identified fraud schemes and trends based on information reported by plan sponsors. Released the Quarterly Medicare Part C Durable Medical Equipment Supplier Risk Assessment report.	May-24
3	Conducted a Part C Fraud, Waste, and Abuse in person training from June 4th, 2024 to June 6th 2024.	Jun-24

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Goals towards Reducing Overpayments	Status	ECD	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1 Issue notice to Medicare Advantage Organizations regarding when the next Risk Adjustment Data Validation audit will begin.	On-Track	Aug-24	1 Recovery Activity	Worked on quality assurance checks of medical record review data for Risk Adjustment Data Validation Audit reports for payment years 2011 through 2015. The audits are used to identify overpayments and initiate recovery activities.	Published a final rule (CMS-4205-F) in April 2024 that provided clarifications to the Risk Adjustment Data Validation audit appeals process.
2 Complete quality assurance checks of medical review results for the Risk Adjustment Data Validation audits for payment years 2011 through 2015. Quality assurance checks are necessary before an official audit report can be finalized and overpayments can start being collected.	On-Track	Dec-24			

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.	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.