Payment Integrity Scorecard

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

Reporting Period
Q2 2025

FY 2024 Overpayment Amount ($M)* **$29,370**

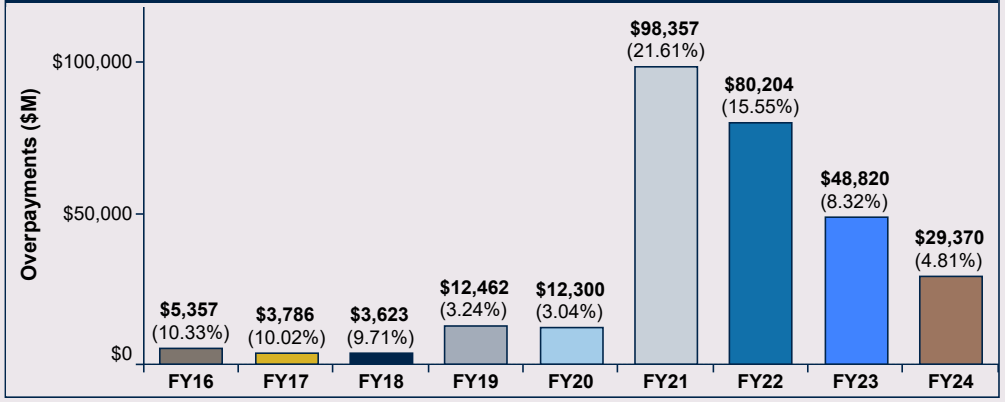
*Estimate based a sampling time frame starting 7/2022 and ending 6/2023

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 2025, CMS 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 maintains additional resource documents for the states, including a centralized moratoria page and provider enrollment directory. 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 a comprehensive overview of the National Plan & Provider Enumeration System and National Provider Identifier Requirements.	Mar-25
2	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-25
3	The Medicaid Integrity Institute developed an education and training strategy for states and territories.	Mar-25

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	Goals towards Reducing Overpayments	Status	ECD
1	Identify five states for in-person visits in 2025 (New Mexico, Louisiana, Florida, Wisconsin, and Connecticut) to provide targeted assistance with achieving compliance with all applicable provider enrollment, screening, and disclosure requirements, ultimately reducing payment error rates.	On-Track	Jun-25
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	Jun-25

	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 eligibility-related overpayments to be recovered through the Payment Error Rate Measurement program. Other payment errors are recoverable on a sample basis.	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 state's administrative process.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$29,370M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	Providers not screened with risk-based criteria before the claim payment; missing Type 1 National Provider Identifier for Ordering/Referring Provider; insufficient documentation for eligibility or redetermination; providers not responding 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.