Part C Improper Payment Measure (Part C IPM)
Fiscal Year 2022 (FY 2022) Payment Error Rate Results

For fiscal year 2022 (FY 2022), CMS reported an Improper Payment Measurement (IPM) for the Part C program based on calendar year 2020 (CY 2020) payments.[1] The CY 2020 Part C IPM payment error rate of 5.42% is not comparable to prior years because of refined policy and methodology enhancements that CMS implemented, as described below.

The CY 2020 estimated gross payment error for Part C is approximately $13.94 billion and the estimated net payment error is approximately $11.43 billion. **Table 1** presents the CY 2020 Part C Payment Error Estimate results.

Table 1: CY 2020 Part C Payment Error Estimates for FY 2022 Reporting

Type of Estimate	Part C Payment Error
Overpayments	$12,686,060,323
Underpayments	$1,254,763,569
Gross Payments in Error (error rate numerator)	$13,940,823,901
Part C Denominator (total Part C expenditures)	$257,174,116,535
Improper Payment Error Rate	5.42%
Net Payment in Error	$11,431,296,764
Net Payment Error Rate	4.44%
Portion of improper payments due to missing documentation*	$486,637,274
Portion of improper payments in Error Due to Missing Documentation	0.19%

*Missing documentation indicates no medical records were submitted to support the payments. Missing documentation is a subset of total overpayments.

Change to Part C IPM Error Rate Calculation Methodology for FY 2022

In FY 2022, CMS finalized its policy regarding treatment of spontaneous "additionals" in the improper payment rate calculation.[2] Diagnoses that were not submitted to the United States

[1] Information on the Part C Improper Payment Measure is available in the U.S. Department of Health and Human Services Agency Financial Report for FY 2022, and prior years' data are available at https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

[2] There are two major categories of "additionals": (1) new, or spontaneous, "additionals" identified as an artifact of CMS' IPM review and were not originally submitted by the Medicare Advantage (MA) Organization for payment purposes and (2) "additionals" within the same hierarchy as the audited CMS-Hierarchical Condition Categories (CMS-HCCs). "Additionals" occur during the medical record review process when the medical record submitted by the MA Organization supports a CMS-HCC that was never submitted for payment, or the medical record supports a more severe diagnosis within the same hierarchy as the CMS-HCC submitted for payment. Spontaneous "additionals" do not meet the definition of improper payment and are excluded under HHS' FY 2022 methodology.

(U.S.) Department of Health and Human Services (HHS) for payment have been excluded from the payment error calculation to get a true measure of payment error. In previous years, these potential payments were reflected in the underpayment rate and overall payment error calculation; however, including the spontaneous "additionals" in the gross underpayment portion resulted in an overstatement of the overall improper payment rate. The implemented policy for FY 2022 contributed to a decrease in the projected Part C improper payment rate, representing a new baseline improper payment rate for Part C and is not directly comparable with prior reporting years. Moreover, FY 2021 also represented a baseline due to various methodology changes, most significantly, a refined denominator calculation.

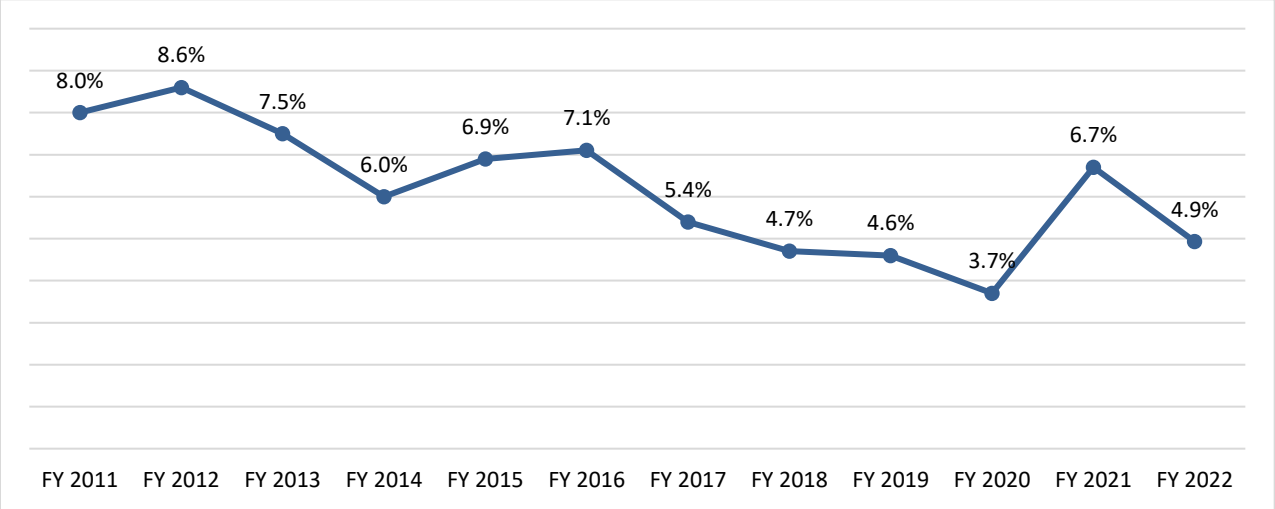
Findings on Overpayments

When Medicare Advantage (MA) Organizations report diagnoses to the CMS Encounter Data System (EDS) or the Risk Adjustment Processing System (RAPS) for payment, CMS uses the CMS Hierarchical Condition Category (CMS-HCC) Risk Adjustment model to assign CMS-HCCs and calculate a risk score for each enrollee. Overpayments occur when CMS-HCCs originally reported to EDS or the RAPS for payment are not supported by the medical record or are identified during medical record review as lower manifestations within the disease hierarchies of the CMS-HCC risk adjustment model. Overpayments also reflect instances when missing or insufficient documentation was provided to validate the CMS-HCC.

The primary overpayment category of FY 2022 Medicare Part C IPM consists of medical record discrepancies (4.74 percent) and a smaller portion of unknown payments resulting from missing or insufficient documentation to determine whether payment was proper or improper (0.19 percent).

Figure 1 presents the percentage of the payment error attributed to overpayments for FY 2011 through FY 2022.

Figure 1: Part C Population Error (%) from Overpayments, FY 2011 – FY 2022



Findings on Underpayments

Underpayments occur when CMS-HCCs of higher manifestations of the audited CMS-HCCs, in the same disease hierarchies of the CMS-HCC risk adjustment model, are identified during medical record review. The underpayments category of FY 2022 Medicare Part C IPM consists of medical record discrepancies (0.49 percent in underpayments).

Figure 2 presents the percentage of the payment error attributed to underpayment for FY 2011 through FY 2022.

Figure 2: Part C Population Error (%) from Underpayments, FY 2011 – FY 2022