Medicaid and CHIP 2015 Improper Payments Report

I. EXECUTIVE SUMMARY

The Improper Payments Information Act (IPIA) of 2002[1] requires that federal agencies annually review programs that they administer in order to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments;
- Submit those estimates to Congress; and
- Report on the actions the Agency is taking to reduce the improper payments.

Medicaid and the Children's Health Insurance Program (CHIP) have been identified as programs at risk for significant erroneous payments. The Centers for Medicare & Medicaid Services (CMS) measures Medicaid and CHIP improper payments annually through the **Payment Error Rate Measurement (PERM)** program. The PERM program reviews three groups of payments, known as components, which are:

1) Fee-For-Service (FFS) claims;
2) Managed care capitation payments; and
3) The payments resulting from eligibility determinations. As explained further herein, eligibility reviews for the current measurement cycle were suspended and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) was used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.[2]

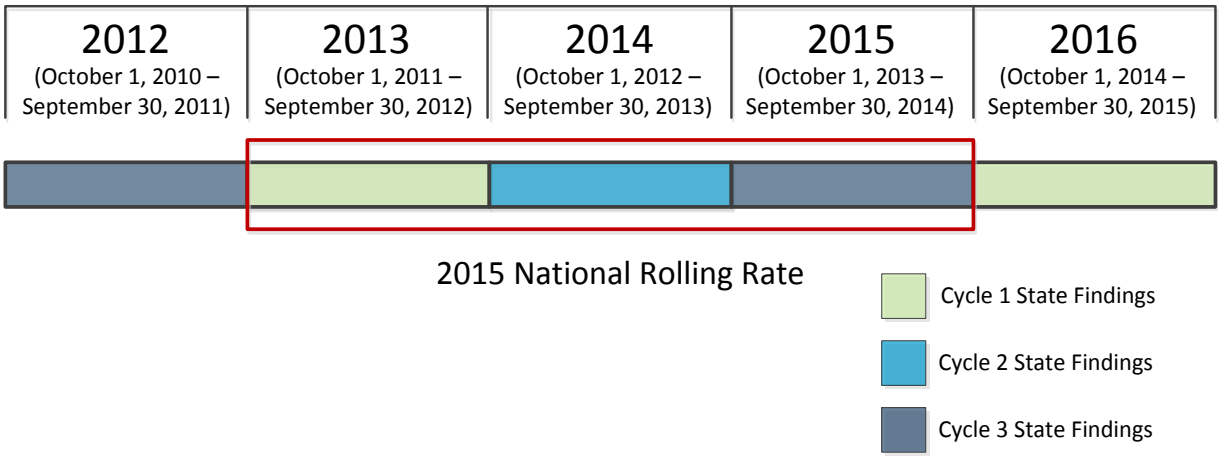
Improper payments are defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements or where documentation is missing or not available.

The PERM program uses a 17-state, three-year rotation cycle for measuring improper payments. This means that each Fiscal Year (FY), CMS measures a third of the states and all states are reviewed once every three years. Official Medicaid and CHIP program improper payment rates are rolling improper payment rates that include findings from the most recent three cycle measurements so that all 50 states and the District of Columbia are captured in one rate. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are added in (see Figure 1).

[1] Amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).

[2] The eligibility rates used as a proxy in the 2015 improper payment rate were the same eligibility rates used in the 2014 improper payment rate, comprising findings from states participating in the 2012, 2013, and 2014 PERM cycle measurements.

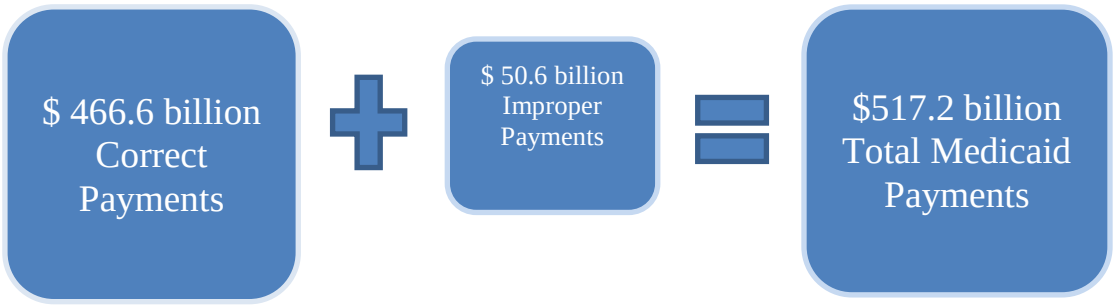
FIGURE 1. 2015 NATIONAL IMPROPER PAYMENT RATE COMBINES THE THREE MOST RECENT CYCLE MEASUREMENT FINDINGS



The following graphics provide an overview of the Medicaid and CHIP 2015 improper payment rates.

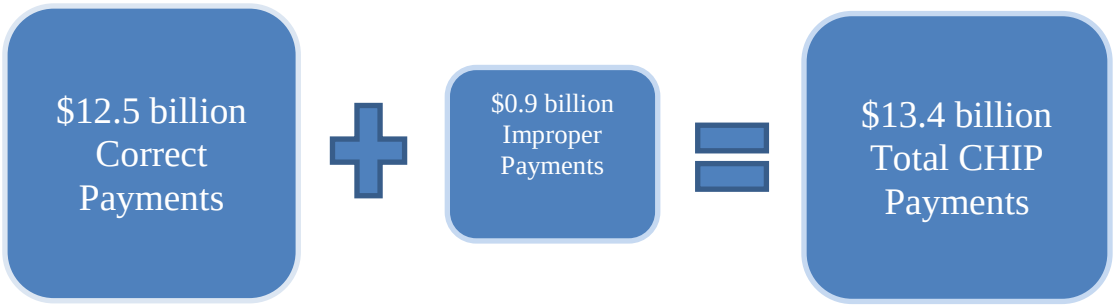
MEDICAID – 9.8 PERCENT IMPROPER PAYMENT RATE[3]

CORRECT PAYMENTS[4] + IMPROPER PAYMENTS = TOTAL MEDICAID PAYMENTS



CHIP – 6.8 PERCENT IMPROPER PAYMENT RATE

CORRECT PAYMENTS + IMPROPER PAYMENTS = TOTAL CHIP PAYMENTS



[3] As reported in the FY 2015 Agency Financial Report, the 2015 Medicaid improper payment rate was reported as 9.78 percent. This report rounds that rate and other rates for ease of comparison with rates from previous years.

[4] For purposes of this report, correct payments are considered total Medicaid/CHIP payments minus payments considered an improper payment as identified through PERM. Please note that instances of fraud or other problems not discerned during the PERM review could still be present. In addition, the figures presented on this page and throughout the report represent Federal and State combined outlays and combined improper payment estimates, unless otherwise noted.

Table 1.1 summarizes the 2015 national Medicaid improper payment rate findings and projected improper payments by component.

TABLE 1.1. 2015 NATIONAL MEDICAID IMPROPER PAYMENT RATES

Component	Improper Payment Rate	Total Projected Improper Payments ($billions)	Federal Share Projected Improper Payments ($billions)
MEDICAID			
FFS	10.6%	$35.4	$20.3
Managed Care	0.1%	$0.2	$0.1
Eligibility*	3.1%	$16.1	$9.2
Overall[5]	9.8%	$50.6	$29.1
* Note: Eligibility reviews were suspended for the current measurement cycle and eligibility results from the most recent cycles prior to 2015 are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.			

Table 1.2 summarizes the 2015 national CHIP improper payment rate findings and projected improper payments by component.

TABLE 1.2. 2015 NATIONAL CHIP IMPROPER PAYMENT RATES

Component	Improper Payment Rate	Total Projected Improper Payments ($billions)	Federal Share Projected Improper Payments ($billions)
CHIP			
FFS	7.3%	$0.3	$0.2
Managed Care	0.4%	$0.0	$0.0
Eligibility*	4.2%	$0.6	$0.4
Overall	**6.8%**	**$0.9**	**$0.6**
* Note: Eligibility reviews were suspended for the current measurement cycle and eligibility results from the most recent cycles prior to 2015 are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.			

The Medicaid improper payment rate increased from 6.7% in 2014 to 9.8% in 2015. The 2015 CHIP improper payment rate of 6.8% is also higher than the 2014 rate of 6.5%. The increases in both the Medicaid and CHIP improper payment rate were driven by increases specifically in FFS improper payments due to states needing additional time to comply with new requirements, as further described below. Despite the rate increase, it is important to note that the 2015 Medicaid and CHIP rates do not necessarily constitute a decline in state performance. Rather, the states are being reviewed under the new, stricter requirements, which did not previously deem these instances as errors. While these requirements will ultimately strengthen the integrity of the program, increases in improper payment rates often occur following the implementation of new policies or revisions to current policies as it

[5] Overall projected improper payments are based on the overall improper payment rate with respect to the overall payments. Note that the overall improper payment rate is the claims improper payment rate (combined FFS and managed care improper payment rates) combined with the eligibility improper payment rate minus any overlap between the two. Therefore, the improper payments from the components may not sum to the overall improper payments.

takes time and money for states to make systems changes to comply. Analysis of factors heavily influencing the improper payment rate, known as drivers, indicates that both Medicaid and CHIP improper payment rates would have decreased if the review criteria had not been updated to reflect recent policy changes.

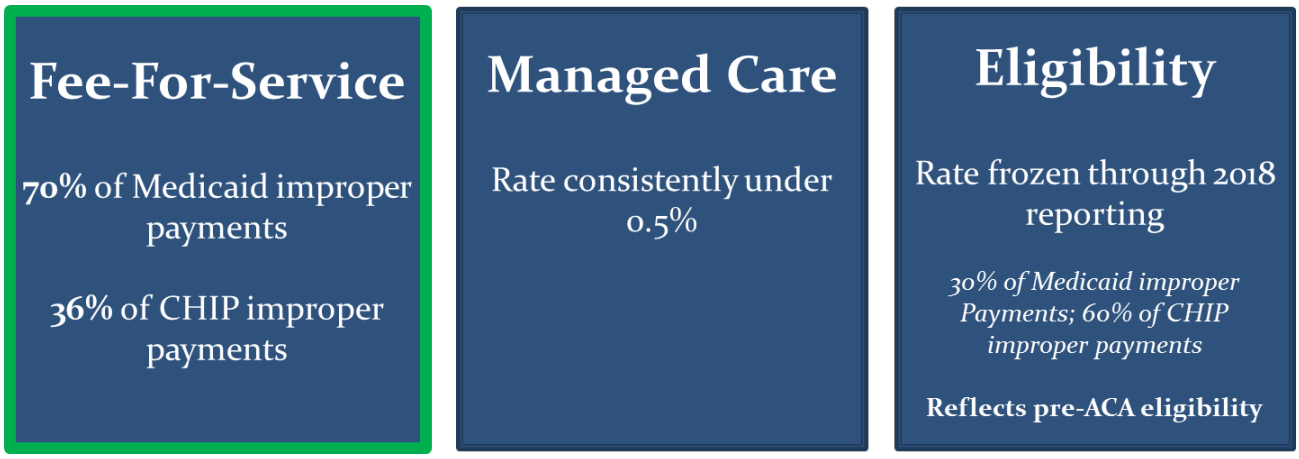
Further, these errors do not necessarily represent payments to illegitimate providers who should not have been enrolled in Medicaid or CHIP and do not necessarily represent examples of abuse or fraud. Rather, the majority of erroneous payments represented situations where information required for payment was missing from the claims or states did not follow the appropriate process for enrolling providers. Had such information been on the claims and/or had the state followed the correct enrollment process, the claims may have been payable.

In 2014, Medicaid and CHIP improper payment rates reflected the first group of 17 states measured under these requirements and, as a result, the Medicaid improper payment rate increased for the first time since 2010. The 2015 Medicaid and CHIP improper payment rates reflect the second group of 17 states measured under these requirements, for a total of 34 states. In 2016, Medicaid and CHIP improper payment rates will reflect the measurement of the final group of 17 states subject to the requirements. CMS expects to see a decrease in these errors in the following years due to corrective actions as states are measured again.

The first baseline error rate to measure new requirements in all 50 states and the District of Columbia will not occur until 2016. Therefore, CMS cautions against equating rate increases to improper payment regression before the baseline is established.

Figure 2 offers the 2015 improper payment drivers by component. As shown in the figure, the FFS rate is the clear driver of the Medicaid improper payment rate and is the only component that can currently be addressed by CMS and the states through corrective action, as the eligibility measurement has been suspended through 2018.

FIGURE 2. IMPROPER PAYMENT DRIVERS BY COMPONENT



Similar to 2014, the primary reason for 2015 improper payments was errors related to state difficulties bringing systems and processes into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider National

Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation of new requirements because it takes time for states to make systems changes required for compliance. Below, the specific drivers of the 2015 improper payments are described in more detail.

Delayed state implementation of the Affordable Care Act (ACA) requirements for Provider Enrollment and Risk-Based Screening

Payments were cited as improper when state Medicaid and CHIP claims processing systems paid claims that did not include referring/ordering providers' NPI, where referring/ordering providers were not enrolled in the Medicaid program as participating providers, and where newly enrolled providers were not screened in accordance with ACA risk-based screening criteria.

These errors are expected to decrease as states implement corrective actions including: updates to the claims processing system; improvements to provider enrollment processes for complete risk-based screening; and education of billing providers on claim submission requirements.

Delayed state implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 Transaction Standards

Payments were cited as improper when state Medicaid and CHIP claims processing systems paid electronically filed institutional claims (e.g., hospital and long term care services) that did not include the attending/rendering provider's NPI.

Billing providers are not submitting the required NPIs on electronically-submitted institutional claims and state Medicaid claims processing systems are not properly editing claims to reject those that do not meet this requirement. These errors are expected to decrease as states implement corrective actions to make the claims processing system changes needed and educate the billing providers on this requirement.

These requirements are designed to reduce the exposure of the program and its beneficiaries to fraudulent providers. Improving state compliance is foundational to program integrity and delivery system reform. CMS will refine and enhance the technical assistance provided to states and others to ensure compliance with regulations and reporting requirements that impact the improper payment rate. CMS believes these steps will lead to a lower rate of improper payments, while continuing to transform the health system to achieve better care, smarter spending, and healthier people.

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II. PERM PROGRAM BACKGROUND

The Improper Payments Information Act (IPIA) of 2002[6] requires federal agencies to annually review programs that they administer in order to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments;
- Submit those estimates to Congress; and
- Report on the actions the Agency is taking to reduce the improper payments.

The Centers for Medicare & Medicaid Services (CMS) measures Medicaid and CHIP improper payments annually through the **Payment Error Rate Measurement (PERM)** program. Improper payments are defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.

Overview of Medicaid and CHIP Programs

The Medicaid program was enacted in 1965 and its governing statutes are found at Title XIX of the Social Security Act ("Act") and CHIP was enacted in 1997 and its governing statutes are at Title XXI of the Act. Both programs provide health care coverage for low-income individuals and families. Under these federal authorities, each state partners with the federal government to enact Medicaid and CHIP programs for its residents. States and the federal government share responsibility for operating Medicaid and CHIP and CMS is the federal agency responsible for interpreting and implementing the federal Medicaid and CHIP statutes and ensuring that federal funds are appropriately spent. Although CMS provides this federal oversight, both programs are administered at the state level with significant state financing and states have a statutory obligation and fiscal interest in assuring program integrity.

While every state has operated both Medicaid and CHIP for many years, the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), significantly affected each program by adding new requirements, expanding eligibility, and offering additional federal funding to states for eligibility system updates and development. States continue to plan and implement major changes to their Medicaid and CHIP programs to comply with the ACA and to improve accountability and quality of care.

Accordingly, new PERM eligibility measurement regulations need to be promulgated to reflect the required changes states are making to their eligibility processes and systems. Therefore, for Fiscal

[6] Amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).

Year (FY) 2014 – 2017 (Cycles 3, 1, 2, and 3 respectively), which will be reported in 2015 – 2018, CMS is suspending the formal eligibility component of PERM. While CMS develops the new eligibility review methodology, it is using the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) as a proxy in calculating the overall Medicaid and CHIP improper payment rate calculation, along with data from the PERM FFS and managed care payment reviews that continue as normal during this period. The proxy rate will only have an impact on the national-level improper payment rates, as all state-specific rates will be comprised of only the PERM FFS and managed care components until eligibility review is resumed for reporting in 2019. In lieu of the suspended PERM eligibility review, CMS has required states to conduct Medicaid and CHIP Eligibility Review Pilots to continue to assess and drive down eligibility-related errors.

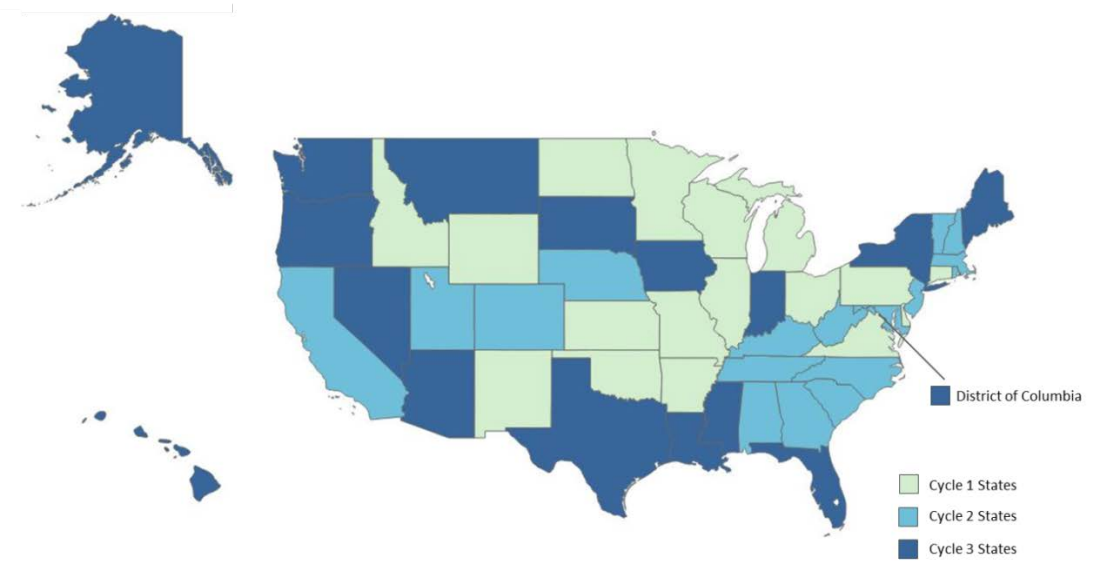
PERM Program Objectives

The PERM program requires a joint effort between CMS and the states to calculate the Medicaid and CHIP program improper payment rates. To meet this objective, the PERM program uses a 17-state, three-year rotation cycle to measure improper payments. This means that each FY, CMS measures a third of the states and all states are reviewed once every three years. The states in each cycle are shown in Table 2.1 below as well as in Figure 3, which provides the state cycle information graphically.

TABLE 2.1. STATES IN EACH CYCLE

Cycle 1	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3	**Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington**
Note: States measured in the most recent cycle for the 2015 improper payment rate (i.e., Cycle 3) are in **bold**.	

FIGURE 3. STATES IN EACH CYCLE

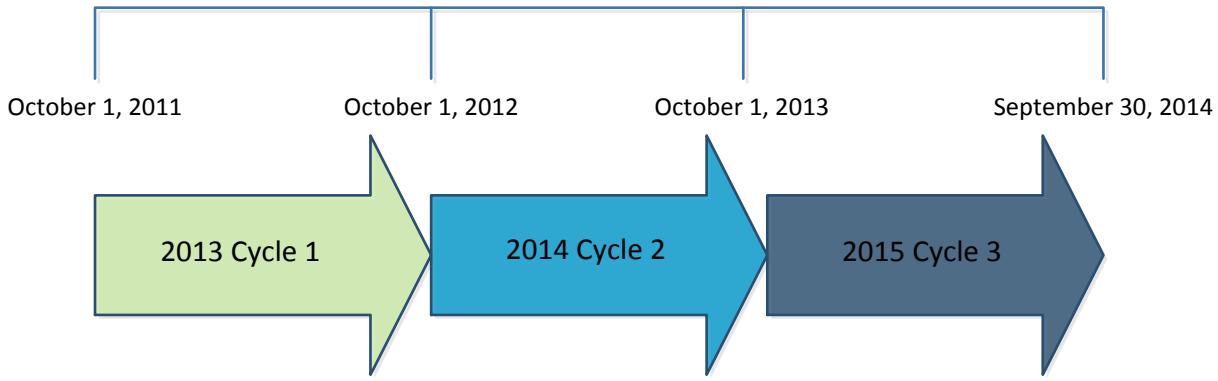


III. PERM METHODOLOGY

The measurement of improper payments in Medicaid and CHIP is a complex, multi-step process. Each state has considerable flexibility in structuring its Medicaid and CHIP programs, resulting in variation even among programs that are similar in size and population. However, the PERM methodology supports a consistent measurement across states and programs through standardized data collection, rigorous quality control review of submitted data, and a sampling methodology that ensures a statistically valid random sample is used to calculate improper payments. The resulting improper payment rate reflects all Medicaid and CHIP payments matched with federal funds during each of the three review periods encompassed in each reporting year.

It is important to note that, given the time necessary to collect payment data, select samples, complete reviews, and calculate rates, the 2015 Medicaid and CHIP improper payment rates represent a review period (i.e., the time period from which the sampled claims were actually paid) spanning FY 2012 through FY 2014. The three review periods displayed in Figure 4, below, comprise reporting year 2015.

FIGURE 4. PERIOD UNDER REVIEW FOR THE 2015 PERM MEDICAID AND CHIP NATIONAL IMPROPER PAYMENT RATES



PERM measures improper payments in three components of both Medicaid and CHIP, which are:

1. Fee-For-Service (FFS) claims;
2. Managed care payments[7], and
3. The payments resulting from eligibility determinations. Eligibility reviews for the current measurement cycle are suspended and eligibility results from the most recent cycles prior to

[7] For PERM, managed care reviews look only at the capitation payments made by states to managed care organizations, not payments made by the plans to providers.

2015 are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology. [8]

CMS uses federal contractors to review a random sample of FFS and managed care payments. The section below describes each step of the calculation process and presents high-level review of findings for the 2015 Medicaid and CHIP improper payment rates.

Sample Selection

The first step in the PERM process is selecting a random sample for each component. The federal Statistical Contractor takes random samples of FFS and managed care payment data submitted by states on a quarterly basis.[9]

This sampling methodology follows the Office of Management and Budget's (OMB) guidance and meets all its requirements. State-specific sample sizes are calculated for each program (Medicaid and CHIP) and component (FFS, managed care, and eligibility) based on the results from the state's previous PERM cycle using the state-specific improper payment rate and standard error.[10] The maximum sample size is set at 1,000 for each component in each state. Table 3.1 presents the sample sizes from all 17 states in the most recent cycle years.

TABLE 3.1. SAMPLE SIZES BY CYCLE AND CLAIM TYPE[11]

Claim Type	2013 Cycle 1	2014 Cycle 2	2015 Cycle 3
MEDICAID			
FFS	6,696	6,119	7,599
Managed Care	3,214	3,390	3,110
Eligibility Active	8,286	9,794	N/A
Overall	**18,196**	**19,303**	**10,709**

[8] The eligibility rates used as a proxy in the 2015 improper payment rate were the same eligibility rates used in the 2014 improper payment rate, comprising findings from states participating in the 2012, 2013, and 2014 PERM cycle measurements.

[9] When a FFS or managed care component for a state accounted for less than two percent of the state's total Medicaid or CHIP expenditures, the state's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation happened for FFS and managed care claims in six states for Medicaid and in three states for CHIP across the three cycles.

[10] Standard error is a measure of variability for the estimated improper payment rate. Attempting to meet a +/- 3 percentage point margin of error at the 95% confidence interval for state level improper payment rates ensures that the national improper payment rate will surpass IPERIA national requirements.

[11] Note that states also select a negative eligibility sample with a sample size based on the prior cycle negative case rate. However, since the negative eligibility improper payment rate has no associated payments and is not included in the payment weighted rolling rate, the sample sizes are not provided in Table 2.2.

Claim Type	2013 Cycle 1	2014 Cycle 2	2015 Cycle 3
CHIP			
FFS	7,993	7,779	5,934
Managed Care	3,906	2,869	3,121
Eligibility Active	8,621	8,268	N/A
Overall	**20,520**	**18,916**	**9,055**
Note: Eligibility reviews are suspended for the most recent cycle and eligibility results from the most recent cycles prior to 2015 are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology. Therefore, no eligibility sample sizes are reported for 2015.			

Once the samples are selected, the claims and cases are reviewed for accuracy. The review process, including each type of review and the implications for the state, is described in the following sections.

Data Processing Reviews

To validate that claims are processed correctly based on information found in the state's claims processing system, a federal contractor conducts data processing reviews on each sampled FFS claim and managed care payment. A data processing error is a payment error that results in an overpayment or underpayment and that could have been avoided through the state's Medicaid Management Information System (MMIS) or other payment system.

Incorrect programming, missing provider information, and lack of edits in states' claims processing systems are common causes of data processing errors. State systems are programmed to process claims according to regulation and policy and they prevent improper payments by discerning and capturing required information or rejecting incorrectly submitted claims. System edits are also designed to prevent payments for such claims that contain a gender conflict (claim for a male beneficiary for a procedure that is only relevant for female beneficiaries) or payment for services dated after the end of eligibility/death of a beneficiary. With the passage of ACA and the resulting new requirements for Provider Enrollment and Screening, states must focus efforts on making systems changes to comply with these new requirements.

Claims not processed through a state's MMIS (such as health insurance premium payments) are subject to validation through a paper audit trail, state summary, or other proof of payment. Below, both FFS and managed care data processing reviews are discussed in more detail.

FFS Data Processing Reviews

Medicaid and CHIP claims payments are reviewed to determine whether the payment was made:

- In the correct amount;
- For the correct and eligible beneficiary; and
- To the correct and enrolled provider.

During the data processing FFS review, the following items in the states' claims processing and eligibility systems, or paper records, are examined with respect to each sampled claim, including:

- The aid category and eligibility of the beneficiary for the date of service to ensure the beneficiary had an approved eligibility span that covered the date of service of the payment under review;
- Whether the service should have been covered by a Medicaid/CHIP managed care plan;
- Whether the service was preauthorized, when required;
- Whether any other type of insurance, including Medicare, should have paid for the service;
- Re-pricing each claim manually to verify the payment was for the correct amount;
- Checking for adjustments made within 60 days to the payment under review and making sure the payment does not duplicate a previously paid claim;
- Whether the billing, servicing, and referring/ordering providers were enrolled in Medicaid/CHIP and had valid medical licenses (when required); and
- For providers newly enrolled after March 24, 2011, if risk-based screening was conducted prior to enrollment, including completion of all database checks and other requirements for the correct risk level as outlined in regulation.

Managed Care Data Processing Reviews

Capitation payments made to risk-based managed care health plans are also sampled for data processing reviews. Managed care payments may be fully or partially capitated and include:

- Premiums for "full risk" indemnity insurance, including payments to Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), and Health Insurance Organizations (HIOs);
- Premiums for partial risk insurance contracts, such as Pre-paid Inpatient Health Plans (PIHPs) and Pre-paid Ambulatory Health Plans (PAHPs);
- Payments to service-specific providers paid on a capitated/at-risk basis (e.g., pharmacy, mental health);

- Condition-specific managed care payments for special needs beneficiaries (e.g., at-risk payments for HIV/AIDS); and
- Certain non-capitated, beneficiary-specific payments made to managed care organizations such as delivery supplemental payments or "kick" payments, which are paid at a negotiated rate.

A number of elements are reviewed, including the beneficiary's eligibility aid category for the coverage period (month) of the payment and the county or location of the beneficiary to determine the geographical service area. The health plan receiving the payment must be approved as a health plan for the geographical service area where the beneficiary resides. The health plan contracts are also reviewed to determine:

- Proration policy (when eligibility or coverage starts or ends mid-month);
- Rate cells; and
- Contracted rates for the coverage period.

Rate cells may be based on:

- Age;
- Sex;
- County of residence;
- Aid category;
- Medicare coverage; or
- Other factors as determined by state policy.

The beneficiary's circumstances must match the assigned rate cell. The payment is also reviewed to ensure there are no duplicates and to verify adjustments made within 60 days of the original payment.

Medical Reviews

Medical reviews are conducted on the FFS claims identified as part of the sample. The PERM program requests the associated medical records and other pertinent documentation from the provider that submitted the claim. Records are requested and reviewed for the majority of FFS claims, with the exception of the following[12].

[12] Four FFS claims sampled in the 2013 measurement (from Cycle 2 FY 2012) inadvertently did not get medical review. CMS elected to drop the claims from the Medicaid and CHIP samples. Dropping the affected claims did not bias the improper payment rates since the claims were randomly distributed across states and so few claims were affected. Calling the claims correctly paid would have understated the improper payment rate and determining them to be in error would have overstated the improper payment rate. Dropping the claims from the sample allowed the remaining sampled claims that were fully reviewed to estimate the correct improper payment rate. The HHS Office of the Inspector General (OIG) also presented the option of imputing a medical review improper payment rate on these claims which resulted in the same improper payment rate as dropping the claims. CMS has put steps in place to prevent these errors from occuring in future cycles. For the 2015 measurement, all other claims sampled that required medical review, were approrpriately reviewed.

- Zero paid claims: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles and patient liability, or other causes.
- Fixed payments: Some payments made by the states for a beneficiary are not tied to a service provided. For example, primary care case management monthly payments to a Primary Care Provider or other set amount payments made on a per member per month basis regardless of whether a service was provided.
- Medicare premium payments: Medicare premium buy-in payments are paid by the state for certain dual eligible beneficiaries. For these individuals, the state pays the Medicare Part B or sometimes, the Part A premium, for the recipient.

  Medicare crossover claims: A Medicare crossover claim is a claim that was first processed by Medicare for a beneficiary that is dually eligible for Medicare and Medicaid and has been passed along to the state Medicaid agency to pay any portion the Medicaid benefit plan will cover. The Medicaid payment may cover all coinsurance and deductibles or only up to the Medicaid allowed amount.
- Denied claims: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and not approved for payment in whole or in part.

All requests for medical records are documented in a letter that is either faxed or mailed to the providers. Prior to sending the first medical record request, the federal contractor calls the provider to explain the purpose of the request and verifies the provider's contact information. If the provider does not respond to the initial request, the contractor sends reminder letters at 30, 45, and 60-day increments. Should no documentation be received within 75 days of the first request, the claim is cited as an improper payment due to a "no documentation error." When documentation is received, should a medical review of the record determine that the documentation is insufficient to support the claim, additional documentation requests for specific documents missing are faxed or mailed to the providers. If the provider does not respond to the initial request, the contractor sends a reminder letter at the 7th day interval. Should no additional documentation be received within 14 days of the first request, the claim is cited as an improper payment due to an "insufficient documentation error."

Any documentation received after the 75th day (original record requests) and/or after the 14th day (additional documentation requests) is considered late. If the PERM contractor receives late documentation prior to the cycle cut-off date, the records are reviewed in the same fashion as if the documentation was submitted timely. The cut-off date is typically July 15th following the measurement year, which is the deadline for submitting information for review. All information submitted in time is reviewed and findings are included in the national improper payment rate.

Once the medical record is received, FFS claims undergo a medical review to determine whether the claim was paid properly. A medical review error is a payment error that is determined by analyzing the claim based on:

- The medical documentation submitted;
- Relevant federal and state statutes, regulations, and policies; and
- Provider manuals and guidelines.

These reviews are conducted to ensure:

- Documentation supports the claims;
- Services performed were medically necessary;
- Services were provided in the same way as ordered and billed;
- Federal and state statutes, regulations, and policies and guidelines were followed; and
- Claims were correctly coded.

Difference Resolution and Appeals Process

When the federal contractor identifies an error, it notifies the state, which then has an opportunity to review the documentation associated with the payment and, if it disagrees with the contractor's conclusion, may dispute the finding. The contractor performs an independent difference resolution review to consider the state's information and to make their final decision.

Should the state disagree with the contractor's final decision, it may appeal to the PERM program within CMS.

Error findings that are not challenged by the state or upheld following the difference resolution and appeal process are included in the improper payment rate calculation. When a claim has payment errors in both the data processing review and medical review, the total error amount will be no greater than the total paid amount for the claim. However, for cases of underpayment or zero paid claims, the total error amount may exceed the total paid amount.

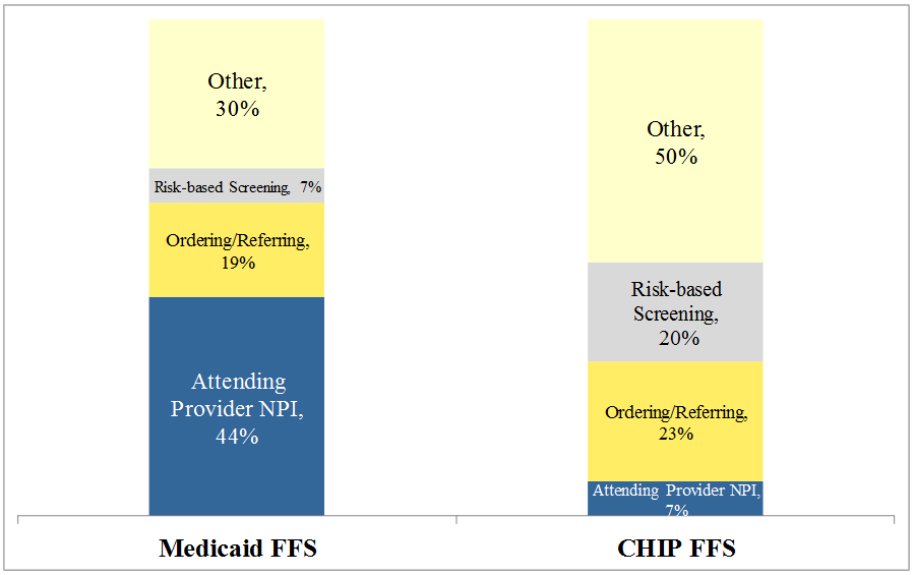
IV. FEE-FOR-SERVICE RESULTS

Fee-For-Service (FFS) reviews include: 1) payments by claims processing systems, and 2) documentation in the medical records to support claims as billed. The Medicaid FFS 2015 improper payment rate based on claims processing is 8.8%, while the CHIP claims processing rate is 4.6%. The 2015 medical record improper rate for Medicaid is 2.2% and the CHIP rate is 2.9%.

As shown in Figure 5, below, 71% of the Medicaid FFS rate and 50% of the CHIP FFS rate are attributable to three specific drivers related to state non-compliance with the following new requirements, including:

- HIPAA standard that requires Attending Provider NPI on all electronically filed institutional claims;
- All referring/ordering providers are required to be enrolled in Medicaid and the NPI must be on the claim; and
- States are required to screen providers under a risk-based screening process prior to enrollment.

FIGURE 5. MEDICAID AND CHIP FFS 2015 IMPROPER PAYMENT DRIVERS



- Attending Provider NPI not listed on institutional claims was a larger issue for Medicaid than CHIP. The Medicaid population generally has more significant and severe health issues than the CHIP population, resulting in a higher number of more expensive institutional claims subject to the HIPAA requirement.

- Risk-based screening was a more significant issue for CHIP, specifically for states with standalone programs. States can create their CHIP programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. Standalone programs generally operate under a separate set of federal rules and these programs required more intensive technical assistance to comply with ACA standards.
- Errors classified as "other" include primarily provider documentation errors in both Medicaid and CHIP.

Data Processing Reviews

MEDICAID

Table 4.1 identifies the number of payment errors by error type as well as the corresponding projected improper payments for Medicaid FFS data processing errors.

TABLE 4.1. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN MEDICAID FFS DATA PROCESSING

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Medicaid						
Non-covered Service	1,579	92.2%	$4,790,089.4	98.9%	$28,487.4	96.7%
Data Entry Error	4	0.2%	$1,908.5	0.0%	$390.6	1.3%
Third-party Liability	12	0.7%	$9,714.0	0.2%	$271.2	0.9%
Pricing Error	91	5.3%	$21,614.7	0.4%	$123.1	0.4%
Duplicate Item	5	0.3%	$9,907.1	0.2%	$72.5	0.2%
Logic Edit	5	0.3%	$331.2	0.0%	$54.8	0.2%
FFS Claim for Managed Care Service	9	0.5%	$5,287.5	0.1%	$32.8	0.1%
Administrative/Other	8	0.5%	$5,070.7	0.1%	$19.2	0.1%
Managed Care Payment Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Rate Cell Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**1,713**	**100.0%**	**$4,843,923.1**	**100.0%**	**$29,451.6**	**100.0%**

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.

For Medicaid claims sampled, non-covered service represented the vast majority of the total Medicaid FFS data processing projected improper payments at 96.7%.

Non-Covered Service Errors

PERM cites a non-covered service error when the beneficiary is ineligible for the service or the provider is ineligible to bill, provide, or order the service. Non-covered service errors were primarily due to state non-compliance with HIPAA claims standards and ACA provider enrollment requirements. Examples of these errors are provided below.

Non-Covered Service (Attending or rendering provider NPI) Error Example: A hospital claim was submitted without the individual attending physician's National Provider Identifier (NPI) on the claim. Electronic institutional claims filed on or after July 1, 2012 are required to include the attending physician's NPI on the claim to comply with the HIPAA 5010 transaction standards. This state's claims payment system was set to override the attending provider NPI requirement for diagnosis codes indicating an emergency. The state was not in compliance with federal requirements because the system was set to override edits for required information. Therefore, this claim resulted in an overpayment error.

Non-Covered Service (Referring/ordering provider NPI) Error Example: A pharmacy claim processed by the state's Pharmacy Benefit Manager (PBM) did not capture the provider's NPI on the claim submitted for payment. The PBM requires the physician's Drug Enforcement Administration (DEA) number to process claims and does not require the NPI nor edits to capture the NPI of the prescribing provider on claims. The prescribing provider's DEA number is not an accepted identifier to comply with the federal regulation at 42 CFR § 455.440 that provides the state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the NPI of the physician or other professional who ordered or referred such items or services. The NPI is required, regardless of whether the state uses its own MMIS system for processing claims or contracts with a PBM to process the state's pharmacy claims. The ordering provider NPI was not listed on this claim, therefore the claim resulted in an overpayment error.

Non-Covered Service (New provider not enrolled using risk-based screening criteria) Error Example: A Nursing Facility submitted a claim for 30 days of room and board. The state enrolled the billing provider in Medicaid effective June 1, 2013, but did not properly screen the provider in accordance with 42 CFR §§ 455.436 and 450. Federal database checks require the state to check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), and the Excluded Parties List System (EPLS) (which is now part of the System for Award Management (SAM)). The state must also conduct database checks on a pre- and post-enrollment basis. The state was unable to provide proof that the Death Master File and verification of the provider's license were completed prior to enrolling the provider and the System for Award Management and National Plan and Provider Enumeration System checks were not completed until after enrollment. Therefore, this claim was determined to be an overpayment error.

Pricing Errors

Pricing errors do not rise to the frequency or dollar amount of non-covered services errors, but pricing errors are commonly found in every cycle of the PERM review. A pricing error can occur for several reasons, including:

- An error in the system programming or a manual calculation that is incorrect;
- The rate or one component of the rate computation may have been entered incorrectly, resulting in an incorrect payment; or
- A copayment is deducted when it does not apply to the beneficiary or type of claim.

An example of a pricing error is provided below.

Pricing Error Example: A physician submitted a professional claim for a newborn visit. This claim paid less than the published rate due to a system calculation error. The sampled claim line paid $163.71, when the correct fee schedule payment was $163.72, resulting in a $0.01 underpayment. The components in the pricing equation are required to be calculated four (4) digits past the decimal point, however, when the state vendor's claims system was implemented, this equation was programmed to calculate two (2) digits past the decimal, causing the system to pay a different rate than published for this service. This claim was determined to be an underpayment.

CHIP

Table 4.2 identifies the count of payment errors by error type as well as the corresponding projected improper payments for CHIP FFS data processing errors.

TABLE 4.2. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN CHIP FFS DATA PROCESSING

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
CHIP						
Non-covered Service	1,552	82.8%	$2,108,418.1	90.8%	$188.0	90.6%
Administrative/Other	19	1.0%	$16,915.7	0.7%	$5.1	2.4%
FFS Claim for Managed Care Service	8	0.4%	$63,574.1	2.7%	$3.9	1.9%
Pricing Error	193	10.3%	$45,455.5	2.0%	$3.7	1.8%
Third-party Liability	31	1.7%	$2,022.9	0.1%	$3.5	1.7%
Logic Edit	17	0.9%	$471.3	0.0%	$1.2	0.6%
Duplicate Item	15	0.8%	$52,258.9	2.3%	$1.1	0.5%
Data Entry Error	39	2.1%	$32,294.4	1.4%	$1.0	0.5%

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Managed Care Payment Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Rate Cell Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**1,874**	**100.0%**	**$2,321,410.8**	**100.0%**	**$207.5**	**100.0%**
Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.						

As with Medicaid, non-covered service errors represented the vast majority of the total CHIP FFS data processing projected improper payments at 90.6%. These errors were primarily due to state system non-compliance with HIPAA and ACA provider requirements.

Non-Covered Service Errors

Non-covered service errors were primarily due to provider and/or state non-compliance with HIPAA claims standards and state non-compliance with ACA provider enrollment requirements. Examples of these errors are provided below.

Non-Covered Service (Referring/ordering provider NPI) Error Example: A pharmacy submitted a claim for medication and the state pharmacy vendor paid the claim on December 31, 2013. The claim did not include the NPI of the prescribing physician, as required to comply with federal regulations at 42 CFR § 455.440, which requires all referring/ordering (includes prescribing) provider NPIs to be documented on all claims. The prescribing provider identifier accepted by the pharmacy vendor was the physician's DEA number and the vendor did not screen for the NPI before paying the claim as required. The NPI is required, regardless of whether the state uses its own MMIS system for processing claims or contracts with a pharmacy vendor to process the state's pharmacy claims. The ordering provider NPI was not listed on this claim, therefore the claim resulted in an overpayment error.

Non-Covered Service (Referring/ordering provider not enrolled) Error Example: A CHIP provider submitted a laboratory claim. The state failed to assure through system edits that the referring provider for this laboratory claim was an enrolled provider with the state CHIP program. 42 CFR § 455.410(b) requires all ordering or referring physicians or other professionals providing services under the State Plan to be enrolled as a participating provider. Because the provider was not enrolled, this claim was determined to be an overpayment.

Non-Covered Service (New provider not enrolled using risk-based screening criteria) Error Example: The attending provider on a hospital claim was enrolled in the CHIP program on February 17, 2013, but the state did not enroll the provider according to regulations. Federal regulation at 42

CFR § 455.410 requires the state Medicaid/CHIP agency to screen all new provider applications after March 24, 2011. Pursuant to 42 CFR §455.436, the required screening includes checking the Social Security Administration's Death Master File, NPPES, EPLS, and LEIE, which the state failed to do before enrolling the provider. Therefore, this claim was cited as an overpayment error.

Pricing Errors

Pricing errors do not rise to the frequency or dollar amount of non-covered services errors, but are still commonly found in every cycle of the PERM review. Below is an example of a pricing error.

Pricing Error (Co-pay should not have been deducted) Error Example: The state claims system processed a claim for a pregnancy-related service and deducted a copay from the beneficiary that should not have been deducted. Per 42 CFR § 447.56(a)(vii) (formerly codified at 42 C.F.R. § 447.53(b)(2)), pregnancy-related services furnished to pregnant women may not provide for impositions of a deductible, coinsurance, copayment, or similar charge. The state's claims processing system should have edited against the pregnancy aid code and prescription and determined the beneficiary was exempt from the co-pay. States are responsible for making sure co-pays are not deducted for pregnancy-related services. Because the co-pay was deducted, the claim was determined to be an underpayment error.

Medical Reviews

MEDICAID

Table 4.3 shows the medical review errors by error type and the projected improper payments for Medicaid FFS.

TABLE 4.3. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN MEDICAID FFS MEDICAL REVIEW

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Medicaid						
Insufficient Documentation	225	43.5%	$180,651.6	49.2%	$3,498.2	47.3%
No Documentation	161	31.1%	$87,541.8	23.8%	$1,250.7	16.9%
Policy Violation	62	12.0%	$60,750.1	16.5%	$1,111.6	15.0%
Administrative/Other	18	3.5%	$3,419.0	0.9%	$581.4	7.9%
Number of Unit(s) Error	25	4.8%	$3,210.6	0.9%	$559.3	7.6%
Procedure Coding Error	11	2.1%	$1,420.0	0.4%	$250.6	3.4%
Diagnosis Coding Error	9	1.7%	$29,323.1	8.0%	$132.2	1.8%
Unbundling	3	0.6%	$7.7	0.0%	$3.0	0.0%

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Medically Unnecessary	3	0.6%	$1,226.0	0.3%	$2.4	0.0%
Total	**517**	**100.0%**	**$367,549.9**	**100.0%**	**$7,389.4**	**100.0%**
Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.						

Documentation errors due to providers submitting either no or insufficient documentation represented 64.2% of the total Medicaid FFS medical review projected improper payments. Policy violations, primarily due to pharmacies not maintaining required signature logs for evidence of medication receipt and not recording beneficiaries' acceptance or refusal of drug counseling, accounted for 15.0% of the total Medicaid FFS medical review project improper payments.

Insufficient Documentation Errors

Insufficient Documentation means there is inadequate documentation to support the service billed. Errors are cited when the provider supplies inadequate documentation to determine the medical necessity of the claim or the medical records do not document the tasks performed on the date of service (DOS) billed. Examples of these errors are provided below.

Insufficient Documentation Error Example: A nursing facility submitted a claim. The physician's 60-day visit progress note to support billed services for sub-acute care for sampled dates of service was requested to validate the claim, but it was not provided. The provider indicated the physician's progress note was not present for the dates of service under review. The documentation submitted included the medication administration record, care plan, and hospital discharge summary. Nursing facility physician history and physical notes were submitted as well but they were both dated more than two months prior to the sampled dates and were therefore not applicable to the sampled dates of service. The documentation submitted by the nursing facility was insufficient to support the claim and resulted in an overpayment.

Insufficient Documentation Error Example: A home and community-based provider submitted a personal care services claim. The record submitted included a personal care assessment service plan dated more than a year prior to the sampled dates of service and a letter stating it was the only authorized service plan available. The provider did not submit the approved plan of care covering the dates of service under review to support the claim. Therefore, the documentation submitted was insufficient to support the claim and resulted in an overpayment.

Table 4.4 identifies the types of documents that are most commonly missing when insufficient documentation errors are cited in Medicaid.

TABLE 4.4. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2015 MEDICAID IMPROPER PAYMENT RATE SAMPLE

Documentation Type	Total Count
Treatment Plan/Plan of Care	40
Physicians' Orders	35
Progress Notes	29
Flowsheets and Worksheets	20
Attendance Logs	19
Initial Intake Assessment/Reassessment	16
Pharmacy Signature Log/Proof of Delivery	15
Encounter/Office Visit Notes	13
Procedure Record	13
Laboratory/Diagnostic Tests and Reports	12
Start and Stop Times	11
Timesheets	8
Medication Administration Record	7
Beneficiary Signature/Proof of Service Receipt	6
Copy of Valid Prescription	5
Immunization Record	4
Physician Certification/Re-Certification	4
Dental Chart	3
Evaluation and Management/Counseling Notes	2
Case Management Care Plan	1
Psychiatric Certification for Admission	1
Psychological Testing	1
Note: Multiple documents could have been missing for the same medical record.	

Policy Violation Errors

Policy violation errors are cited when the medical documentation submitted does not comply with state policy documentation requirements. Below is an example of a policy violation error.

Policy Violation Error Example: A pharmacy provider submitted a claim. The provider furnished original documentation including the prescription, patient information, inspection report, and refill history/profile, but not the pharmacy signature log, which the pharmacy did not have on file, to

support the claim for the prescribed drug for the sampled date of service. Since the signature log was not submitted as required by the state's policy, this claim resulted in an overpayment error.

No Documentation Errors

No Documentation errors are cited when the provider fails to respond to repeated attempts to obtain supporting documentation or the provider states that it does not have the requested records. Below is an example of a no documentation error.

No Documentation Error Example: A home health agency submitted a claim, but failed to submit a record to support personal care services that were billed and paid. Since no documentation was submitted to support the claim, it was determined to be an overpayment.

Table 4.5 identifies the most common types of providers that are cited for no documentation errors in Medicaid.

TABLE 4.5. COUNT OF PROVIDER TYPES THAT DID NOT SUBMIT DOCUMENTATION IN THE 2015 MEDICAID IMPROPER PAYMENT RATE SAMPLE

Provider Type	Total Count
Home Health Services	23
Day Habilitation and Waiver Programs, Adult Day Care and Foster Care	22
Physician Clinic Services / Physicians & Other Licensed Practitioners' Services	10
Laboratory, X-ray and Imaging Services	6
Hospital Services	5
Dental and Oral Surgery Services	5
Personal Care Services	5
Nursing Facility, Chronic Care Services & Intermediate Care Facilities (ICF)	4
Prescribed Drugs	4
Psychiatric, Mental Health, and Behavioral Health Services	3
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	3
Clinic Services	2
Therapies, Hearing, and Rehabilitation Services	1

Provider Type	Total Count
Durable Medical Equipment (DME) and supplies, Prosthetic / Orthopedic devices, and Environmental Modifications	1
Transportation and Accommodations	1

The top three Medicaid provider types that are non-responsive to PERM record requests are home health agencies, day habilitation and waiver providers, and physician clinics and other licensed practitioners. State provider outreach programs should focus on these provider types to help reduce the no documentation errors and the overall error rate.

CHIP

Table 4.6 identifies the medical review errors found by error type and the associated projected improper payments for CHIP FFS.

TABLE 4.6. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN CHIP FFS MEDICAL REVIEW

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
CHIP						
Insufficient Documentation	316	44.9%	$201,328.4	43.6%	$46.4	36.0%
Policy Violation	118	16.8%	$39,426.6	8.5%	$43.7	33.9%
No Documentation	181	25.7%	$175,102.0	37.9%	$23.1	17.9%
Administrative/Other	30	4.3%	$4,116.6	0.9%	$5.7	4.4%
Procedure Coding Error	20	2.8%	$2,414.2	0.5%	$3.9	3.0%
Diagnosis Coding Error	9	1.3%	$31,119.3	6.7%	$3.1	2.4%
Number of Unit(s) Error	28	4.0%	$8,078.1	1.7%	$2.9	2.3%
Medically Unnecessary	1	0.1%	$95.0	0.0%	$0.1	0.1%
Unbundling	1	0.1%	$4.8	0.0%	$0.0	0.0%
Total	**704**	**100.0%**	**$461,685.1**	**100.0%**	**$129.1**	**100.0%**

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.

In CHIP, no documentation and insufficient documentation errors combined for a total of 53.9% of all CHIP FFS medical review projected improper payments. Policy violation errors, primarily due to

pharmacies not maintaining required signature logs for evidence of medication receipt and not recording beneficiaries' acceptance or refusal of drug counseling, accounted for 33.9% of all CHIP FFS medical review projected improper payments.

Insufficient Documentation Errors

Insufficient Documentation means there is inadequate documentation to support the service billed. Errors are cited when the provider supplies inadequate documentation to determine the medical necessity of the claim or the medical records do not document the tasks performed on the date of service (DOS) billed. Below is an example of an insufficient documentation error.

Insufficient Documentation Error Example: A CHIP provider submitted a psychiatric services claim. The provider submitted a treatment plan dated five months after the sampled date under review, but not the individual plan of care in effect for the sampled date range. The state policy requires that the plan of care be reviewed and updated every one hundred eighty (180) days and be in effect for the DOS on the claim. Since the individual plan of care in effect for the sampled DOS was not submitted, this claim was determined to have an insufficient documentation error and an overpayment was cited.

Table 4.7 identifies the types of documents that are most commonly missing when insufficient documentation errors are cited in CHIP.

TABLE 4.7. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2015 CHIP IMPROPER PAYMENT RATE SAMPLE

Documentation Type	Total Count
Treatment Plan/Plan of Care	48
Physicians' Orders	39
Progress Notes	38
Procedure Record	22
Flowsheets and Worksheets	17
Pharmacy Signature Log/Proof of Delivery	17
Evaluation & Management/Counseling Notes	15
Laboratory/Diagnostic Tests and Reports	13
Start and Stop Times	13
Attendance Logs	11
Encounter/Office Visit Notes	12
Medication Administration Record	11
Copy of Valid Prescription	8

Documentation Type	Total Count
Immunization Record	8
Beneficiary Signature/Proof of Service Receipt	7
Dental Chart	6
Initial Intake Assessment/Reassessment	6
Authorization for Transportation	3
Case Management Care Plan	2
Physician Certification/Re-Certification	1
Psychiatric Certification for Admission	1
Psychological Testing	1
Note: Multiple documents could have been missing for the same medical record.	

Policy Violation Errors

Policy Violation errors are cited when medical documentation submitted does not comply with state policy documentation requirements, such as when records are not maintained in compliance with specific policies as required to qualify for reimbursement. An example of a policy violation error is provided below.

Policy Violation Error Example: A pharmacy provider submitted a claim for reimbursement. The documentation submitted to support the claim did not include the signature log on file for the medication dispensed. The state's policy requires a provider to maintain a signature log, which each beneficiary or an individual acting on behalf of the beneficiary must sign each time a prescription medication is obtained as proof of delivery of prescription drugs. Because the record did not comply with the state policy requirements, this claim resulted in an overpayment error.

No Documentation Errors

No Documentation errors are cited when the provider fails to respond to repeated attempts to obtain the supporting documentation or the provider states that it does not have the requested records. Below is an example of a no documentation error.

No Documentation Error Example: A CHIP-participating dentist submitted a claim for tooth extraction but failed to respond to the requests for records to support the billed claim. Therefore, the claim was determined to be an overpayment.

Table 4.8 identifies the most common types of providers that are cited for no documentation errors in CHIP.

TABLE 4.8. COUNT OF PROVIDER TYPES THAT DID NOT SUBMIT DOCUMENTATION IN THE 2015 CHIP IMPROPER PAYMENT RATE SAMPLE

Provider Type	Total Count
Clinic Services	17
Prescribed Drugs	17
Hospital Services	13
Psychiatric, Mental Health, and Behavioral Health Services	11
Dental and Oral Surgery Services	9
Laboratory, X-ray and Imaging Services	7
Therapies, Hearing, and Rehabilitation Services	6
Day Habilitation and Waiver Programs, Adult Day Care and Foster Care	6
Physician Clinic Services / Physicians & Other Licensed Practitioners' Services	4
Home Health Services	2
Durable Medical Equipment (DME) and supplies, Prosthetic / Orthopedic devices, and Environmental Modifications	2

The top three CHIP provider types that are non-responsive to PERM record requests are clinics, pharmacies, and hospitals. State provider outreach programs should focus on these provider types to help reduce the no documentation errors and the overall error rate.

Service Type Analysis

An analysis by service type compares medical review and data processing errors by covered service categories to show services and providers at greater risk for error in each program. States' outreach efforts and corrective actions should be targeted toward these services and provider types to lower the error rate.

Medicaid

Table 4.9 shows the FFS improper payment rate and projected improper payments broken down by service type for Medicaid. The table shows the top 10 service types in projected improper payments and combines the remaining service types. It includes both data processing and medical review errors.

TABLE 4.9. FFS IMPROPER PAYMENT RATE AND PROJECTED IMPROPER PAYMENTS BY SERVICE TYPE IN MEDICAID

Service Type	Medical Review		Data Processing		Projected Improper Payments		Improper Payment Rate
	Count of Claims	Projected Improper Payments ($millions)	Count of Claims	Projected Improper Payments ($millions)	Projected Improper Payments ($millions)	% of Projected Improper Payments	
Medicaid							
Nursing Facility, Intermediate Care Facilities	35	$1,105	376	$8,760	$9,865	27.9%	12.9%
Prescribed Drugs	58	$966	268	$4,056	$5,022	14.2%	18.5%
ICF for the Intellectually Disabled and Group Homes	4	$225	156	$3,941	$4,166	11.8%	43.5%
Personal Support Services	50	$563	43	$3,063	$3,626	10.2%	12.1%
Habilitation and Waiver Programs, School Services	97	$1,242	77	$1,961	$3,203	9.0%	7.1%
Psychiatric, Mental Health, and Behavioral Health Services	34	$201	107	$1,616	$1,817	5.1%	10.6%
Inpatient and Outpatient Hospital	30	$349	158	$1,430	$1,780	5.0%	3.6%
Outpatient Hospital Services and Clinics	26	$398	50	$1,269	$1,667	4.7%	14.3%
Home Health Services	22	$105	61	$616	$721	2.0%	13.4%
Physicians and Other Licensed Practitioner Services	34	$364	43	$206	$570	1.6%	5.1%
All Other Service Types	63	$375	374	$2,606	$2,981	8.4%	5.7%
Total	**453**	**$5,893**	**1,713**	**$29,525**	**$35,418**	**100%**	**10.6%**

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a few claims to have high projected improper payments and vice versa. In addition, the improper payment rates by service type are calculated using the projected improper payments within each service and the total paid amount in each service (not shown). The total improper payment rate should be the same as the FFS component improper payment rate. The top 10 services are shown individually. The remaining 13 possible service types are grouped into the "All Other Service Types" category.

The top nine service types represented 90.0% of the total Medicaid FFS projected improper payments.

The types of errors that occurred in these service types were mainly:

- Non-covered Service;
- Insufficient Documentation; and
- No Documentation.

The types of errors found by service type are described below.

Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)

The predominant medical review errors for Nursing Facility, Chronic Care Services, and Intermediate Care Facilities were related to missing physician orders, lack of written progress notes, and unsigned orders. The general documentation requirements for these service types are: certification, recertification, plans of care, physician orders, progress notes, and documentation to support daily presence for the dates billed.

While data processing errors are often not related to a service category, during this reporting period, nursing facility claims filed on or after July 1, 2012 were required to include the attending physician's NPI on the claim to comply with the HIPAA transaction standards applying to all electronic institutional claims. Many states did not implement this change timely, resulting in numerous errors.

Habilitation/Waiver Programs/School Services

Medical review errors for Habilitation, Waiver Programs, and School Services were most often cited for insufficient documentation errors related to the provider's failure to submit relevant records for the sampled services, number of unit errors due to failure to adequately document the amount of time spent, and no response to the request for documentation. Documentation requirements generally include physician orders and certification of necessity, plans of care authorizing services, progress notes, timesheets, and attendance logs.

Capitated Care/Fixed Payments

Data Processing errors for Capitated Care/Fixed Payments were cited most often in instances where a state failed to fully implement the risk-based screening requirements required by federal regulations, pursuant to ACA requirements, in effect at the time of enrollment.

Inpatient/Outpatient Hospital

Medical review errors for Inpatient/Outpatient Hospital claims included diagnosis coding errors and no response to the requests for documentation.

While data processing errors are often not related to a service category, during this reporting period, inpatient and outpatient electronic institutional claims filed on or after July 1, 2012 were required to include the attending physician's NPI on the claim to comply with the HIPAA 5010 transaction standards applying to all electronic institutional claims. This change was not implemented timely by all states, resulting in numerous errors.

Prescribed Drugs

The primary medical review errors for Prescribed Drugs were related to a lack of documentation of (1) the beneficiary's acceptance or refusal of counseling and (2) the beneficiary's receipt of

medications. Pharmacies are required to maintain documentation that, generally, includes the original prescription that identifies the beneficiary, date of birth, name of drug, National Drug Code (NDC) code billed, refill history, documentation of acceptance or refusal of beneficiary counseling, and signature log documenting receipt of the prescribed medication.

This service category had a high number of data processing errors because the NPI of the prescribing provider was not listed on claims, as required, and the prescribing provider was not enrolled in Medicaid or CHIP, as required.

Personal Support Services

Most medical review errors cited for Personal Support Services were for insufficient documentation due to missing notes to verify the receipt of services, missing daily documentation of specific tasks, and missing or incorrectly documented numbers of units. Documentation requirements generally include plans of care, documentation of services provided, and timesheets showing in and out times to support the numbers of units billed.

Intermediate Care Facilities/MR

The predominant medical review errors for Intermediate Care Facilities/MR were related to missing physician orders, lack of written progress notes, and unsigned orders. The general documentation requirements for these service types are: certification, recertification, plans of care, physician orders, progress notes, and documentation to support daily presence for the dates billed.

Clinics

Clinics primarily had medical review errors related to missing orders, missing results for billed tests, and clinics not providing requested records. Documentation requirements generally include physician orders, progress notes, nursing notes, preventive and diagnostic test results, and immunization records.

Psychiatric/Mental Health/Behavioral Health Services

Medical review errors cited for Psychiatric/Mental Health/Behavioral Health Services included missing documentation of billed services, no response to requests for documentation, and no documentation of the time spent with the beneficiary. Documentation requirements generally include physician orders and certification, plans of care, progress notes, attendance logs, and documentation of time spent for units billed.

While data processing errors are often not related to a service category, during this reporting period, electronic institutional claims, which includes psychiatric inpatient claims, filed on or after July 1, 2012, were required to include the attending physician's NPI on the claim to comply with the HIPAA

5010 transaction standards applying to all electronic institutional claims. Not all states implemented this change timely, resulting in numerous errors.

CHIP

Table 4.10 shows the FFS improper payment rate and projected improper payments broken down by service type for CHIP. The table presents the top ten service types in terms of projected improper payments and combines the remaining service types. It includes both data processing and medical review errors.

TABLE 4.10. FFS IMPROPER PAYMENT RATE AND PROJECTED IMPROPER PAYMENTS BY SERVICE TYPE IN CHIP

Service Type	Medical Review		Data Processing		Projected Improper Payments		Improper Payment Rate
	Count of Claims	Projected Improper Payments ($millions)	Count of Claims	Projected Improper Payments ($millions)	Projected Improper Payments ($millions)	% of Projected Improper Payments	
CHIP							
Prescribed Drugs	214	$55.4	394	$63.2	$118.6	36.2%	16.4%
Dental and Other Oral Surgery Services	39	$7.3	584	$44.6	$51.9	15.8%	7.1%
Inpatient and Outpatient Hospital	50	$7.2	240	$33.8	$41.1	12.5%	4.1%
Psychiatric, Mental Health, and Behavioral Health Services	80	$17.9	138	$17.5	$35.4	10.8%	6.2%
Physicians and Other Licensed Practitioner Services	54	$7.5	95	$18.8	$26.3	8.0%	5.6%
Outpatient Hospital Services and Clinics	50	$9.5	81	$15.4	$24.8	7.6%	6.0%
Habilitation and Waiver Programs, School Services	49	$6.4	8	$0.3	$6.6	2.0%	4.2%
Therapies, Hearing and Rehabilitation Services	8	$1.2	49	$5.2	$6.4	1.9%	18.0%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	6	$0.7	31	$3.6	$4.3	1.3%	15.4%
Home Health Services	12	$1.2	62	$1.6	$2.9	0.9%	16.4%
All Other Service Types	65	$4.9	192	$4.6	$9.6	2.9%	3.0%
Total	**627**	**$119**	**1,874**	**$209**	**$328**	**100%**	**7.3%**

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a few claims to have high projected improper payments and vice versa. In addition, the improper payment rates by service type are calculated using the projected improper payments within each service and the total paid amount in each service (not shown).

Service Type	Medical Review		Data Processing		Projected Improper Payments		Improper Payment Rate
	Count of Claims	Projected Improper Payments ($millions)	Count of Claims	Projected Improper Payments ($millions)	Projected Improper Payments ($millions)	% of Projected Improper Payments	
The total improper payment rate should be the same as the FFS component improper payment rate. The top 10 services are shown individually. The remaining 13 possible service types are grouped into the "All Other Service Types" category.							

The top five service types represented 83.3% of the total CHIP FFS projected improper payments.

As with Medicaid, the types of errors that occurred in these service types for CHIP were mainly:

- Non-covered Service;
- Insufficient Documentation; and
- Pricing Error.

Examples of the types of errors found by service type follow.

Prescribed Drugs

The predominant medical review errors cited for Prescribed Drugs were for policy violations related to no documentation of beneficiary acceptance or refusal of counseling for medications and no response to requests for documentation of the service billed. Prescription documentation requirements generally include the original prescription that identifies the beneficiary, date of birth, name of drug and NDC code billed, refill history, documentation of acceptance or refusal of medication counseling, and signature log documenting receipt of the prescribed medication.

The primary data processing error for this service category was the NPI of the prescribing provider not being listed on the submitted claims, as required.

Inpatient/Outpatient Hospital

Medical review errors for Inpatient/Outpatient Hospital claims included diagnosis coding errors and no response to requests for documentation. While data processing errors are often not related to a service category, during this reporting period, inpatient and outpatient electronic institutional claims filed on or after July 1, 2012 were required to include the attending physician's NPI on the claim to comply with the HIPAA transaction standards for all electronic institutional claims. Not all states implemented this change timely, resulting in numerous errors.

Dental and Other Oral Surgery Services

Medical review errors related to Dental and Other Oral Surgery Services were most often cited due to the provider not responding to requests for documentation, insufficient documentation errors (most commonly missing signatures), failure to name the provider who rendered the services, and policy violations, most commonly missing patient identification and date of birth. Documentation requirements generally include dental progress notes, treatment plans, documentation of beneficiary's age, dental condition, and treatment services rendered.

While data processing errors are often not related to a service category, many states enrolled a disproportionately high percentage of new dental providers during this reporting period and some of those states had not fully implemented the risk-based screening provisions required by federal regulations at time of enrollment, resulting in a high number of errors for this service category.

Physicians/Other Licensed Practitioner Services

Physicians/Other Licensed Practitioner Services primarily had medical errors cited for insufficient documentation (mostly related to missing orders or test results), diagnosis-coding errors, and no documentation errors due to failing to respond to requests for records. Documentation requirements generally include physician orders, progress notes, nursing notes, preventive and diagnostic test results, and immunization records.

Psychiatric, Mental Health, Behavioral Health Services

The primary medical review errors related to Psychiatric, Mental Health, and Behavioral Health Services were cited for insufficient documentation errors due to missing documentation of billed services, no response to requests for documentation, and policy violations (due to the provider not documenting the "in" and "out" times of the services provided). Documentation requirements generally include physician orders and certification, plans of care, progress notes, attendance logs, and documentation of time spent for units billed.

While data processing errors are often not related to a service category, during this reporting period, electronic institutional claims, which includes psychiatric inpatient claims, filed on or after July 1, 2012 were required to include the attending physician's NPI on the claim to comply with the HIPAA transaction standards for all electronic institutional claims. Not all states implemented this change timely, resulting in numerous errors.

V. MANAGED CARE

A Managed Care Organization (MCO) is paid a pre-determined, capitated amount for a specified time period (usually one month) for each enrolled beneficiary. The MCO is then responsible to pay for all covered medically necessary services for the enrollee. Because the amount of services a beneficiary will require during that time period is unknown, MCOs are considered to be financially "at-risk."

In PERM, only the managed care capitation payment made from the state to the MCO is reviewed. Payments made by MCOs to providers are not reviewed under PERM. Capitation payments made to MCOs that assume full financial risk for benefits provided[13] are included in the managed care universe for PERM and receive a data processing review in PERM. A number of elements are reviewed, including:

In PERM, only the managed care capitation payment made from the state to the MCO is reviewed. Payments made by MCOs to providers are not reviewed under PERM.

- The beneficiary's eligibility aid category;
- The county or location of the beneficiary to verify that the primary residence is in a geographical location supported by the plan;
- The health plan contracts which are reviewed to determine proration policy, rate cells, and the contracted rates for the coverage period;
- The beneficiary's circumstances (age, sex, county of residence, aid category, Medicare coverage, or other factors as determined by state policy) must match the assigned rate cell; and
- The payment, which is reviewed for duplicates and adjustments made within 60 days of the original payment under review.

MEDICAID

Table 5.1 shows the breakdown of data processing errors in Medicaid managed care.

[13] Note that capitation payments made to entities that provide a very narrow set of services (e.g., non-emergency transportation) are considered to be "fixed" payments included in the FFS universe. Additionally, states that have arrangements with entities that do not assume full risk are review by CMS on a case-by-case basis and are often determined to be more appropriately placed in the FFS unvierse.

TABLE 5.1. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN MEDICAID MANAGED CARE DATA PROCESSING

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Medicaid						
Non-covered Service	11	20.0%	$16,415.3	52.6%	$177.9	79.6%
Duplicate Item	2	3.6%	$12,786.9	41.0%	$28.0	12.5%
Rate Cell Error	1	1.8%	$937.3	3.0%	$12.7	5.7%
Managed Care Payment Error	40	72.7%	$1,014.3	3.3%	$4.6	2.1%
Pricing Error	1	1.8%	$51.2	0.2%	$0.3	0.1%
Administrative/Other	0	0.0%	$0.0	0.0%	$0.0	0.0%
Data Entry Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
FFS Claim for Managed Care Service	0	0.0%	$0.0	0.0%	$0.0	0.0%
Logic Edit	0	0.0%	$0.0	0.0%	$0.0	0.0%
Third-party Liability	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**55**	**100.0%**	**$31,205.0**	**100.0%**	**$223.6**	**100.0%**

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.

There are fewer errors in managed care than in FFS, which is reflected in its smaller contribution to the overall improper payment rate. Non-covered service errors, where the entire payment is in error, cause the greatest dollar impact, at 79.6% of all Medicaid managed care projected improper payments. Managed care payment errors account for a larger number of errors, at 72.7%, than non-covered services, but cause far smaller dollar impact because this type of error is only a partial payment error.

Non-Covered Service Errors

Non-covered service errors were chiefly due to beneficiaries' Medicaid ineligibility. In some cases, the beneficiary was ineligible for managed care because he or she no longer had active Medicaid eligibility for the period under review, or had passed away prior to the capitation payment to the health plan. Below is an example of a non-covered service error.

Non-Covered Service Error Example: A Medicaid managed care capitation payment was made by the state for a beneficiary with a date of death prior to the coverage period being paid. MMIS showed a managed care enrollment status change due to beneficiary death on November 15, 2013, prior to the capitation payment on November 19, 2013. The capitation payment was not recouped until February 2, 2014, which is beyond the allowed 60-day window for adjustments. Therefore, the claim was determined to be an overpayment error for $828.26.

Managed Care Payment Errors

Managed care payment errors are identified when the wrong amount is paid for an eligible Medicaid managed care beneficiary or the beneficiary was Medicaid eligible but ineligible to be enrolled in a managed care plan based on state policy regarding mandatory, voluntary, or exclusions from enrollment for certain populations. Below is an example of a managed care payment error.

Managed Care Payment Error Example: A managed care capitation payment was sampled for PERM review. The beneficiary was dually eligible for Medicare and Medicaid when enrolled in managed care. The beneficiary was assigned an incorrect rate cell (hence the managed care plan was paid the wrong capitation rate), as the MMIS had not been updated with the beneficiary's Medicare eligibility when the rate cell that determines the capitation rate was assigned. Although rate cells or cohort definitions (age, sex, aid code, with and without Medicare, etc.) vary from state to state, in most states, beneficiaries with Medicare are assigned a rate cell with a lower capitation rate because the health plan coordinates benefits with Medicare. In this case, the capitation payment was made for $937.32 more than what should have been paid, resulting in a PERM overpayment error.

CHIP

Table 5.2 shows the breakdown of data processing errors in CHIP managed care, which were generally consistent with Medicaid managed care findings.

TABLE 5.2. PERCENTAGE AND PROJECTED IMPROPER PAYMENTS IN CHIP MANAGED CARE DATA PROCESSING

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
CHIP						
Non-covered Service	22	22.4%	$5,057.3	95.2%	$31.4	94.5%
Rate Cell Error	3	3.1%	$153.5	2.9%	$1.4	4.3%
Third-party Liability	1	1.0%	$89.2	1.7%	$0.4	1.3%
Managed Care Payment Error	72	73.5%	$14.6	0.3%	$0.0	0.0%
Administrative/Other	0	0.0%	$0.0	0.0%	$0.0	0.0%
Data Entry Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Duplicate Item	0	0.0%	$0.0	0.0%	$0.0	0.0%
FFS Claim for Managed Care Service	0	0.0%	$0.0	0.0%	$0.0	0.0%
Logic Edit	0	0.0%	$0.0	0.0%	$0.0	0.0%
Pricing Error	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**98**	**100.0%**	**$5,314.6**	**100.0%**	**$33.3**	**100.0%**

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total

Note: Dollar values and/or percentages do not always sum to the total due to rounding. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for a small number of claims in error to have high projected improper payments and vice versa.

The top error type, representing 94.5% of all CHIP managed care projected improper payments, was non-covered service. Rate cell errors accounted for the second most projected improper payments, although only three such errors were identified.

Non-Covered Service Errors

Managed care errors cited were mostly due to the beneficiary being ineligible for managed care; therefore, the capitated monthly payment was made for a non-covered service. In many cases, the beneficiary was ineligible for managed care because the beneficiary no longer had active eligibility for CHIP for the period under review. Below is an example of a non-covered service error.

Non-Covered Service Error Example: A state made a CHIP managed care payment for the month of July in 2014. The PERM contractor found a conflict, as the state's eligibility report showed the beneficiary's eligibility ended on July 21, 2014 due to the beneficiary moving out of state, while the MMIS system showed the eligibility end date was July 25, 2014, leaving a four-day overpayment. On July 26, 2014, the original capitation payment was adjusted (within the allowed 60 day period) and paid for the period July 1, 2014 through July 25, 2014, but should have only paid through July 21, 2014, so the claim was determined to have been overpaid by $31.72.

Managed Care Payment Errors

Managed care payment errors are identified when the wrong amount is paid for an eligible CHIP managed care beneficiary or the beneficiary was CHIP eligible but ineligible to be enrolled in a managed care plan based on state policy regarding mandatory, voluntary, or exclusions from enrollment for certain populations. An example of a managed care payment error is provided below.

Managed Care Payment Error Example: A $0.01 underpayment error was cited where the capitation amount paid to a health plan did not match the published rate for the rate cell assigned to the beneficiary. According to the state, the error was made when publishing the rate.

VI. DETERMINING THE IMPROPER PAYMENT RATE

All improper payment rate calculations for the PERM program (the FFS component, managed care component, eligibility component[14], and national Medicaid and CHIP improper payment rates) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual state improper payment rate components are combined to calculate the national component improper payment rates.

For each reporting year, CMS calculates a national improper payment rate and a cycle-specific improper payment rate.

1. **National improper payment rate**: The national improper payment rate is a rolling rate. This rate combines the findings from the three prior measurement cycles, using information from all 50 states and the District of Columbia, to produce the improper payment rate for the current FY, which is published in the Department of Health and Human Services (HHS) Agency Financial Report. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are added in.

2. **Cycle-specific rate**: This rate combines the findings from the 17 states sampled in the most recent measurement cycle. The result may be used to compare cycle specific changes from when the states were last sampled.

National Medicaid and CHIP program and component improper payment rates are weighted by expenditures (state expenditures and federal expenditures), so that a state with a $10 billion program "counts" 10 times more toward the national rate than a state with a $1 billion program. The national program improper payment rates represent the combination of FFS, managed care, and eligibility[15] improper payment rates. A small correction factor ensures that eligibility improper payments are not "double counted."[16]

The PERM program treats both overpayments and underpayments to be improper payments. Table 6.1 summarizes the error findings and the projected over- and underpayments for the four types of reviews: FFS and managed care data processing reviews, FFS medical reviews, and eligibility determinations. As noted earlier in the report, state–specific eligibility rates are not being calculated for this cycle, and 2014 national eligibility improper payment rates (results from the most recent

[14] For the current measurement, eligibility reviews are on hold and the 2014 national eligibility improper payment rateis used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

[15] PERM calculates three eligibility improper payment rates per program: an active case improper payment rate, an active improper case rate, and a negative improper case rate. The active case improper payment rate serves as the official eligibility component rate and is used to calculate the overall rate since this is the only eligibility rate that is associated with payments.

[16] There may be some overlap between claims (FFS and managed care) and eligibility. The correction factor ensures that any overlap is removed so that no claim is counted twice in the improper payment calculation.

cycles prior to 2015) are used as a proxy in the 2015 overall improper payment calculations. Therefore, 2014 reported eligibility over- and underpayments are represented in table 6.1.

TABLE 6.1. SUMMARY OF 2015 PROJECTED OVERPAYMENTS AND UNDERPAYMENTS

Category	Overpayments			Underpayments		
	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments ($Millions)	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments ($Millions)
Medicaid						
FFS Medical Review	512	$360,680.8	$7,364.0	5	$6,869.2	$25.3
FFS Data Processing	1,668	$4,837,027.8	$28,992.3	45	$6,895.3	$459.2
Managed Care	27	$30,401.8	$222.3	28	$803.2	$1.3
*Eligibility**	*841*	*$414,366.4*	*$15,647.6*	*44*	*$5,581.7*	*$421.8*
Total	**3,048**	**$5,642,476.8**	**$52,226.2**	**122**	**$20,149.4**	**$907.7**
CHIP						
FFS Medical Review	699	$458,055.4	$128.6	5	$3,629.7	$0.5
FFS Data Processing	1,776	$2,317,680.5	$205.2	98	$3,730.2	$2.3
Managed Care	26	$5,300.0	$33.3	72	$14.6	$0.0
*Eligibility**	*1,439*	*$238,406.1*	*$559.0*	*88*	*$2,215.0*	*$5.9*
Total	**3,940**	**$3,019,442.0**	**$926.1**	**263**	**$9,589.6**	**$8.7**

Notes: Dollar values and/or percentages do not always sum to the total due to rounding. For the purposes of this table, Medical Review and Data processing errors are counted separately. Overlaps between the two are reported in both categories, which may result in double counting. Due to the sampling process and sampling weights, the number of claims sampled with improper payments, sample improper payments, and projected improper payments may not be correlated. In other words, it is possible for just a few erroneous claims to yield high projected improper payments and vice versa.

*For the current measurement, eligibility reviews are suspended and 2014 national eligibility improper payments (results from the most recent cycles prior to 2015) are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

Readers should keep in mind that the impact of state program variations when reviewing Medicaid and CHIP improper payment rates. Due to the considerable flexibility that states have in designing their programs within federal rules, the individual state programs differ widely in program structure, eligibility, and financing. They also vary in the level of sophistication and integration of management information systems. Therefore, improper payment measurement is both difficult to generalize and often results in large differences across states.

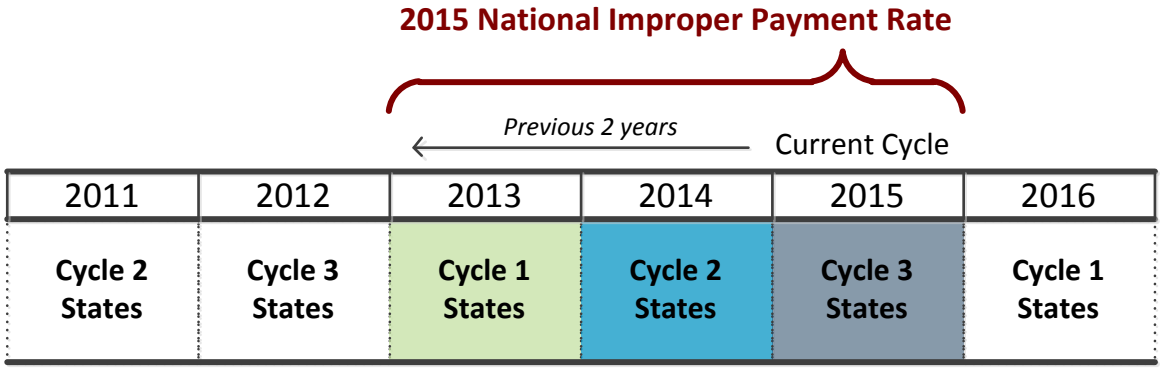
CMS attributes the variation in state-specific improper payment rates to multiple factors related to differences in how the states implement and administer their programs, as well as the enrolled population size. For example, states with proportionately larger managed care programs are likely to have lower overall improper payment rates. As opposed to directly paying providers in a FFS system, these states make more payments via monthly capitation payments to plans, which are based on fewer variables than FFS payments, resulting in a data processing review only, with no medical record review. Not only does this cause differences in improper payment rates among states in a cycle, but

it could cause differences in improper payment rates between cycle measurements for the same state if, in future years, the state elects to adopt (or to abandon) managed care programs.

2015 National Rolling Improper Payment Rate

The national rolling improper payment rate includes findings from the most recent three measurements to reflect findings for all 50 states and the District of Columbia. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are added. The national rolling improper payment rate is then calculated across all states by component, after which the FFS, managed care, and eligibility national rolling improper payment rates are combined to create an overall improper payment rate. For the current measurement, eligibility reviews are suspended and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) is used as a proxy in the overall improper payment rate calculation. Figure 6, below, shows the measurements that are included in the national rolling improper payment rate.

FIGURE 6. PERM NATIONAL ROLLING IMPROPER PAYMENT RATE



The national rolling rate reflects any data changes that occurred after cycle cutoff dates for the two oldest measurements. Data changes could occur after the cycle cutoff date for a limited number of reasons including continued claim processing[17] or corrections to data to resolve previously undiscovered data inaccuracies. Due to the timing of improper payment rate reporting, the most recent cycle in the rolling improper payment rate does not include any changes made to the data based on continued processing, since they occur after the improper payment rate is reported.

The following sections detail the 2015 Medicaid and CHIP official national rolling improper payment rates.

[17] Continued claims processing is the review of claims after a cycle end date if late documentation is received or difference resolution and/or appeals are requested after the cycle end date.

2015 National Medicaid Improper Payment Rate

Table 6.2, below, summarizes the 2015 rolling national Medicaid improper payment rate findings.

TABLE 6.2. 2015 NATIONAL MEDICAID IMPROPER PAYMENT RATES SUMMARY

	2015 Medicaid Rolling Improper Payment Rate
Improper Payment Rate	9.8%
Total Projected Improper Payments ($Billions)	$50.6
Federal Share Projected Improper Payments ($Billions)	$29.1

The **2015 national Medicaid rolling improper payment rate**, which is based on measurements that were conducted in 2013, 2014, and 2015, is **9.8%**. This represents an estimated $29.1 billion in improper federal expenditures and $50.6 billion in estimated total improper Medicaid payments (state and federal shares) annually. These projected improper payments are based on the sum of the absolute value of the identified under- and overpayments.

To better understand the drivers of the overall national improper payment rates, PERM calculates the improper payment rates for each component. As shown in Table 6.3, FFS was a major contributor to the Medicaid improper payment rate, while managed care payments accounted for just a limited portion of all improper payments.

TABLE 6.3. 2015 MEDICAID IMPROPER PAYMENT RATES BY COMPONENT

Component	2015 Medicaid Rolling Improper Payment Rate
FFS	10.6%
Managed Care	0.1%
*Eligibility**	*3.1%*
National	**9.8%**

Notes: The national improper payment rates are comprised of a weighted average of FFS and managed care, the addition of eligibility, and the removal of a statistical overlap between the weighted average of FFS and managed care with the eligibility review processes.

*For the current measurement, eligibility reviews are on hold and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

The 2015 Medicaid improper payment rate is higher than the CMS target of 6.7%.

As shown in Table 6.4, the increase in data processing errors is significant. The overall FFS results, which combine data processing and medical review errors, significantly increased from 2014 to 2015.

It is important to note that the difference between the 2014 and 2015 national rolling improper payment rate is the replacement of the 2012 Cycle 3 states' data (in the former rate) with the more recently sampled 2015 Cycle 3 states' data (in the latter rate). Therefore, any changes in the rolling improper payment rate are attributable to the 2015 cycle states.

TABLE 6.4. 2015 - 2014 MEDICAID FFS DATA PROCESSING AND MEDICAL REVIEW ROLLING IMPROPER PAYMENT RATES

	2015 National Rolling			2014 National Rolling		
	Improper Payment Rate	Standard Error	90% Confidence Interval	Improper Payment Rate	Standard Error	90% Confidence Interval
Medicaid						
FFS	10.6%	0.6%	9.6% - 11.6%	5.1%	0.5%	4.2% - 5.9%
FFS Data Processing	8.8%	0.6%	7.8% - 9.8%	3.4%	0.5%	2.6% - 4.3%
FFS Medical Review	2.2%	0.2%	1.8% - 2.6%	1.8%	0.2%	1.5% - 2.1%

The 2015 national Medicaid improper payment rates meet the IPIA precision requirement of +/- 2.5 percentage points, suggesting that the results would be highly similar if the study was to be repeated.

Using the component specific improper payment rates, CMS calculates the projected improper payments and the dollars associated with the federal share, as shown in Table 6.5. To understand the reasonability of this estimate, the 90 percent confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90 percent of the time if the study were repeated many times.

Table 6.5. 2015 Medicaid Improper Payment Rate Applied to Total Expenditures and the Federal Share (Dollars in Billions)

Component	2015 Expenditures ($billions)	Projected Improper Payments ($billions)	Lower 90% Confidence Limit ($billions)	Upper 90% Confidence Limit ($billions)
Medicaid				
FFS Total	$334.4	$35.4	$32.1	$38.8
Federal Share	$191.3	$20.3	$18.3	$22.2
Managed Care Total	$182.9	$0.2	$0.1	$0.3
Federal Share	$106.4	$0.1	$0.1	$0.2
*Eligibility Total**	*$517.2*	*$16.1*	*$12.0*	*$20.1*

*Federal Share**	*$297.7*	*$9.2*	*$6.9*	*$11.6*
National Total**	$517.2	$50.6	$45.6	$55.6
Federal Share**	$297.7	$29.1	$26.3	$32.0

* For the current measurement, eligibility reviews are suspended and the 2014 national eligibility improper payments (results from the most recent cycles prior to 2015) are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

**The national payment error amounts (projected improper payments) are the product of the improper payment rates (or associated statistics) and the documented amounts paid by the states and the federal program for relevant activities. Also, the expenditures for eligibility encompass both FFS and managed care and therefore are equal to the national total. Rounding and overlaps between categories will impact the sums versus the aggregate values a bit differently.

2015 National CHIP Improper Payment Rate

Table 6.6 below summarizes the 2015 rolling national CHIP improper payment rate findings.

TABLE 6.6. 2015 NATIONAL CHIP IMPROPER PAYMENT RATES SUMMARY

	2015 CHIP Rolling Improper Payment Rate
Improper Payment Rate	6.8%
Total Projected Improper Payments ($Billions)	$0.9
Federal Share Projected Improper Payments ($Billions)	$0.6

The **2015 national CHIP rolling improper payment rate**, which is based on measurements that were conducted in 2013, 2014, and 2015, is **6.8%**. This represents an estimated $0.6 billion in improper federal expenditures and $0.9 billion in estimated improper payments for CHIP as a whole (state and federal) annually.

To better understand the drivers of the overall national improper payment rates, PERM calculates the improper payment rates for each component. As can be seen in Table 6.7, FFS was a major contributor to the CHIP improper payment rates, while managed care payments accounted for just a limited portion of all improper payments.

TABLE 6.7. 2015 CHIP IMPROPER PAYMENT RATES BY COMPONENT

Component	2015 CHIP Rolling Improper Payment Rate
FFS	7.3%
Managed Care	0.4%
*Eligibility**	*4.2%*
National	**6.8%**

Notes: The national improper payment rates are comprised of a weighted average of FFS and managed care, the addition of eligibility, and the removal of a statistical overlap between the weighted average of FFS and managed care with the eligibility review processes.

* For the current measurement, eligibility reviews are on hold and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

The 2015 CHIP improper payment rate is higher than the CMS target of 6.5%.

The 2015 national CHIP improper payment rates meet the IPIA precision requirement of +/- 2.5 percentage points, suggesting that the results would be highly similar if the study were to be repeated.

Using the component specific improper payment rates, CMS calculates the projected improper payments and the dollars associated with the federal share, as shown in Table 6.8. To understand the reasonability of this estimate, the 90 percent confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90 percent of the time if the study were repeated many times.

TABLE 6.8. 2015 CHIP IMPROPER PAYMENT RATE APPLIED TO TOTAL EXPENDITURES AND THE FEDERAL SHARE (DOLLARS IN BILLIONS)

Component	2015 Expenditures ($billions)	Projected Improper Payments ($billions)	Lower 90% Confidence Limit ($billions)	Upper 90% Confidence Limit ($billions)
CHIP				
FFS Total	$4.5	$0.3	$0.3	$0.4
Federal Share	$3.2	$0.2	$0.2	$0.3
Managed Care Total	$8.9	$0.0	$0.0	$0.1
Federal Share	$6.1	$0.0	$0.0	$0.0
*Eligibility Total**	*$13.4*	*$0.6*	*$0.5*	*$0.6*
*Federal Share**	*$9.3*	*$0.4*	*$0.4*	*$0.4*
National Total**	**$13.4**	**$0.9**	**$0.8**	**$1.0**
Federal Share**	**$9.3**	**$0.6**	**$0.6**	**$0.7**

Component	2015 Expenditures ($billions)	Projected Improper Payments ($billions)	Lower 90% Confidence Limit ($billions)	Upper 90% Confidence Limit ($billions)
* For the current measurement, eligibility reviews are suspended and the 2014 national eligibility improper payments (results from the most recent cycles prior to 2015) are used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology. **The national payment error amounts (projected improper payments) are the product of the improper payment rates (or associated statistics) and the documented amounts paid by the states and the federal program for relevant activities. Also the expenditures for eligibility encompass both FFS and managed care and therefore are equal to the national total. Rounding and overlaps between categories will impact the sums versus the aggregate values a bit differently.				

2015 Cycle-Specific Improper Payment Rate

A cycle rate is an improper payment rate based on the 17 states measured in a cycle. The cycle improper payment rate does not reflect findings from the entire nation as the rolling rate does, but provides a snapshot of the results specific to the states participating in a given cycle. Table 6.9 lists the cycle rates from the three most recent PERM cycles that are the measurements included in the 2015 rolling rate.

TABLE 6.9. 2013 – 2015 MEDICAID AND CHIP IMPROPER PAYMENT CYCLE RATES

	2013 Cycle 1	2014 Cycle 2	2015 Cycle 3
MEDICAID			
Improper Payment Rate*	5.7%	8.1%	14.3%
CHIP			
Improper Payment Rate*	7.3%	4.7%	9.0%
*The cycle improper payment rates are comprised of a weighted average of FFS and managed care, the addition of eligibility, and the removal of a statistical overlap between the weighted average of FFS and managed care with the eligibility review processes. Previously, the cycle-specific rate was calculated using data from the 17 states sampled and projected to the national level. For the rates in the three years of this table, the cycle-specific rate represents only the 17 states sampled. Also, for the 2015 Cycle 3 rate, the 2012 Cycle 3 eligibility component rate (the most recent Cycle 3 measurement prior to 2015) is used as a proxy in the overall 2015 Cycle 3 improper payment rate calculation. Since these cycle rates are used for the national rolling rate, eligibility is included in this table. In addition, the 2013 Cycle 1 and 2014 Cycle 2 rates include state-level improper payment rate recalculations.			

As seen in Table 6.9, the 2015 Medicaid Cycle 3 improper payment rate is 14.3%. The 2015 CHIP Cycle 3 improper payment rate is 9.0%. The Cycle 3 states reviewed in 2015 were the same states reviewed in 2012 and 2009. The 2015 Medicaid Cycle 3 improper payment rate increased from the 2012 Cycle 3 improper payment rate of 6.2% for these states. The Medicaid and CHIP rates increased in Cycle 3 due to state difficulties getting into compliance with new requirements. The increase in the Medicaid Cycle 3 improper payment rate caused the rolling improper payment rate to increase from 6.7% in 2014 to 9.8% in 2015.

Table 6.10 shows the Medicaid Cycle 3 rates by component in 2009 and 2012 compared to the current cycle rates in 2015.

TABLE 6.10. 2009 - 2015 MEDICAID CYCLE RATES BY COMPONENT

Component	2009 Cycle 3 Improper Payment Rate	2012 Cycle 3 Improper Payment Rate	2015 Cycle 3 Improper Payment Rate
FFS	2.5%	3.2%	18.6%
Managed Care	0.1%	0.3%	0.1%
Cycle	**2.0%**	**2.5%**	**11.0%**
Note: For the current measurement, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed from the cycle rates in this table for comparison purposes. The 2009 and 2012 rates include state-level improper payment rate recalculations and the 17 state cycle rates were previously not reported.			

Table 6.11 shows the CHIP Cycle 3 rates by component in 2012 and 2015 since there were no CHIP rates prior to 2011.

TABLE 6.11. 2015 CHIP CYCLE RATES BY COMPONENT

Component	2012 Cycle 3 Improper Payment Rate	2015 Cycle 3 Improper Payment Rate
FFS	7.6%	13.1%
Managed Care	0.1%	0.6%
Cycle	**2.3%**	**3.2%**
Note: For the current measurement, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed from the cycle rates in this table for comparison purposes. As in Table 6.10, the 2012 rate includes state-level improper payment rate recalculations and the 17 state cycle rates were previously not reported.		

Reconciling Improper Payments Identified by the PERM Program

The last step in the PERM process is correcting the improper payments identified by recovering the overpayments and implementing corrective actions. Overpayment recoveries are governed by longstanding statutory and regulatory requirements – for Medicaid, under section 1903(d)(2) of the Act and 42 C.F.R. Part 433, Subpart F, and for CHIP under sections 2105(c)(6)(B) and 2105(e) of the Act and 42 C.F.R. Part 457, Subparts B and F. CMS recovers the federal share of Medicaid and CHIP overpayments identified in the FFS and managed care samples from the states on a claim-by-claim basis.

VII. REDUCING IMPROPER PAYMENTS

Reducing improper payments is a high priority for CMS, and states are critical partners in the corrective action phase of the PERM cycle. States' systems, claims payment methodologies, eligibility determination processes, provider billing errors, and provider compliance with record requests all contribute to the national improper payment rates in various ways. PERM identifies and classifies different types of errors, but states must conduct root cause analyses to identify why the errors occur to then implement effective corrective actions. CMS is also working on multiple fronts to reduce improper payments in an effort to meet improper payment rate targets, as shown in Table 7.1. CMS continuously reviews the causes of errors and implements national and state-focused activities to decrease Medicaid and CHIP improper payments.

TABLE 7.1. IMPROPER PAYMENT RATE TARGETS

	2016	2017	2018
MEDICAID			
Improper Payment Rate	11.5%	10.5%	7.4%
CHIP			
Improper Payment Rate	6.8%	6.2%	5.9%

The Medicaid and CHIP 2016 improper payment rate targets have increased from the 2015 improper payment rates because, although all states are included in the improper payment rates, CMS only reviews 17 states each year. State difficulties coming into compliance with new requirements is a main driver of the Medicaid and CHIP improper payment rates. In 2014, CMS reported a rate reflecting the first 17 states measured under the new requirements. The 2015 improper payment rates reflect the second group of 17 states subject to new requirements for a total of 34 states. In 2016, CMS will report a rate that reflects the measurement of the final group of 17 states under the new requirements and will be the first baseline improper payment rate reflecting measurement of all states under the new requirements, resulting in the highest expected rolling rate. CMS expects to see a gradual decrease in the following years due to corrective actions as each cycle of states is measured again. In 2017, the first group of states will be measured for a second time under the new requirements, after implementation of corrective actions designed to improve the errors. The 2018 target reflects a larger decrease, as 17 more states are measured again after corrective action implementation. The 2019 rate will represent the first rolling improper payment rate for all states following implementation of corrective actions to address errors resulting from measurement under the new requirements.

Below is an overview of the state corrective action plan process, its impact on error findings, and a review of CMS program improvements to support reducing improper payments.

PERM Corrective Action Plan Process

Through the improper payment rate measurement process, CMS identifies and classifies types of errors and shares this information with each state. States then analyze the findings to determine the root causes for improper payments, which is a necessary precursor to developing and implementing effective corrective actions. CMS creates a state-specific Corrective Action Plan (CAP) template each state uses when developing corrective actions. CMS works closely with states following each measurement cycle to provide as-needed technical assistance. States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating their CAPs' effectiveness.

As required by regulations, states submit their CAPs to CMS 90 days following the receipt of their official state-specific improper payment rate reports. The states' CAPs include information and documentation on the following types of activities:

- Data analysis – analyses of the findings to identify the reasons for errors and where errors are occurring;
- Program analysis – analyses of the findings to determine the root causes of errors in program operations;
- Corrective action planning – steps taken to determine cost-effective actions that can be implemented for achieving long-lasting error reduction;
- Implementation and monitoring – plans to operationalize the corrective actions, including milestones and timeframes for achieving quantitative improper payment rate reductions, and monitoring to determine whether the implemented CAP yields intended results and meets identified goals for reducing errors; and
- Evaluation – assessment of whether the corrective actions are in place and are effectively reducing or eliminating the targeted root causes of the errors, including rapid cycle feedback or other relevant time-cycle components. In addition to current corrective action evaluations, states must submit updates on previous corrective action plans from the prior PERM cycle and evaluate effectiveness of previous corrective actions.

CMS conducts webinars with each state after CAP submissions have been made for each cycle. Post-CAP meetings are held to recap the previous cycle, discuss improper payment trends, share strategies for future success, and discuss the state's submitted CAP.

State Corrective Actions

Note that for Medicaid, the 17 states reviewed in 2015 were the same set of 17 states reviewed in 2012 (Cycle 3 states). The improper payment rate for these states increased from 2012 to 2015, causing the 2015 Medicaid rolling improper payment rate to increase from 6.7% to 9.8%. The Cycle 3 states submitted CAPs following their 2012 PERM measurement and can evaluate effectiveness of those corrective actions based on their 2015 results. Specifically, states can evaluate corrective actions focused on areas not related to the new requirements, where improvement has been made. It is important to note that those new requirements were not measured in 2012 and were thereby not included in previous CAPs.

Medical Review Corrective Actions

Because insufficient documentation contributes to the Medicaid FFS improper payment rate, state CAPs have also focused on provider communication and education to reduce errors. These methods include:

- Provider training sessions;
- Meetings with provider associations;
- Notices, bulletins, and provider alerts;
- Provider surveys;
- Improvements and clarifications to written state policies emphasizing documentation requirements; and
- Performing more provider audits to identify areas of vulnerability and target solutions.

CMS believes these methods have proven successful as documentation errors have declined with each wave of active intervention and have consistently decreased since the PERM program's inception.

Data Processing Corrective Actions

Since the Medicaid and CHIP improper payment rates were primarily driven by data processing errors, state CAPs focus on systems changes to reduce these errors. Methods include:

- Implementing systems edits to enforce new requirements and to enforce additional field requirements for claim submission within the MMIS systems.
- Migrating to a new, more sophisticated MMIS system that is anticipated to prevent these types of errors in the future.

- Implementing state policy that requires attending provider information as outlined in the HIPAA standard.
- Implementing new provider enrollment processes.

States are updating and upgrading systems and processes to comply with new requirements.

CMS Program Improvements

Provider Outreach

CMS has made significant provider outreach-related efforts to reduce Medicaid and CHIP improper payments. Most FFS medical review errors resulted from providers failing to submit the necessary documentation to support the claims. It is possible that some, or even all, of the payments made for these claims were accurate, but CMS and its contractors could not verify their validity in the absence of sufficient documentation. CMS efforts have included:

- Providing states with more information on the potential impact of documentation errors;
- Sponsoring a series of interactive PERM provider education webinars to educate providers on what they are required to do if they receive a request for documentation; and
- Enhancing the CMS PERM website with up-to-date information regarding the PERM program, including developing a separate web page with relevant educational materials developed for providers, offering links to support states' provider education efforts, and establishing an e-mail account for providers to communicate directly with CMS.

State Outreach

Due to the complexity of Medicaid and CHIP and variations in state systems' sophistication, program structures, program management, and payment processes, CMS must work closely with states to reduce improper payments. As a result, CMS has collaborated with the states to implement a number of state outreach efforts, as listed below.

- CMS conducts "mini-PERM audits" with states. Mini-PERMs are voluntary state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during FYs in which states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease Medicaid and CHIP improper payments.
- CMS worked with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and

program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicaid and CMS data for program integrity purposes.

- CMS has determined that, beginning in FY 2016, state program integrity reviews will assess states' progress on PERM CAPs in the years between successive PERM reviews to provide more timely feedback.
- CMS allows states to rely on Medicare's enrollment screening of providers, which can help to prevent PERM-related enrollment errors. For example, state Medicaid agencies may rely on Medicare's site visits, in specific circumstances where the provider is enrolled in Medicare and Medicaid. CMS also shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements and provides states with ongoing education and outreach on federal requirements for Medicaid enrollment and screening.
- CMS continues to follow up with states on the status of implemented corrective actions.
- CMS continues to offer training, technical assistance, and support to state Medicaid program officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2015, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 6,200 enrollments in 136 courses and 9 workgroups, at no cost to the states.
- CMS continues the state systems workgroup to address individual state systems problems that may cause payment errors and/or make it difficult for states to submit accurate claims data for PERM review.
- CMS convenes quarterly national CAP best practice calls to facilitate sharing ideas and lessons learned among the states. States present their corrective action success stories so other states can implement similar initiatives.

Regulations

CMS published a final rule, titled "Medicaid Program: Recovery Audit Contractors" on September 16, 2011, implementing the ACA requirement for states to establish Medicaid Recovery Audit Contractors (RAC) programs.[18]

Medicaid RACs will review Medicaid provider claims to identify and recover overpayments and identify underpayments made for services provided under Medicaid State Plans and Medicaid waivers. CMS believes these regulations will contribute to decreasing improper payments. By September 30, 2015, 47 states and the District of Columbia had implemented RAC programs to

[18] 76 Fed. Reg. 57807 (Sept. 16, 2011).

identify and recover overpayments and identify underpayments made for services in their Medicaid programs.

Systems Enhancements

CMS developed a comprehensive plan to modernize the federal Medicaid and CHIP data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that CMS can provide more effective oversight of its programs. The plan will also result in a reduction of state burden and the availability of more robust data for the PERM program.

CMS also developed the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to CMS, expand the MSIS dataset, and allow CMS to review the completeness and quality of state MSIS submittals in real-time. CMS will use this data for the Medicaid improper payment measurement and to satisfy other CMS requirements. Through the use of T-MSIS, CMS will not only acquire higher quality data, but will also reduce state data requests.

CMS Program Integrity Board

In November 2014, CMS established a Program Integrity Board (the Board) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in the Agency's programs, including Medicaid and CHIP. The Board is comprised of CMS executive leaders, all of whom have a stake in the identification and prevention of improper and fraudulent payments. The Board directs corrective actions to combat high priority vulnerabilities and is responsible for directing program integrity activities, prioritizing vulnerabilities, resolving incidents, and addressing emerging issues.

- Beyond just the Board, a separate Program Integrity Workgroup will consider payment trends, vulnerabilities, and strategic issues to make recommendations for new corrective actions for the Board's consideration. The Program Integrity Workgroup will also implement the decisions and priorities articulated from the Board across the agency. The Program Integrity Workgroup will establish multiple Integrated Project Teams, focused on operational aspects of program integrity vulnerabilities that will each focus on one particular vulnerability area and research and develop possible solutions.
- The Program Integrity Workgroup and Integrated Project Teams will utilize data provided by an Improper Payments Corrective Action Team to target drivers and root causes of improper payments. The Improper Payments Corrective Action Team analyses and communicates data gathered from improper payment measurements such as the PERM program.

- CMS will utilize the Board to leverage all of the Agency's resources to explore new and innovative ways to improve program integrity to prevent and reduce improper payments.

Eligibility Review Pilots

The Affordable Care Act created significant nationwide changes to Medicaid and CHIP eligibility. In planning future improper payment measurements and accountability, special consideration needs to be paid to the interaction of the Marketplaces, Medicaid, and CHIP, and the cross-program interdependencies and coordination built to create an efficient system of coverage. Accordingly, the current methodologies applied to measurement of eligibility accuracy under PERM are being updated to reflect the changes states are making in their eligibility processes and systems and incorporate new regulations concerning the changes. Therefore, CMS implemented an interim methodology to conduct PERM eligibility reviews from 2015 to 2018. During this four-year period, all states are required to participate in Medicaid and CHIP Eligibility Review Pilots to provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to:

- Provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility;
- Identify strengths and weaknesses in operations and systems leading to errors; and
- Test the effectiveness of corrections and improvements in reducing or eliminating those errors.

The eligibility review pilots have identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes, as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html.

APPENDIX A: ERROR CODE DEFINITIONS

The **DATA PROCESSING REVIEWS** consisted of reviewing the sampled claims for the following errors.

- **Duplicate item** - An exact duplicate of the claim or payment was previously paid.
- **Non-covered service** - The provider was not enrolled in Medicaid/CHIP according to federal regulations and state policy; a claim was missing required attending, referring or ordering provider NPIs; and/or state policies indicate that the service is not payable under the state plan or for the coverage category under which the person is eligible.
- **Managed care service** - The beneficiary is enrolled in a managed care plan and the managed care plan should have covered the service rather than being paid under FFS.
- **Third-party liability** - Medicaid or CHIP paid for the service as the primary payer, but a third-party carrier should have paid for the service.
- **Pricing error** - Payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.
- **Logic edit** - A system edit was not in place to follow state policy or a system edit was in place, but was not working correctly and the claim was paid inappropriately.
- **Data entry error** – A claim was paid in error due to clerical errors in the data entry of the claim.
- **Rate cell error** - The beneficiary was enrolled in managed care and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell.
- **Managed care payment error** - The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.
- **Administrative/other** - A payment error was discovered during a data processing review, but the error was not a DP01 – DP09 error. The specific nature of the error is recorded.

The **MEDICAL REVIEWS** consist of reviewing sampled FFS claims for the following errors.

- **No documentation** - The provider did not respond to the request for records or the provider responded that he/she did not have the requested documentation.

- **Insufficient documentation** - The provider did not return information requested or did not submit sufficient documentation for the reviewer to determine whether the allowed services were provided at the level billed and/or medically necessary.

- **Procedure coding error** - The provider performed a procedure or provided a medical service that was medically necessary and provided at the proper level of care, but billed and was paid using an incorrect procedure code.

- **Diagnosis coding error** - The provider billed and was paid using an incorrect principal diagnosis code and/or DRG.

- **Unbundling** - The provider billed for separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set, rather than as individual services.

- **Number of unit(s) error** - The provider billed for an incorrect number of units for a particular procedure/service, NDC code, or revenue code.

- **Medically unnecessary** - The provider billed for a service determined to have been medically unnecessary based upon the information regarding the patient's condition in the medical record.

- **Policy violation** - Either the provider billed and was paid for a service that was not in agreement with state policy or the provider billed and was not paid for a service that, according to state policy, should have been paid.

- **Administrative/other** - A payment error was discovered during a medical review, but it was not an MR01 – MR08. The specific nature of the error is recorded.

APPENDIX B: GLOSSARY OF TERMS

Adjudicated claim: In reference to denied claims, an adjudicated claim is one that has been accepted and reviewed by the claim processing system and the decision to deny the claim has been made. In reference to paid claims, an adjudicated claim refers to a submitted claim that has been accepted and fully reviewed and a positive determination has been made regarding the payment amount. For denied claims, the adjudication date should be used to determine whether a claim is included in a fiscal quarter if the state system does not capture a "paid date" for these claims. For paid claims, the date paid should be used for this determination.

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Annual sample size: The number of FFS claims, managed care payments, or eligibility cases necessary to meet precision requirements in a given PERM cycle.

Capitation: A fixed payment, usually made on a monthly basis, for each beneficiary enrolled in a managed care plan or for each beneficiary eligible for a specific service or set of services.

Children's Health Insurance Program (CHIP): A program authorized and funded under Title XXI of the Social Security Act. Federal regulations governing this program are at 42 CFR Part 457.

CHIP universe (Claims): Claims and payments where all services are paid with Title XXI funds, including Title XXI Medicaid expansion claims and payments (where beneficiaries are enrolled in Medicaid, but their claims and payments are matched with Title XXI funding) that are funded under CHIP.

Claim: A request for payment, on either an approved form or electronic media, for services rendered generally relating to the care and treatment of a disease or injury or for preventative care. A claim may consist of one or several line items or services.

Cycle: The 17-state, three-year rotation based on FY used to measure improper payments.

Cycle rate: The payment rate for the 17 states measured in the current FY's cycle.

Denied claim or line item: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Difference resolution: A process that allows states to dispute the Review Contractor's (RC's) error findings.

Eligibility: Meeting the state's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Fee-For-Service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the state Medicaid/CHIP system (exclusive of medical reviews and eligibility reviews).

Improper payment: Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible beneficiary, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts.

Managed care: A system where the state contracts with health plans, on a prospective full-risk or partial-risk basis, to deliver health services through a specified network of doctors and hospitals. The health plan is then responsible for reimbursing providers for specific services delivered.

Managed Care Organization (MCO): An entity that has entered into a risk contract with a state Medicaid and/or CHIP agency to provide a specified package of benefits to Medicaid and/or CHIP enrollees. The MCO assumes financial responsibility for services delivered and is responsible for contracting with and reimbursing servicing providers. State payments to MCOs are typically done on the basis of a monthly capitation payment per enrolled beneficiary.

Medicaid: A joint Federal and state program, authorized under Title XIX of the Social Security Act (the Act) that provides medical care to people with low incomes and limited resources.

Medicaid universe (Claims): Claims and payments where all services are paid with Title XIX funds.

Medical review error: An error that is determined from a review of the medical documentation in conjunction with state medical policies and information presented on the claim.

Overpayment: Overpayments occur when the state pays more than the amount the provider was entitled to receive or paid more than its share of the cost.

Paid claim: A claim or line item that was accepted by the claims processing or payment system, adjudicated for payment, determined to be a covered service eligible for payment, and for which a payment was issued or no payment was issued due to circumstances such as payment by a third party insurer.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

Payment: Any payment to a provider, insurer, or MCO for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP FFP. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

Payment error rate: An annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

PERM Website: The official CMS website for the PERM program located at http://www.cms.gov/PERM.

PERM+: A claims and payment data submission method where the state submits claims, provider, and beneficiary data to the Statistical Contractor (SC). The SC uses the data to build universes from which a random sample of claims is selected. After drawing the samples, the SC sends the samples to the RC and the states. The SC then populates the sampled FFS claims with detailed service and payment information and sends these samples to the RC.

Routine PERM: A claims and payment data submission method where the state submits claims universes to the SC. The SC draws a random sample of claims from the quarterly universes submitted by the state. After drawing the samples, the SC sends the samples to the RC. The SC also sends the states a list of their sampled claims, and states populate sampled FFS claims with detailed service and payment information for the SC. The SC formats the state submissions and sends them to the RC.

Sample: A random sample of claims selected from a universe (see "universe" definition below).

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in a managed care plan or a monthly Medicare premium). Depending on the universe (e.g., FFS or managed care), the sampling unit includes: claim, line item, premium payment, or capitation payment.

State error: This includes, but is not limited to, data processing errors and eligibility errors as described in 42 CFR 431.960(b) and (d), as determined in accordance with documented state or Federal policies or both.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe (Claims): The universe is the set of sampling units from which the sample for a particular program area is drawn and the set of payments for which the error rate is inferred from the sample. The term "claim" is used interchangeably with the term "sampling unit."

Zero-paid claim: A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars. This can occur due to third-party liability, application of deductibles and patient liability, or other causes.

APPENDIX C: ACRONYMS

- Affordable Care Act (ACA or PPACA)
- Centers for Medicare & Medicaid Services (CMS)
- Children's Health Insurance Program (CHIP)
- Corrective Action Plan (CAP)
- Code of Federal Regulations (CFR)
- Drug Enforcement Administration (DEA)
- Date of Service (DOS)
- Durable Medical Equipment (DME)
- Fiscal Year (FY)
- Fee-For-Service (FFS)
- Health Maintenance Organization (HMO)
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Insurance Organization (HIO)
- Intermediate Care Facilities (ICF)
- Improper Payments Elimination and Recovery Act of 2010 (IPERA)
- Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)
- Improper Payments Information Act of 2002 (IPIA)
- Medicaid Eligibility Quality Control (MEQC)
- Medicaid Management Information System (MMIS)
- Managed Care Organization (MCO)
- Medicaid Integrity Institute (MII)
- National Drug Code (NDC)
- National Provider Identifier (NPI)
- National Association of Medicaid Directors (NAMD)
- Office of the Inspector General (OIG)
- Office of Management and Budget (OMB)
- Pre-paid Inpatient Health Plan (PIHP)
- Pre-paid Ambulatory Health Plan (PAHP)

- The Program Integrity Board of CMS (the Board)
- Patient Protection and Affordable Care Act (PPACA or ACA)
- Payment Error Rate Measurement (PERM)
- Medicaid Recovery Audit Contractor (RAC)
- Review Contractor (RC)
- State Plan Amendment (SPA)
- Statistical Contractor (SC)
- Social Security Act (SSA)
- Transformed Medicaid Statistical Information System (T-MSIS)
- United States Department of Health and Human Services (HHS)