Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) - Medicare Advantage (Part C)	Q1 2025

FY 2024 Overpayment Amount ($M)* **$17,204**

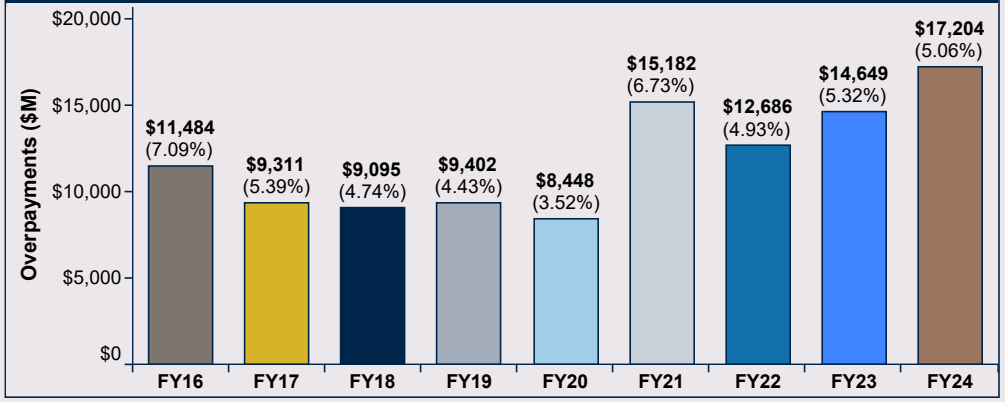
*Estimate based a sampling time frame starting 1/2022 and ending 12/2022

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 initiated payment year 2018 contract-specific Risk Adjustment Data Validation audits and issued payment year 2011 Risk Adjustment Data Validation audit reports to audited Medicare Advantage organizations. 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.

	Accomplishments in Reducing Overpayment	Date
1	Disseminated Medicare Part C Utilization Trend Analysis in November 2024. Disseminated Medicare Part C Durable Medical Equipment Supplier Risk Assessment in December 2024.	Dec-24
2	CMS issued payment year 2011 Risk Adjustment Data Validation audit reports to audited Medicare Advantage organizations in January 2025.	Jan-25

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Reporting Period
Q1 2025

	Goals towards Reducing Overpayments	Status	ECD
1	Initiate payment year 2019 contract-specific Risk Adjustment Data Validation audits.	On-Track	May-25
2	Send notice of intent to release audit reports to Medicare Advantage organizations for payment year 2012 Risk Adjustment Data Validation audits.	On-Track	May-25

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Activity**	Issue audit reports for completed contract-specific Risk Adjustment Data Validation audits.	Issued payment year 2011 Risk Adjustment Data Validation audit reports to audited Medicare Advantage organizations in January 2025.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$17,204M	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.
			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.
			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.