Medicaid and CHIP 2016 Improper Payments Report

I. EXECUTIVE SUMMARY

This report supplements the improper payment information in the annual Department of Health and Human Services Agency Financial Report (AFR).

The Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), (hereafter collectively referred to as IPIA),[1] requires that federal agencies annually review programs that they administer 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.

Improper Payments ≠ Fraud

While all payments made as a result of fraud are considered "improper payments," not all improper payments constitute fraud. The improper payment rate is a measure of compliance with and adherence to federal rules and requirements and does not mean these are payments that should not have been made in the first place.

An improper payment is defined as any payment made:

- In error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;
- To an ineligible beneficiary;
- For ineligible goods or services;
- For goods or services not received (except for such payments where authorized by law);
- That duplicates a payment;
- That does not account for credit for applicable discounts;
- Without supporting documentation; and
- Where documentation is missing or not available.

Medicaid and the Children's Health Insurance Program (CHIP) have been identified as programs at risk for significant improper payments and, therefore, are required to report improper payments estimates. 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

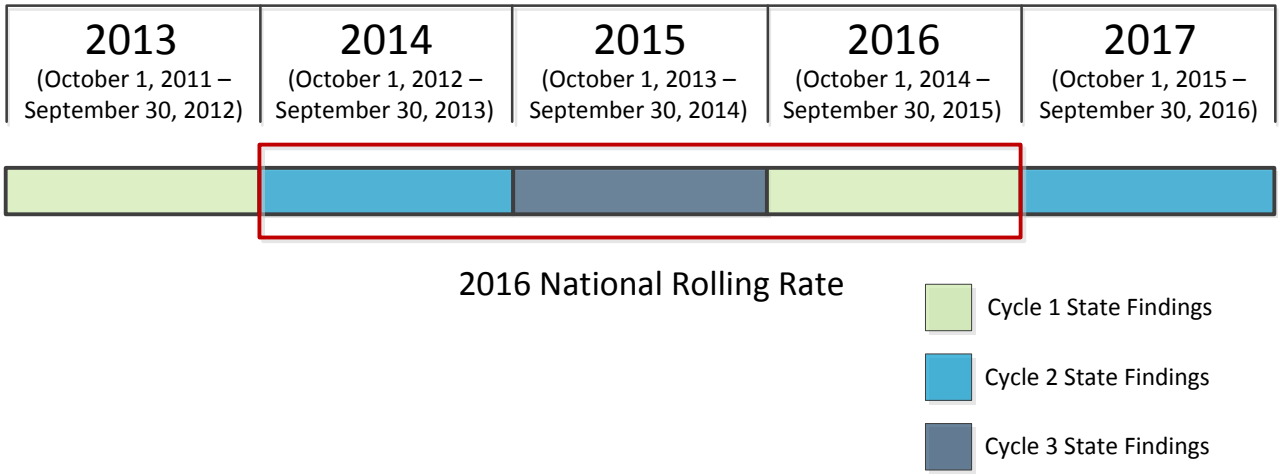
[1] The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Estimation and Remediation of Improper Payments* provides IPIA implementing guidance.

3) Payments resulting from eligibility determinations.[2]

The PERM program strictly adheres to IPIA requirements and measures Medicaid and CHIP payments to the highest standard. Medicaid and CHIP improper payment rates include instances where reviews could not be completed due to no or insufficient documentation, improper payments of all dollar amounts (i.e., no dollar threshold under which errors will not be cited), and improper payments caused by policy changes as of the effective date of the new policy (i.e., no grace period permitted).

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. The official Medicaid and CHIP 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 the PERM program, the previous findings for that group of states are dropped from the calculation and the newest findings are added in (see Figure 1).

FIGURE 1. 2016 NATIONAL IMPROPER PAYMENT RATE COMBINES THE THREE MOST RECENT CYCLE MEASUREMENT FINDINGS

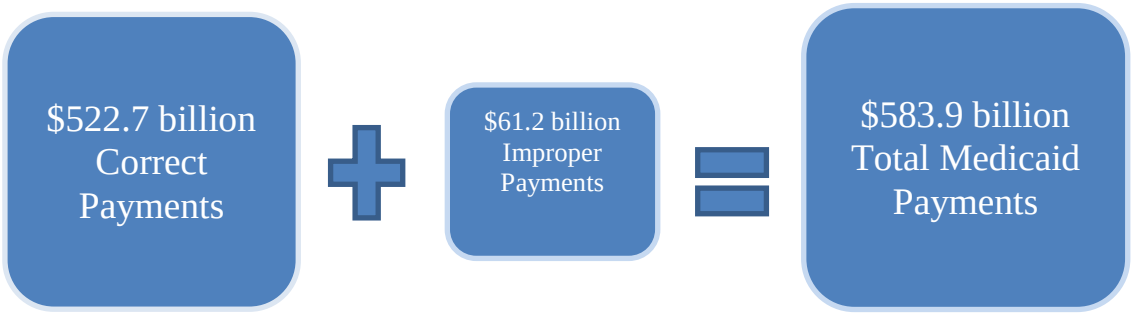


The following graphics provide an overview of the Medicaid and CHIP 2016 improper payment rates.

[2] As explained further herein, eligibility reviews are suspended beginning with rates reported in 2015 while CMS develops a new eligibility review methodology. Consistent with the 2015 improper payment rate, the eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates used in the 2014 improper payment rate.

MEDICAID – 10.5% IMPROPER PAYMENT RATE[3]

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

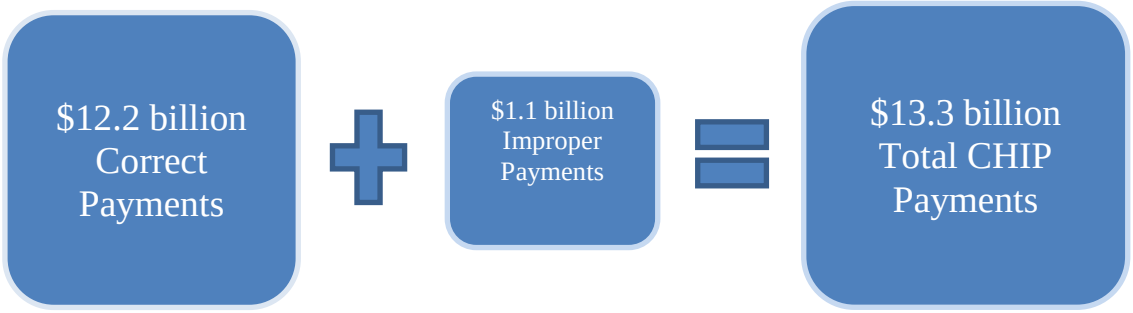


Component	Improper Payment Rate	Total Projected Improper Payments ($billions)	Federal Share Projected Improper Payments ($billions)
FFS	12.4%	$43.8	$25.5
Managed Care	0.3%	$0.6	$0.4
Eligibility*	3.1%	$18.1	$10.7
Overall[5]	**10.5%**	**$61.2**	**$36.3**

* Note: Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates used in the 2014 improper payment rates.

CHIP – 8.0% IMPROPER PAYMENT RATE

CORRECT PAYMENTS + IMPROPER PAYMENTS = TOTAL CHIP PAYMENTS



[3] As reported in the 2016 Department of Health and Human Services' Agency Financial Report, the 2016 Medicaid improper payment rate was reported as 10.48% and the CHIP improper payment rate was reported as 7.99%. This report rounds those rates 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.

[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.

Component	Improper Payment Rate	Total Projected Improper Payments ($billions)	Federal Share Projected Improper Payments ($billions)
FFS	10.2%	$0.4	$0.3
Managed Care	1.0%	$0.1	$0.1
Eligibility*	4.2%	$0.6	$0.4
Overall	**8.0%**	**$1.1**	**$0.7**

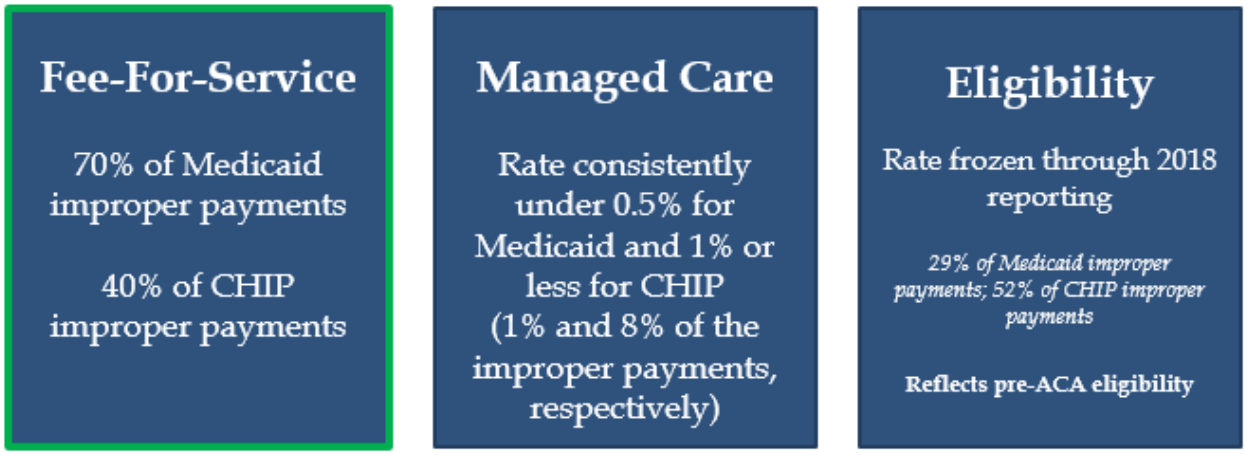
* Note: Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

2016 MEDICAID AND CHIP IMPROPER PAYMENT RATES INCREASE BUT MEDICAID MEETS TARGET

The Medicaid improper payment rate increased from 9.8% in 2015 to 10.5% in 2016. However, Medicaid met the 2016 improper payment rate target of 11.5%. The 2016 CHIP improper payment rate of 8.0% is also higher than the 2015 rate of 6.8%. The increases in both the Medicaid and CHIP improper payment rates continued to be driven by increases, specifically in FFS improper payments, due to state difficulties coming into compliance with new requirements.

2016 represents the first baseline improper payment rate for state compliance with new requirements. CMS cautions against equating rate increases to improper payment regression until states are measured again.

In 2014, CMS began measuring states for compliance with requirements that were established to strengthen program integrity. It is not unusual to see increases in improper payment rates following the implementation and initial measurement of new requirements because it takes time for states to make changes to comply. Since CMS reviews 17 states each year, it takes three years to measure all states. Therefore, the Medicaid and CHIP improper payment rates saw an increase in the three-year period from 2014 – 2016, as this three-year period represents the first time all states were reviewed under the new requirements. Now that all states have been measured under these requirements, CMS expects improper payments related to non-compliance with the new requirements to decrease beginning in 2017, as CMS works with each state to develop and implement corrective actions to address the errors identified and improve the results in their next PERM cycle. Although the Medicaid improper payment rate increased as the last group of states were measured, CMS met the 2016 improper payment rate target.



Below, the specific policy changes (or new requirements mentioned earlier) resulting in higher 2014 – 2016 improper payments are described in more detail.

- Ordering and Referring Physicians and other professionals (ORP) are required to be enrolled in Medicaid/CHIP.
- ORP National Provider Identifier (NPI) is required to be submitted on the claim.
- States are required to screen providers under a risk-based screening process prior to enrollment.

- Attending provider NPI is required to be submitted on electronically filed institutional claims (e.g., hospital and long term care services).

These errors are expected to decrease as states implement corrective actions.

Improper payments related to non-compliance with these new requirements do not necessarily represent payments to illegitimate providers. Typically, improper payments were cited when information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. If the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable. If these new requirements were not measured, the Medicaid improper payment rate would have continued to consistently decrease since 2010 and the 2016 Medicaid rate would have been 4.9%.

Unlike many other federal agencies that provide exceptions in their improper payment measurements for cases for which reviews cannot be completed (i.e., no or insufficient documentation), improper payments under a certain threshold amount, or improper payments caused by policy changes, the PERM program strictly adheres to IPIA requirements. As a result, this strict adherence leads to a larger number of improper payments identified, a higher rate, and a greater opportunity for corrective actions than other agencies performing similar reviews. Reference: GAO-16-708T

Table of Contents

Index of Tables

II. PERM PROGRAM BACKGROUND

The Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), (hereafter collectively referred to as IPIA),[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 the Medicaid program and CHIP

The Medicaid program was enacted in 1965 and its governing statutes are found at Title XIX of the Social Security Act ("Act"). 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 (specifically low-income children for CHIP). Under these federal authorities, each state partners with the federal government to enact the Medicaid program and CHIP 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 both their Medicaid program and CHIP 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 Cycles 3, 1, 2, and 3 (reported in 2015 – 2018, respectively), CMS is suspending the formal eligibility review component of PERM. While CMS develops the new eligibility review methodology, the eligibility improper payment rates used in the 2014 improper payment rate are used as a proxy in calculating the overall Medicaid and CHIP improper payment rates, along with data from the PERM FFS and

[6] The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Estimation and Remediation of Improper Payments* provides IPIA implementing guidance.

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 required states to conduct Medicaid and CHIP Eligibility Review Pilots (see the Eligibility Review Pilots section beginning on page 55 for more information on the pilots) to continue to assess their eligibility determination processes and policies post-ACA, to prepare for the resumption of PERM eligibility.

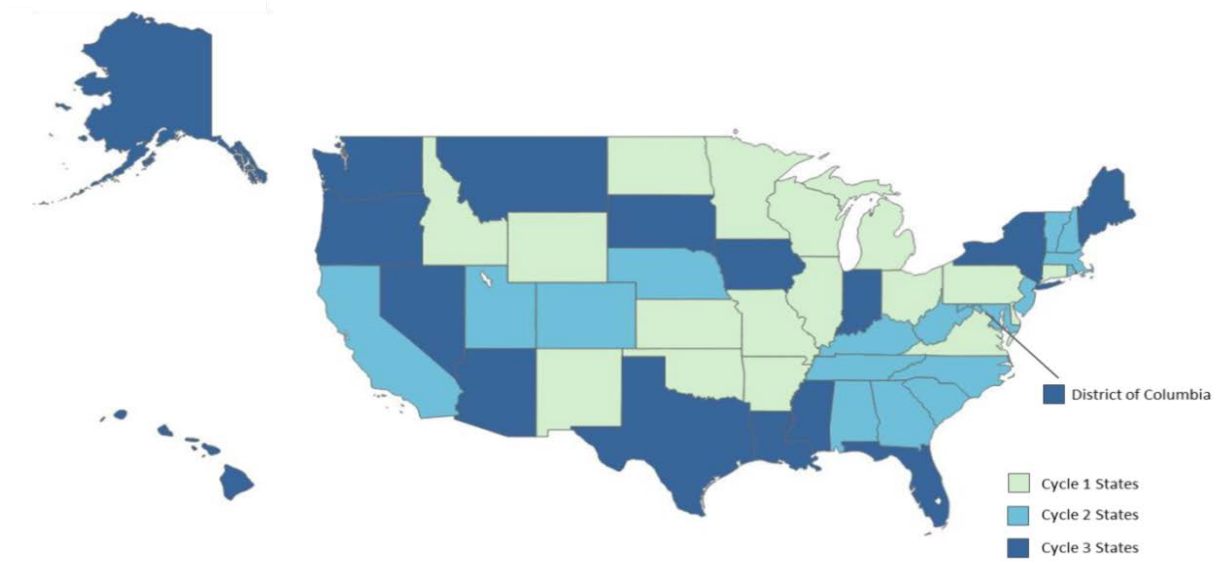
PERM Program Objectives

The PERM program requires a joint effort between CMS and the states to calculate the Medicaid and CHIP 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 1.1, as well as in Figure 2, below, which provides the state cycle information graphically.

TABLE 1.1. STATES IN EACH CYCLE

Cycle	States
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 2016 improper payment rate (i.e., Cycle 1) are in **bold**.	

FIGURE 2. STATES IN EACH CYCLE

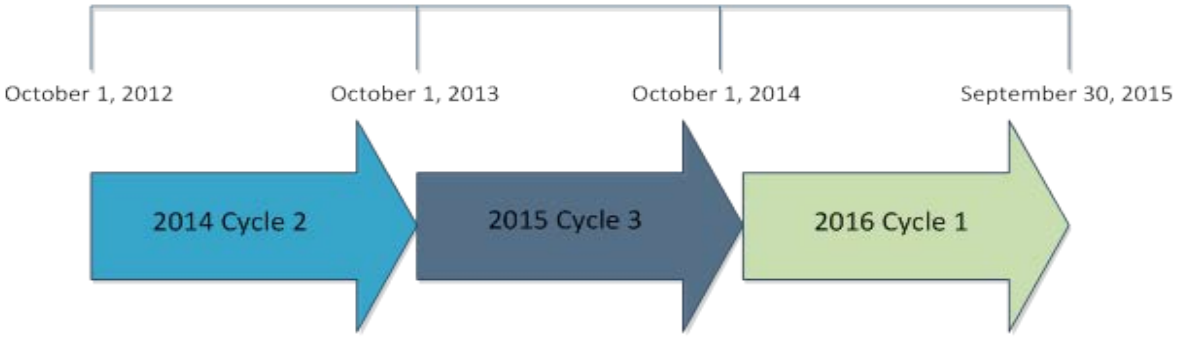


III. PERM METHODOLOGY

The measurement of improper payments in Medicaid and CHIP is a complex, multi-step process. Each state has considerable flexibility in structuring its Medicaid program and CHIP, 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 2016 Medicaid and CHIP improper payment rates represent a review period (i.e., the time period from which the sampled claims were actually paid) for all 50 states and the District of Columbia spanning from October 2012 to September 2015. The three review periods displayed in Figure 3 comprise reporting year 2016.

FIGURE 3. PERIOD UNDER REVIEW FOR THE 2016 PERM MEDICAID AND CHIP NATIONAL IMPROPER PAYMENT RATES



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

1. Fee-For-Service (FFS) claims;
2. Managed care capitation payments,[7] and
3. The payments resulting from eligibility determinations.[8]

CMS uses federal contractors to review a random sample of FFS and managed care payments. The section below describes each step of the sampling and review process, along with a high-level presentation of findings for the 2016 Medicaid and CHIP improper payment rates.

[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.

[8] Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates used in the 2014 improper payment rate.

Sample Selection

The first step in the PERM process is selecting a random sample for each component. The 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 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 2.1 presents the sample sizes from all 17 states in the most recent cycle years.

TABLE 2.1. SAMPLE SIZES BY CYCLE AND CLAIM TYPE[11]

Claim Type	2014 Cycle 2	2015 Cycle 3	2016 Cycle 1
MEDICAID			
FFS	6,119	7,599	9,964
Managed Care	3,390	3,110	3,191
Eligibility Active	9,794	N/A	N/A
Overall	**19,303**	**10,709**	**13,155**
CHIP			
FFS	7,779	5,934	7,499
Managed Care	2,869	3,121	3,360
Eligibility Active	8,268	N/A	N/A
Overall	**18,916**	**9,055**	**10,859**

Note: Eligibility reviews are suspended beginning with rates reported in 2015 while CMS develops a new eligibility review methodology. Consistent with the 2015 improper payment rate, the eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate. Therefore, no eligibility sample sizes are reported for 2015 or 2016.

[9] When a FFS or managed care component for a state accounted for less than 2% 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 five states for Medicaid and in one state 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% margin of error at the 95% confidence interval for state level improper payment rates ensures that the national improper payment rate will surpass IPIA 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 this table.

Once the samples are selected, the claims and cases are reviewed for accuracy. The review process consists of data processing reviews and medical record reviews. The review process, including each type of review and the difference resolutions process, 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, the Review 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 should have been avoided through the state's Medicaid Management Information System (MMIS) or other payment system(s).

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. Additionally, system edits are also designed to prevent payments for claims such as those that contain a gender conflict (e.g., 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 the 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 provider, servicing provider, and Ordering and Referring Physicians and other professionals (ORP) 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, Managed Care Organizations (MCOs), and Health Insurance Organizations;
- Premiums for partial risk insurance contracts, such as Pre-paid Inpatient Health Plans and Pre-paid Ambulatory Health Plans;
- 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 FFS claims, with the exception of the following (which will still receive a data processing review):

- 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 beneficiary.
- 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 (medical review may be required for denied claims if the state denied the claim for medical necessity or other reason verifiable only through review of the medical record).

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 Review 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 missing documents 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 additional documentation request, the claim is cited as an improper payment due to an "incomplete 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 Review 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 Review 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 Review Contractor's conclusion, dispute the finding. The Review 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 Review Contractor's final decision, it may appeal to the PERM Appeals Panel within the CMS PERM program.

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 that resulted in an overpayment, the total error amount will be no greater than the total paid amount for the claim. However, for cases of underpayments, including zero paid claims, the total error amount may exceed the total paid amount.

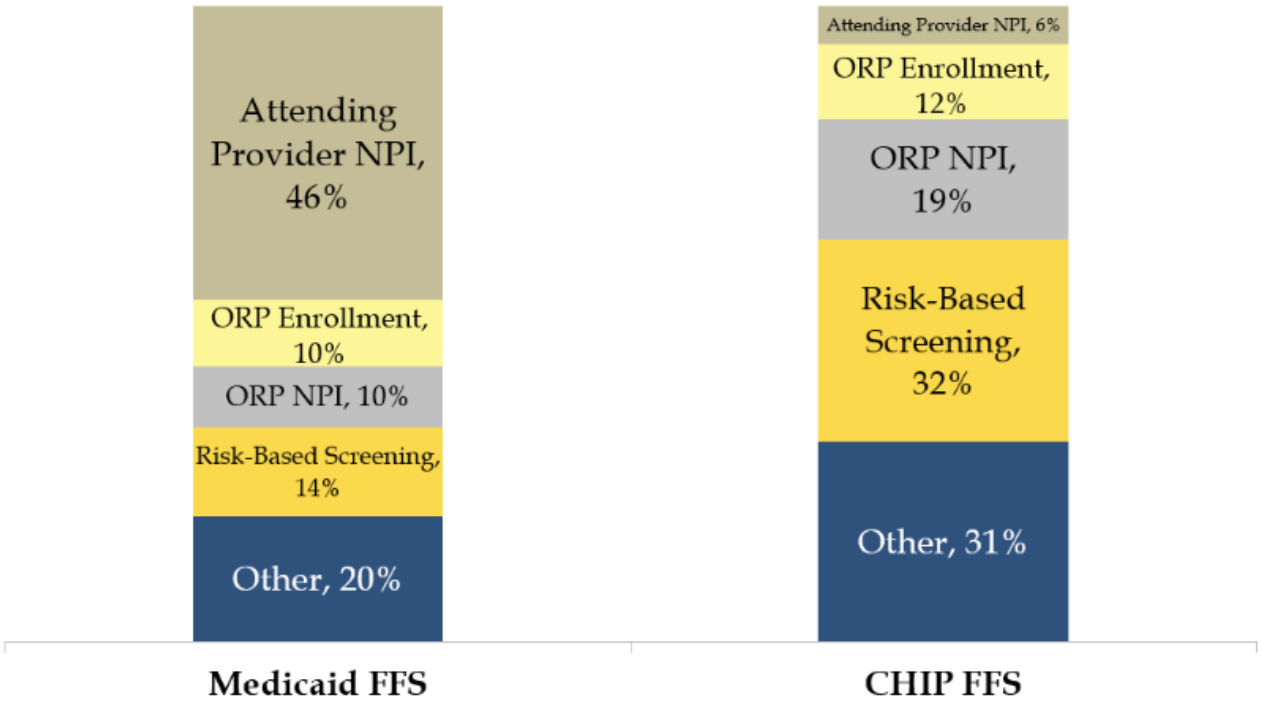
IV. FEE-FOR-SERVICE RESULTS

FFS reviews include: 1) payments by claims processing systems, and 2) documentation in the medical records to support claims as billed. The Medicaid FFS 2016 improper payment rate based on claims data processing is 11.1% while the CHIP claims data processing rate is 8.3%. The 2016 medical review improper rate for Medicaid is 1.9% and the CHIP rate is 2.2%.

As shown in Figure 4, 80% of the Medicaid FFS rate and 69% of the CHIP FFS rate are attributable to four specific drivers related to state non-compliance with the following new requirements, including:

- HIPAA standard that requires the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims;
- All ORP are required to be enrolled in Medicaid/CHIP;
- All ORP must have the NPI on the claim; and
- States are required to screen providers under a risk-based screening process prior to enrollment.

FIGURE 4. MEDICAID AND CHIP FFS 2016 IMPROPER PAYMENT DRIVERS



Although the primary drivers of the FFS improper payment rates of both Medicaid and CHIP are attributable to these four issues related to state non-compliance with following new requirements, the primary driver within each program differs.

- Attending provider NPI not listed on institutional claims was a significantly 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 CHIP as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. Because standalone programs generally operate independently from Medicaid, some states failed to comply with ACA standards with respect to these programs. Additionally, a higher percentage of CHIP providers were not enrolled in Medicare and, therefore, there were more cases where states were not able to rely on Medicare's screening of providers (which is discussed in more detail on Page 53) in lieu of conducting state screening.
- Errors classified as "other" include primarily provider documentation errors in both Medicaid and CHIP.

Data Processing Reviews

MEDICAID

Table 3.1 identifies the number of payment errors by error type as well as the corresponding projected improper payments for Medicaid FFS data processing errors.

TABLE 3.1. 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
Provider Information/Enrollment Error (DP10)	2,532	84.1%	$8,341,821.0	97.4%	$37,484.8	95.8%
Non-covered Service/Beneficiary (DP2)[12]	117	3.9%	$153,518.0	1.8%	$602.3	1.5%
Data Entry Error (DP7)	7	0.2%	$3,167.9	0.0%	$408.4	1.0%
Third-party Liability Error (DP4)	9	0.3%	$9,225.3	0.1%	$268.0	0.7%
Pricing Error (DP5)	96	3.2%	$35,895.4	0.4%	$184.6	0.5%
Administrative/Other (DP12)	10	0.3%	$2,740.3	0.0%	$84.2	0.2%
Duplicate Claim (DP1)	2	0.1%	$9,868.0	0.1%	$54.7	0.1%
FFS Payment for Managed Care Service (DP3)	2	0.1%	$5,117.6	0.1%	$14.1	0.0%
System Logic Edit Error (DP6)	3	0.1%	$228.7	0.0%	$6.8	0.0%
Claim Filed Untimely (DP11)	1	0.0%	$2,928.6	0.0%	$4.1	0.0%
Data Processing Technical Deficiency (DTD)	232	7.7%	$0.0	0.0%	$0.0	0.0%

[12] Note that beneficiary has replaced the term "recipient" throughout this report, including within the DP2 error code used in other reporting documents, in order to better describe those receiving Medicaid and CHIP benefits.

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Managed Care Rate Cell Error (DP8)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Managed Care Payment Error (DP9)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**3,011**	**100.0%**	**$8,564,510.7**	**100.0%**	**$39,112.0**	**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, Provider Information/Enrollment Error (DP10) represented the vast majority of the total Medicaid FFS data processing projected improper payments, at 95.8%. These errors were primarily due to state system non-compliance with HIPAA and ACA provider requirements.

Provider Information/Enrollment Errors

The PERM program cites a Provider Information/Enrollment (DP10) error when the provider was not enrolled in Medicaid as required by federal regulations and state policy, or when required provider information was missing from the claim. Provider Information/Enrollment errors primarily occurred because states did not comply with HIPAA claims standards and ACA provider enrollment requirements. Examples of these errors are provided below.

Provider Information/Enrollment (Attending provider NPI required, but not submitted on institutional claim) Error Example: A hospital claim was submitted without the individual attending physician's NPI. Per 45 CFR 162.1102, all claims submitted electronically on or after July 1, 2012 must comply with Accredited Standards Committee (ASC) X12 Version 5010 as the HIPAA electronic transaction standard. This standard requires the individual attending provider's NPI to be documented on all institutional claims other than non-scheduled transportation claims. The provider electronically submitted this institutional claim using the older Version 4010 format, violating the applicable HIPAA electronic transaction standard. Therefore, this claim constituted an overpayment error.

Provider Information/Enrollment (Attending/rendering provider not enrolled) Error Example: This error is cited because the attending provider was not enrolled with Medicaid on the date of service. The attending provider who wrote the admission order (the ORP) was required to be enrolled in Medicaid, but had been terminated from enrollment prior to the date of service. Per 42 CFR 455.410, the state Medicaid agency must require all ORP providing services under the state plan or under a waiver of the plan to be enrolled as participating providers. Because the provider was not enrolled as required, this claim constituted an overpayment error.

Provider Information/Enrollment (Provider not screened using ACA risk-based criteria prior to enrollment) Error Example: The attending provider was enrolled prior to completion of the risk-

based screening requirements. As required by 42 CFR 455.450, the state (Medicaid/CHIP) agency must screen all initial provider enrollment applications, including those for a new practice location, and applications requesting re-enrollment or revalidation. The state provided documentation that all database checks were completed, but the screening did not occur until after the state enrolled the provider and paid the claim. Therefore, this claim constituted an overpayment error.

Non-covered Service/Beneficiary Errors

The PERM program cites Non-covered Service/Beneficiary (DP2) errors when a state pays claims for services that are not payable by the Medicaid program pursuant to state policy, or the beneficiary was ineligible for the billed service. This error type represents only 1.5% of the Medicaid FFS data processing errors. An example of a non-covered service/beneficiary error is provided below.

Non-covered Service/Beneficiary (Beneficiary was ineligible for applicable program on date of service) Error Example: The state's eligibility source system, which houses active and inactive eligibility, did not show coverage was in effect for the beneficiary on the sampled date of service. Therefore, this claim constituted an overpayment error.

Data Entry Errors

The PERM program cites Data Entry (DP7) errors when a claim or line item is erroneously paid due to clerical errors in the claim's data entry. This error type represents less than 1.0% of the Medicaid FFS data processing errors. An example of a data entry error is provided below.

Data Entry (Rates incorrectly entered into system rate file) Error Example: When entering claim information into its system, the state entered an incorrect Diagnosis-Related Group rate, causing an underpayment error.

CHIP

Table 3.2 identifies the count of payment errors by error type as well as the corresponding projected improper payments for CHIP FFS data processing errors.

TABLE 3.2. 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
Provider Information/Enrollment Error (DP10)	1,673	57.9%	$2,923,008.5	81.3%	$309.3	86.9%
Non-covered Service/Beneficiary (DP2)	649	22.5%	$534,093.7	14.8%	$33.0	9.3%
Administrative/Other (DP12)	19	0.7%	$2,457.4	0.1%	$5.7	1.6%
Pricing Error (DP5)	142	4.9%	$37,509.1	1.0%	$3.0	0.9%
Third-party Liability Error (DP4)	17	0.6%	$761.7	0.0%	$2.5	0.7%

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Duplicate Claim (DP1)	11	0.4%				0.3%
Data Entry Error (DP7)	42	1.5%				0.3%
FFS Payment for Managed Care Service (DP3)	3	0.1%				0.1%
Claim Filed Untimely (DP11)	3	0.1%				0.1%
Data Processing Technical Deficiency (DTD)	329	11.4%				0.0%
System Logic Edit Error (DP6)	0	0.0%				0.0%
Managed Care Rate Cell Error (DP8)	0	0.0%				0.0%
Managed Care Payment Error (DP9)	0	0.0%				0.0%
Total	**2,888**	**100.0%**				**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, Provider Information/Enrollment errors (DP10) represented the vast majority of the total CHIP FFS data processing projected improper payments, at 86.9%. These errors were primarily due to state system non-compliance with HIPAA and ACA provider requirements.

Provider Information/Enrollment Errors

The PERM program cites a Provider Information/Enrollment (DP10) error when the provider was not enrolled in CHIP as required by federal regulations and state policy, or when required provider information was missing from the claim. Provider information/enrollment errors primarily occurred because states did not comply with ACA provider enrollment requirements and HIPAA claims standards. Examples of Provider Information/Enrollment (DP10) errors are provided below.

Provider Information/Enrollment (Provider not screened using ACA risk-based criteria prior to enrollment) Error Example: The state enrolled the rendering provider in CHIP effective July 14, 2013, without properly screening the provider per 42 CFR 455.450, including the database checks required by 42 CFR 455.436. These databases include the Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), and the Excluded Parties List System (EPLS). As of March 24, 2011, states are required to comply with the ACA's risk-based screening requirements for all newly enrolled providers. Because the state did not complete the required database checks or provide supporting documentation of its screening process, this claim constituted an overpayment error.

Provider Information/Enrollment (ORP NPI required, but not listed on claim) Error Example: A claim was submitted without the required ordering (prescribing) provider's NPI. In accordance with 42 CFR 455.440, all claims for ordered or referred items and services must be submitted with the NPI of the physician or other professional who ordered or referred such items or services. Because

the claim did not include the ordering (prescribing) provider's NPI, it constituted an overpayment error.

Provider Information/Enrollment (ORP not enrolled) Error Example: A pharmacy claim was submitted, which requires an order from a physician or licensed practitioner per 42 CFR 440.120. However, the ordering provider was not enrolled in CHIP. As required by 42 CFR 455.410(b), all ORP providing services under the State Plan must be enrolled as participating providers. Because the ordering provider was not enrolled, the claim constituted an overpayment error.

Non-covered Service/Beneficiary Errors

The PERM program cites Non-covered Service/Beneficiary (DP2) errors when a state pays claims for services that are not payable by CHIP pursuant to state policy, or the beneficiary was ineligible for the billed service. This error type represents 9.3% of the CHIP FFS data processing errors. An example of a Non-covered Service/Beneficiary (DP2) error is provided below.

Non-covered Service/Beneficiary (Beneficiary was ineligible for the applicable program on date of service) Error Example: A claim was paid using Title XXI (CHIP) funding, but the beneficiary's aid category on the date of service indicated eligibility for Medicaid, not CHIP. The state's eligibility source system indicated the beneficiary was Medicaid eligible, but the claims processing system showed the beneficiary was CHIP eligible. Because the state was unable to provide verification of the beneficiary's true eligibility on the date of service, the claim constituted an overpayment error.

Pricing Errors

The PERM program cites Pricing (DP5) errors when the payment for a service does not correspond with the pricing schedule on file and in effect for the sampled date of service. This error type represents 0.9% of the CHIP FFS data processing errors. An example of a Pricing (DP5) error is provided below.

Pricing (Co-pay should not have been deducted from payment) Error Example: An inpatient hospital co-payment per day was deducted from the payment of this pregnancy-related claim. Per 42 CFR 447.56(a)(1)(vii), states may not impose deductibles, copayments, or any other similar charges for pregnancy-related services furnished to pregnant women. Because the state deducted a co-payment, the claim constituted an underpayment error.

Medical Reviews

MEDICAID

Table 3.3, below, shows the medical review errors by error type and the projected improper payments for Medicaid FFS.

TABLE 3.3. 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
Incomplete Documentation (MR2)	343	51.7%	$427,547.9	74.4%	$3,630.6	53.3%
No Documentation (MR1)	227	34.2%	$113,540.6	19.8%	$1,748.9	25.7%
Number of Unit(s) Error (MR6)	27	4.1%	$10,980.2	1.9%	$569.4	8.4%
Administrative/Other (MR10)	6	0.9%	$1,967.3	0.3%	$395.3	5.8%
Inadequate Documentation (MR9)	15	2.3%	$11,903.6	2.1%	$233.9	3.4%
Procedure Coding Error (MR3)	8	1.2%	$1,508.0	0.3%	$214.9	3.2%
Policy Violation (MR8)	5	0.8%	$7,346.1	1.3%	$15.9	0.2%
Unbundling (MR5)	4	0.6%	$13.5	0.0%	$3.8	0.1%
Medically Unnecessary (MR7)	1	0.2%	$15.0	0.0%	$0.4	0.0%
Medical Technical Deficiency (MTD)	27	4.1%	$0.0	0.0%	$0.0	0.0%
Diagnosis Coding Error (MR4)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**663**	**100.0%**	**$574,822.3**	**100.0%**	**$6,813.2**	**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, No Documentation (MR1), Incomplete Documentation (MR2), and Inadequate Documentation (MR9), represented 82.4% of the total Medicaid FFS medical review projected improper payments. Number of unit(s) errors account for 8.4% of the total Medicaid FFS medical review projected improper payments.

Incomplete Documentation Errors

The PERM program cites Incomplete Documentation (MR2) errors when the information submitted is incomplete and does not support the service billed, such as when the provider supplies incomplete documentation to determine the medical necessity of the claim, or the medical records submitted do not document the tasks performed on the sampled date of service. Examples of Incomplete Documentation (MR2) errors are provided below.

Incomplete Documentation (Provider did not submit the pharmacy signature log and/or documentation of patient counseling) Error Example: A pharmacy submitted a claim for a prescribed drug. The Review Contractor requested documentation that the patient accepted or refused counseling, and proof the patient received the prescribed drug to support the sampled claim. The documentation submitted by the pharmacy was incomplete to support the claim, resulting in an overpayment error.

Incomplete Documentation (Provider did not submit required progress notes applicable to the sampled DOS) Error Example: A nursing facility submitted a claim. The Review Contractor requested the physician's 60-day visit progress note to validate the claim for sub-acute care services

billed for the sampled dates of service. The provider indicated the physician's progress note was not available for the dates of service under review, submitting instead the medication administration record, care plan, and hospital discharge summary. Nursing facility physician history and physical notes also were submitted, but were not applicable because they were dated more than two months before the sampled date. Because the documentation submitted by the nursing facility was incomplete to support the claim, the claim constituted an overpayment error.

Incomplete Documentation (Provider did not submit the service plan) Error Example: A home and community-based service provider submitted a personal care services claim. The records submitted included a personal care assessment service plan dated more than a year before the sampled Date of Service (DOS) and a letter stating it was the only authorized service plan available. The state policy required the service plan to be updated every six months and to be in effect for the DOS on the claim. Because the provider did not submit the approved service plan covering the sampled dates of service, the claim constituted an overpayment error.

Table 3.4 identifies the types of documents that are most commonly missing when PERM cites Incomplete Documentation errors in Medicaid claims.

TABLE 3.4. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2016 MEDICAID IMPROPER PAYMENT RATE SAMPLE

Documentation Type	Total Count
Member Pharmacy Signature Log / Proof of Delivery	72
Progress Notes for All Disciplines / Departments	22
Plan of Care / Service / Treatment Plan	18
Individual Education Plan (IEP); Individual Program Plan (IPP); Individual Service Plan (ISP); or Individual Family Service Plan (IFSP)	14
Physician Orders	12
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records	11
Proof of acceptance or refusal of counseling	9
Treatment Plan & Goals	8
Timesheet, completed & signed	6
Physician Certification / Recertification	5
Medication Administration Record (MAR)	3
Mental Health Progress / Therapy Notes / Daily Attendance Logs	3
Treatment Plan	3
Documentation of Daily Patient Presence	2
Dental / Orthodontic Clinical Notes	2
Beneficiary's signature / proof of service receipt	1
Dialysis Treatment Record / Notes	1
Total Time Spent for Units Billed	1
Occupational Therapy: Evaluation/ Re-evaluation/Notes	1
Proof of Delivery / Signature Logs	1
Orders	1

Documentation Type	Total Count
Speech Language Pathology: Evaluation/Re-evaluation/Notes	1
Treatment Administration Record / Notes	1
Progress Notes	1
Encounter / Office Visit Record / Notes	1
Nursing Assessment, Notes, & Flowsheets	1
Ground Mileage / Pick-up & Drop Off Details	1
Psychological Testing, Mental Health counseling notes, treatment plan, & progress toward goals	1
Related Testing / Evaluations and Reports	1
Nursing Flowsheets / Notes	1
Service / Treatment Plan and Goals	1
Service Logs	1
Physician's physical exam notes	1
Member Profile with Refill History	1
Initial Intake Assessment / Reassessment	1
Emergency Department Record / Notes	1
Procedure Record / Notes	1
Other - Please provide the admission history and physical exam notes.	1
Copy of Prescription	1
Physical & Occupational Therapy Assessments / Notes	1

Note: Multiple documents are sometimes missing for the same medical record.

Inadequate Documentation Errors

The PERM program cites Inadequate Documentation (MR9) errors when the provider submits all the medical documentation requested, but the submitted documentation does not comply with state policy requirements by omitting required elements such as beneficiary name or date of birth, provider signatures or credentials, or service start and stop times. Below is an example of an Inadequate Documentation (MR9) error.

Inadequate Documentation (Required provider signature and/or credentials are not present) Error Example: A nursing facility submitted a claim. The provider furnished the requested documentation including the treatment plan, progress note, and orders, but the documentation did not include the required provider's dated signature for the services provided on the sampled date of service. Because the record submitted did not include all documentation required by state policy, this claim resulted in an overpayment error.

No Documentation Errors

The PERM program cites No Documentation (MR1) errors 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 (MR1) error.

No Documentation (Provider did not respond to the request for records) Error Example: A pharmacy submitted a claim, but failed to submit a record to support the medication that was billed and paid. Since no documentation was submitted to support the claim, the claim constituted an overpayment error.

Table 3.5 identifies the most common types of providers that are cited for No Documentation (MR1) errors in Medicaid claims.

TABLE 3.5. COUNT OF PROVIDER TYPES THAT DID NOT SUBMIT DOCUMENTATION IN THE 2016 MEDICAID IMPROPER PAYMENT RATE SAMPLE

Provider Type	Total Count
Personal Support Services	35
Prescribed Drugs	15
Day Habilitation and Waiver Programs, Adult Day Care, Foster Care, and School Based Services	11
Nursing Facility, Chronic Care Services & Intermediate Care Facilities (ICF)	6
Outpatient Hospital Services	4
Physicians, Physician Clinics, and other Licensed Practitioners' Services	4
Psychiatric, Mental Health, and Behavioral Health Services	4
Dental and Oral Surgery Services	4
Durable Medical Equipment and supplies, Prosthetic / Orthopedic devices, and Environmental Modifications	2
Clinic Services	1
Laboratory, X-ray and Imaging Services	1
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	1

The top three Medicaid provider types that fail to respond to PERM record requests are personal support service providers, pharmacies, and day habilitation and waiver providers. State provider outreach programs should focus on these provider types to help reduce No Documentation (MR1) errors and the overall improper payment rate.

CHIP

Table 3.6, below, identifies the medical review errors found by error type and the associated projected improper payments for CHIP FFS claims.

TABLE 3.6. 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
Incomplete Documentation (MR2)	408	54.3%	$199,918.0	48.2%	$58.3	61.4%
No Documentation (MR1)	211	28.1%	$186,520.6	45.0%	$29.0	30.6%
Number of Unit(s) Error (MR6)	30	4.0%	$16,502.1	4.0%	$2.5	2.6%
Procedure Coding Error (MR3)	8	1.1%	$3,165.4	0.8%	$1.4	1.5%
Administrative/Other (MR10)	11	1.5%	$2,791.3	0.7%	$1.2	1.3%
Inadequate Documentation (MR9)	12	1.6%	$2,738.6	0.7%	$1.1	1.2%
Policy Violation (MR8)	3	0.4%	$2,389.5	0.6%	$1.0	1.1%
Medically Unnecessary (MR7)	1	0.1%	$95.0	0.0%	$0.1	0.1%
Unbundling (MR5)	2	0.3%	$184.8	0.0%	$0.1	0.1%
Diagnosis Coding Error (MR4)	2	0.3%	$160.0	0.0%	$0.1	0.1%
Medical Technical Deficiency (MTD)	63	8.4%	$0.0	0.0%	$0.0	0.0%
Total	**751**	**100.0%**	**$414,465.2**	**100.0%**	**$94.9**	**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, Incomplete Documentation (MR2), No Documentation (MR1), and Inadequate Documentation (MR9) errors combined for a total of 93.2% of all CHIP FFS medical review projected improper payments. All other error categories accounted for fewer than 3% of medical review projected improper payments each.

Incomplete Documentation Errors

The PERM program cites Incomplete Documentation (MR2) errors when the information submitted is incomplete and does not support the service billed, such as when the provider supplies incomplete documentation to determine the medical necessity of the claim, or the medical records submitted do not document the tasks performed on the sampled date of service. Examples of Incomplete Documentation (MR2) errors are provided below.

Incomplete Documentation (Plan Of Care (POC) was present, but not applicable to the sampled DOS) Error Example: A provider submitted a POC dated five months after the sampled date under review for a psychiatric services claim, but not the POC in effect for the sampled date. The state policy required that the POC be reviewed and updated every 180 days and be in effect for the date of service on the claim. Because the provider did not submit the POC in effect for the sampled date of service, the claim constituted an overpayment error.

Table 3.7, below, identifies the types of documents that are most commonly missing when incomplete documentation errors are cited in CHIP FFS claims.

TABLE 3.7. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2016 CHIP IMPROPER PAYMENT RATE SAMPLE

Documentation Type	Total Count
Member Pharmacy Signature Log / Proof of Delivery	104
Treatment Plan & Goals	19
Proof of acceptance or refusal of counseling	5
Individual Education Plan (IEP); Individual Program Plan (IPP); Individual Service Plan (ISP); or Individual Family Service Plan (IFSP)	4
Encounter / Office Visit Record / Notes	4
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records	4
Ground Mileage / Pick-up & Drop Off Details	3
Dental / Orthodontic Clinical Notes	2
Treatment Plan	2
Procedure Record / Notes	2
Progress Notes for All Disciplines / Departments	2
Mental Health Progress / Therapy Notes / Daily Attendance Logs	2
Related Testing / Evaluations and Reports	1
Radiology / Imaging Report / Results & Interpretation	1
Documentation reflecting Medical Necessity for Transportation	1
Home Health Aide Notes / Worksheets	1
Related Laboratory / Diagnostic Reports	1
Dental X-Ray Notes	1
Evaluation and Management (E&M) / Counseling Notes	1
Medication Administration Record (MAR)	1
Plan of Care / Service / Treatment Plan	1
Psychiatric Evaluation / Testing	1

Note: Multiple documents are sometimes missing for the same medical record.

Inadequate Documentation Errors

Inadequate documentation errors are cited when all the medical documentation is submitted as required, but the submitted documentation does not comply with state policy documentation requirements by omission of required elements such as beneficiary name or date of birth, provider signatures or credentials, or service start and stop times. Below is an example of an inadequate documentation error.

Inadequate Documentation (Required start and stop times are not included for all sampled DOS) Error Example: A behavioral health provider submitted a claim. The provider submitted the treatment plan and progress note, as required, but the documentation did not include the required start and stop times or the provider's signature on the document, as required by the state's policy. The

documentation submitted was inadequate to support the sampled claim because it did not satisfy the state's policy, resulting in an overpayment error.

No Documentation Errors

No Documentation (MR1) 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 (MR1) error.

No Documentation (Provider did not respond to the request for records) Error Example: A participating physician submitted a claim for an office visit, but failed to respond to requests for records to support the billed claim. Because the provider did not submit the requested records, the claim constituted an overpayment error.

Table 3.8 identifies the most common types of providers that are cited for No Documentation (MR1) errors in CHIP claims.

TABLE 3.8. COUNT OF PROVIDER TYPES THAT DID NOT SUBMIT DOCUMENTATION IN THE 2016 CHIP IMPROPER PAYMENT RATE SAMPLE

Provider Type	Total Count
Physicians, Physician Clinics, and other Licensed Practitioners' Services	18
Pharmacies	13
Laboratory, X-ray and Imaging Services	5
Dental and Oral Surgery Services	4
Clinic Services	3
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	3
Outpatient Hospital Services	3
Psychiatric, Mental Health, and Behavioral Health Services	2
Inpatient Hospital Services	2
Day Habilitation and Waiver Programs, Adult Day Care, Foster Care, and School Based Services	1
Personal Support Services	1

The top three CHIP provider types that fail to respond to PERM record requests are physicians and other professionals, pharmacies, and laboratory, x-ray and imaging service providers. State provider outreach programs should focus on these provider types to help reduce No Documentation (MR1) errors and the overall improper payment 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 improper payment rate.

MEDICAID

Table 3.9 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 3.9. 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	
Nursing Facility, Intermediate Care Facilities	60	$961	632	$10,629	$11,364	25.9%	16.0%
Prescribed Drugs	138	$1,051	509	$5,623	$6,285	14.3%	18.5%
Habilitation and Waiver Programs, School Services	113	$1,336	315	$4,184	$5,395	12.3%	10.3%
ICF for Individuals with Intellectual Disabilities and Group Homes	13	$153	346	$4,980	$4,985	11.4%	43.2%
Personal Support Services	105	$1,388	159	$4,073	$4,658	10.6%	17.4%
Inpatient and Outpatient Hospital	29	$546	241	$2,228	$2,499	5.7%	4.8%
Psychiatric, Mental Health, and Behavioral Health Services	51	$248	159	$1,741	$1,969	4.5%	10.0%
Clinics	11	$165	60	$1,327	$1,474	3.4%	16.3%
Home Health Services	29	$102	67	$832	$917	2.1%	13.1%
Hospice Services			13	$815	$815	1.9%	41.0%
All Other Service Types	114	$864	510	$2,680	$3,483	7.9%	5.2%
Total	**663**	**$6,813**	**3,011**	**$39,112**	**$43,845**	**100.0%**	**12.4%**

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 90.2% of the total Medicaid FFS projected improper payments.

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

- Provider Information/Enrollment Error;

- Incomplete 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.

Data processing errors for this service type primarily occurred because the attending providers' NPIs were not included on institutional claims filed on or after July 1, 2012, as required by the HIPAA transaction standards. Many states did not implement this format change timely, resulting in numerous errors.

Prescribed Drugs

The primary medical review errors for Prescribed Drugs were related to a lack of documentation regarding (1) the beneficiary's acceptance or refusal of counseling and (2) proof of the beneficiary's receipt of medications. Pharmacies are required to maintain documentation that includes the original prescription that identifies the beneficiary, date of birth, name of drug, National Drug Code billed, refill history, documentation of acceptance or refusal of beneficiary counseling, and the signature log documenting receipt of the prescribed medication.

Data processing errors for this service type primarily related to claims submitted without the ordering (prescribing) provider's NPI, or where the provider was not properly screened under the ACA's risk-based criteria.

Habilitation/Waiver Programs/School Services

Medical review errors for Habilitation, Waiver Programs, and School Services were most often cited for Incomplete Documentation (MR2) errors related to the provider's failure to submit relevant records for the sampled services, Number of Unit (MR6) errors due to the provider's failure to adequately document the amount of time spent, and No Documentation (MR1) errors. Documentation requirements generally include physician orders and certification of necessity, plans of care authorizing services, progress notes, timesheets, and attendance logs.

Data processing errors for this service type were primarily due to failure to include ORP NPIs on claims when required, failure to properly screen providers under the ACA's risk-based criteria, and failure to submit prior authorizations in effect for the sampled dates of service.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)

The predominant medical review errors for ICF-IID were documentation errors 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.

Data processing errors for this service type were related to attending/rendering providers ordering services that require an order, however the attending/rendering provider was not enrolled in Medicaid, as required in regulation.

Personal Support Services

Most medical review errors cited for Personal Support Services were Incomplete Documentation (MR2) errors due to missing active plans of care, missing notes verifying 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.

Data processing errors for this service type include Pricing (DP5) errors, and Provider Information/Enrollment (DP10) errors occurring because providers were not properly screened under the ACA's risk-based criteria.

Inpatient and Outpatient Hospital Services

Medical review errors for Inpatient/Outpatient Hospital claims included Diagnosis Coding (MR4) errors and No Documentation (MR1) errors.

Data processing errors for this service type are Provider Information/Enrollment (DP10) errors related to inpatient and outpatient electronic institutional claims that lacked the attending physician's NPI as required by HIPAA transaction standards. Many claims were also in error because the providers were not properly screened under the ACA's risk-based criteria. These changes were not implemented timely by all states, resulting in numerous errors.

Psychiatric, Mental Health and Behavioral Health Services

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

Data processing errors for this service type primarily involved Provider Information/Enrollment (DP10) errors for electronic institutional claims, including psychiatric inpatient claims, that lacked the attending physicians' NPIs as required by HIPAA transaction standards. This change was not implemented timely by all states, resulting in numerous errors.

Clinics

Medical review errors cited for Clinics related to documentation errors for 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.

Data processing errors for this service type primarily involved Provider Information/Enrollment (DP10) errors for providers not screened using ACA risk-based criteria prior to enrollment; provider not enrolled in Medicaid; and attending provider NPI required but not submitted on institutional claims.

CHIP

Table 3.10 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 3.10. 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	
Prescribed Drugs	297	$40	749	$98	$128	29.5%	17.8%
Dental and Other Oral Surgery Services	52	$7	704	$75	$80	18.5%	11.5%
Psychiatric, Mental Health, and Behavioral Health Services	94	$15	232	$39	$53	12.3%	9.3%
Inpatient and Outpatient Hospital	45	$4	373	$39	$42	9.8%	4.1%
Habilitation and Waiver Programs, School Services	51	$6	202	$31	$35	8.1%	23.2%
Physicians and Other Licensed Practitioner Services	62	$6	141	$28	$33	7.7%	7.7%
Clinics	43	$9	89	$17	$26	5.9%	9.5%
Occupational, Respiratory Therapies; Speech Language Pathology, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	18	$3	104	$13	$14	3.2%	13.5%

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	
Personal Support Services	43	$2	25	$5	$7	1.6%	10.0%
Durable Medical Equipment and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	4	$0	55	$5	$5	1.2%	15.7%
All Other Service Types	42	$3	214	$7	$10	2.2%	4.9%
Total	**751**	**$95**	**2,888**	**$356**	**$433**	**100.0%**	**10.2%**

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 service types are grouped into the "All Other Service Types" category.

The top seven service types represented 91.8% of the total CHIP FFS projected improper payments.

The types of errors that occurred in these service types for CHIP were primarily:

- Provider Information/Enrollment Error;
- Non-covered Service/Beneficiary; and
- Incomplete Documentation.

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

Prescribed Drugs

The predominant medical review errors cited for Prescribed Drugs were Incomplete Documentation (MR2) errors related to the lack of beneficiary acceptance or refusal of counseling for medications and No Documentation (MR1) errors. Prescription documentation requirements generally include the original prescription that identifies the beneficiary, date of birth, name of drug and National Drug 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 errors for this service type were Provider Information/Enrollment (DP10) errors related to the state's failure to properly screen newly enrolled providers under the ACA's risk-based criteria. Many other errors arose from claims being submitted without the ordering (prescribing) provider's NPI as required by 42 CFR 455.440.

Dental and Other Oral Surgery Services

The medical review errors cited for Dental Services were primarily Incomplete Documentation (MR2) errors related to providers not keeping required progress notes or documentation of services performed.

The primary data processing errors for this service type were Provider Information/Enrollment (DP10) errors related to the state's failure to properly screen newly enrolled providers under the ACA's risk-based criteria.

Psychiatric, Mental Health, Behavioral Health Services

The primary medical review errors related to Psychiatric, Mental Health, and Behavioral Health Services were Incomplete Documentation (MR2) errors due to missing documentation of billed services, No Documentation (MR1) errors, and Inadequate Documentation (MR9) errors due to providers not documenting the start and stop times of 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.

The primary data processing error for this service type were Provider Information/Enrollment (DP10) errors related to the state's failure to properly screen newly enrolled providers under the ACA's risk-based criteria.

Inpatient and Outpatient Hospital Services

Medical review errors for Inpatient/Outpatient Hospital primarily included Diagnosis Coding (MR3) errors and No Documentation (MR1) errors.

Data processing errors for this service type primarily involved inpatient and outpatient electronic institutional claims that lacked the attending physicians' NPI as required by HIPAA transaction standards. This change was not implemented timely by all states, resulting in numerous errors.

Habilitation/Waiver Programs/School Services

The most frequent medical review errors for Habilitation, Waiver Programs, and School Services were Incomplete Documentation (MR2) errors related to provider failure to submit relevant records for the sampled services, Number of Unit (MR6) errors due to provider failure to adequately document the amount of time spent performing services, and No Documentation (MR1) errors. Documentation requirements generally include physician orders and certification of necessity, plans of care authorizing services, progress notes, timesheets, and attendance logs.

Data processing errors for this service type were primarily due to failure to include ORP NPIs on claims when required, failure to properly screen providers under the ACA***'s*** risk-based criteria**,** and beneficiaries who were ineligible for CHIP on the sampled dates of service.

V. MANAGED CARE

MCOs are paid a pre-determined, capitated amount for a specified time period (usually one month) for each of their enrolled beneficiaries. Each MCO is then responsible to pay for all covered medically necessary services for their enrollees. 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 the PERM program, only the managed care capitation payment made from the state to the MCO is reviewed. Payments made by MCOs to providers are not reviewed.

- 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 4.1 shows the breakdown of data processing errors in Medicaid managed care.

TABLE 4.1. 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
Non-covered Service/Beneficiary (DP2)	19	76.0%	$20,782.2	58.1%	$495.6	85.2%
Provider Information/Enrollment Error (DP10)	2	8.0%	$1,265.0	3.5%	$43.4	7.5%

[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 reviewed by CMS on a case-by-case basis and are often determined to be more appropriately placed in the FFS unvierse.

Error Type	Number of Sample Improper Payments		Sample Improper Payments		Projected Improper Payments	
	Number	% of Total	$	% of Total	$ in Millions	% of Total
Duplicate Claim (DP1)	2	8.0%	$12,786.9	35.7%	$29.2	5.0%
Managed Care Rate Cell Error (DP8)	1	4.0%	$937.3	2.6%	$13.3	2.3%
Data Processing Technical Deficiency (DTD)	1	4.0%	$0.0	0.0%	$0.0	0.0%
FFS Payment for Managed Care Service (DP3)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Third-party Liability Error (DP4)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Pricing Error (DP5)	0	0.0%	$0.0	0.0%	$0.0	0.0%
System Logic Edit Error (DP6)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Data Entry Error (DP7)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Managed Care Payment Error (DP9)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Claim Filed Untimely (DP11)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Administrative/Other (DP12)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**25**	**100.0%**	**$35,771.3**	**100.0%**	**$581.4**	**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.

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/Beneficiary errors, where the entire payment is in error, cause the greatest dollar impact, at 85.2% of all Medicaid managed care projected improper payments.

Non-Covered Service/Beneficiary Errors

Non-covered Service/Beneficiary (DP2) errors for managed care primarily involved payments being made when beneficiaries were not eligible for managed care on the sampled date of service. In some cases, the beneficiary was not eligible for managed care because the beneficiary no longer had active eligibility for Medicaid during the period under review, or had passed away in a month prior to the capitation payment to the health plan.

Non-Covered Service/Beneficiary (Beneficiary was ineligible for the applicable program on DOS) Error Example: The state made a Medicaid managed care capitation payment, but the beneficiary did not have active Medicaid eligibility on the sampled dates of service. The capitation payment was in error because the beneficiary was not eligible for Medicaid. Therefore, the payment resulted in an overpayment error.

CHIP

Table 4.2 shows the breakdown of data processing errors in CHIP managed care, which were generally consistent with Medicaid managed care findings.

TABLE 4.2. 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
Non-covered Service/Beneficiary (DP2)	117	47.8%	$85,047.4	54.2%	$84.1	91.7%
Managed Care Rate Cell Error (DP8)	47	19.2%	$65,846.1	41.9%	$5.6	6.1%
Third-party Liability Error (DP4)	2	0.8%	$229.2	0.1%	$1.7	1.9%
Duplicate Claim (DP1)	3	1.2%	$5,860.4	3.7%	$0.3	0.3%
Managed Care Payment Error (DP9)	71	29.0%	$0.7	0.0%	$0.0	0.0%
Data Processing Technical Deficiency (DTD)	5	2.0%	$0.0	0.0%	$0.0	0.0%
FFS Payment for Managed Care Service (DP3)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Pricing Error (DP5)	0	0.0%	$0.0	0.0%	$0.0	0.0%
System Logic Edit Error (DP6)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Data Entry Error (DP7)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Provider Information/Enrollment Error (DP10)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Claim Filed Untimely (DP11)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Administrative/Other (DP12)	0	0.0%	$0.0	0.0%	$0.0	0.0%
Total	**245**	**100.0%**	**$156,983.8**	**100.0%**	**$91.7**	**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.

The top error type, representing 91.7% of all CHIP managed care projected improper payments, was Non-covered Service/Beneficiary (DP2). Managed Care Rate Cell Errors (DP8) accounted for the second most projected improper payments.

Non-Covered Service/Beneficiary Errors

Non-Covered Service/Beneficiary (DP2) errors in CHIP managed care were mostly due to beneficiaries not being eligible for managed care, therefore the capitated monthly payments were made for non-covered services. In most cases, the beneficiary was not eligible for managed care because the beneficiary no longer had active eligibility for CHIP for the period under review.

Non-Covered Service/Beneficiary (Beneficiary was ineligible for the applicable program on DOS) Error Example: The state made a CHIP Managed Care payment. The beneficiary did not have active CHIP eligibility on the sampled dates of service, therefore the capitated monthly payment was for a non-covered service. Thus, this payment constituted an overpayment error.

Managed Care Rate Cell Errors

The PERM program cited Managed Care Rate Cell (DP8) errors when the wrong rate cell was used to calculate the capitation payment for an eligible beneficiary who was enrolled in the managed care program.

Managed Care Rate Cell (Incorrect rate cell used for aid category) Error Example: The state made a managed care payment that used the incorrect rate cell for a beneficiary's aid category to calculate the monthly capitation payment. The capitation payment was incorrect, resulting in an overpayment error.

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 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 improper payment rates, as well as national 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 improper payment rates. A small correction factor ensures that eligibility improper payments are not "double counted."[15]

The PERM program classifies both overpayments and underpayments as improper payments. Table 5.1, below, 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 previously, state-specific eligibility rates are not calculated for this measurement cycle and eligibility improper payment rates used in the 2014 improper payment rate are used as a proxy in the 2016 overall improper payment calculations. Therefore, previously reported eligibility over- and underpayments are represented in Table 5.1.

[14] For the current measurement, eligibility reviews are on hold and the eligibility improper payment rates from the most recent cycles prior to 2016 were used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

[15] 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.

TABLE 5.1. SUMMARY OF 2016 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	663	$574,822.3	$6,813.2	0	$0.0	$0.0
FFS Data Processing	2,980	$8,557,841.0	$38,690.9	31	$6,669.7	$421.1
Managed Care	25	$35,771.3	$581.4	0	$0.0	$0.0
Eligibility	841	$414,366.4	$17,666.5	44	$5,581.7	$476.3
Total	**4,509**	**$9,582,801.0**	**$63,752.0**	**75**	**$12,251.5**	**$897.4**
CHIP						
FFS Medical Review	750	$414,449.4	$94.8	1	$15.8	$0.1
FFS Data Processing	2,808	$3,595,064.6	$353.5	80	$1,883.2	$2.3
Managed Care	170	$156,962.0	$91.7	75	$21.8	$0.0
Eligibility	1,439	$238,406.1	$556.9	88	$2,215.0	$5.9
Total	**5,167**	**$4,404,882.2**	**$1,096.9**	**244**	**$4,135.8**	**$8.3**

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 and 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.

*Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

Readers should keep in mind 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 difficult to generalize and often results in large differences across states.

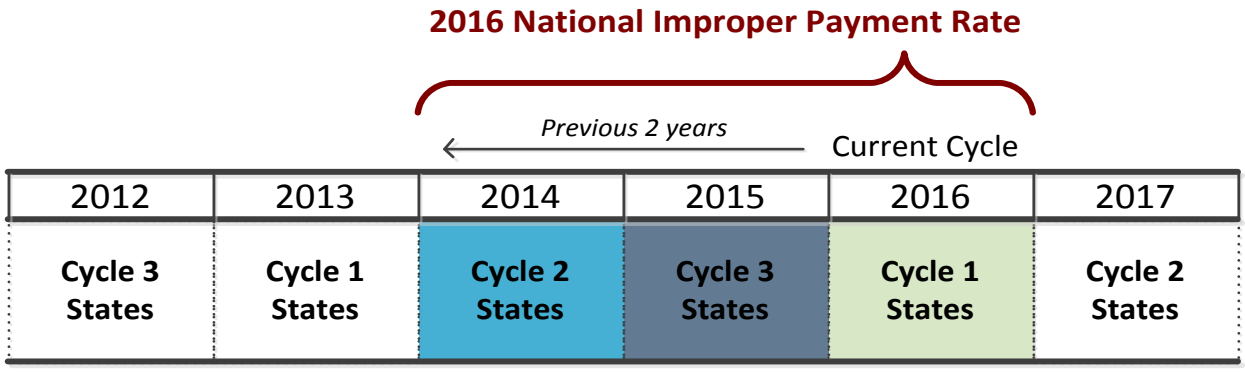
CMS attributes the variation in state-specific improper payment rates to multiple factors related to differences in how the states implement and administer their programs, as well as the enrolled population size. For example, states with proportionately larger managed care programs are likely to have 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 and result 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.

2016 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 cycle, eligibility reviews are suspended and the eligibility improper payment rates used in the 2014 improper payment rate are used as a proxy in the overall improper payment rate calculation. Figure 5 shows the measurements that are included in the national rolling improper payment rate.

FIGURE 5. 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[16] 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 2016 Medicaid and CHIP official national rolling improper payment rates.

2016 National Medicaid Improper Payment Rate

Table 5.2, below, summarizes the 2016 rolling national Medicaid improper payment rate findings.

[16] 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.

TABLE 5.2. 2016 NATIONAL MEDICAID IMPROPER PAYMENT RATES SUMMARY

Category	2016 Medicaid Rolling Improper Payment Rate
Improper Payment Rate	10.5%
Total Projected Improper Payments ($Billions)	$61.2
Federal Share Projected Improper Payments ($Billions)	$36.3

The **2016 national Medicaid rolling improper payment rate**, which is based on measurements that were conducted in 2014, 2015, and 2016, is **10.5%**. This represents an estimated $36.3 billion in improper federal expenditures and $61.2 billion in estimated total improper Medicaid payments (state and federal shares) annually. These projected improper payments include both 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 5.3, 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 5.3. 2016 MEDICAID IMPROPER PAYMENT RATES BY COMPONENT

Component	2016 Medicaid Rolling Improper Payment Rate
FFS	12.4%
Managed Care	0.3%
Eligibility*	3.1%
National	**10.5%**

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.

*Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

The 2016 Medicaid improper payment rate is lower than the CMS target of 11.5%.

As shown in Table 5.4, below, the increase in data processing errors is significant. The overall FFS results, which combine data processing and medical review errors, increased from 2015 to 2016.

It is important to note that the difference between the 2015 and 2016 national rolling improper payment rate is the replacement of the 2013 Cycle 1 states' data (in the former rate) with the more recently sampled 2016 Cycle 1 states' data (in the latter rate). Therefore, any changes in the rolling improper payment rate are attributable to the 2016 Cycle 1 states.

TABLE 5.4. 2015 - 2016 MEDICAID FFS DATA PROCESSING AND MEDICAL REVIEW ROLLING IMPROPER PAYMENT RATES

Component	2016 National Rolling			2015 National Rolling		
	Improper Payment Rate	Standard Error	90% Confidence Interval	Improper Payment Rate	Standard Error	90% Confidence Interval
FFS	12.4%	0.6%	11.4% - 13.4%	10.6%	0.6%	9.6% - 11.6%
FFS Data Processing	11.1%	0.6%	10.1% - 12.1%	8.8%	0.6%	7.8% - 9.8%
FFS Medical Review	1.9%	0.2%	1.6% - 2.3%	2.2%	0.2%	1.8% - 2.6%

The 2016 national Medicaid improper payment rates met the IPIA precision requirement of +/- 2.5%, suggesting that the results would be highly similar if CMS repeated the study.

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 5.5. To understand the reasonability of this estimate, the 90% confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90% of the time if CMS repeated the study many times.

TABLE 5.5. 2016 MEDICAID IMPROPER PAYMENT RATE APPLIED TO TOTAL EXPENDITURES AND THE FEDERAL SHARE (DOLLARS IN BILLIONS)

Component	2016 Expenditures ($billions)	Projected Improper Payments ($billions)	Lower 90% Confidence Limit ($billions)	Upper 90% Confidence Limit ($billions)
FFS Total	$353.2	$43.8	$40.3	$47.4
Federal Share	$205.0	$25.5	$23.4	$27.5
Managed Care Total	$230.8	$0.6	$0.3	$0.8
Federal Share	$140.9	$0.4	$0.2	$0.5
*Eligibility Total**	*$583.9*	*$18.1*	*$13.6*	*$22.7*
*Federal Share**	*$346.0*	*$10.7*	*$8.1*	*$13.4*
National Total**	**$583.9**	**$61.2**	**$55.8**	**$66.6**
Federal Share**	**$346.0**	**$36.3**	**$33.0**	**$39.5**

*Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

**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.

2016 National CHIP Improper Payment Rate

Table 5.6, below, summarizes the 2016 rolling national CHIP improper payment rate findings.

TABLE 5.6. 2016 NATIONAL CHIP IMPROPER PAYMENT RATES SUMMARY

Category	2016 CHIP Rolling Improper Payment Rate
Improper Payment Rate	8.0%
Total Projected Improper Payments ($Billions)	$1.1
Federal Share Projected Improper Payments ($Billions)	$0.7

The **2016 national CHIP rolling improper payment rate**, which is based on measurements that were conducted in 2014, 2015, and 2016, is **8.0%**. This represents an estimated $0.7 billion in improper federal expenditures and $1.1 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 5.7, FFS was a major contributor to the CHIP improper payment rates, while managed care payments accounted for a limited portion of all improper payments.

TABLE 5.7. 2016 CHIP IMPROPER PAYMENT RATES BY COMPONENT

Component	2016 CHIP Rolling Improper Payment Rate
FFS	10.2%
Managed Care	1.0%
Eligibility*	4.2%
National	**8.0%**

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.

*Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

The 2016 CHIP improper payment rate is higher than the CMS target of 6.8%.

The 2016 national CHIP improper payment rates met the IPIA precision requirement of +/- 2.5%, suggesting that the results would be highly similar if CMS repeated the study.

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 5.8, below. To understand the reasonability of this estimate, the 90% confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90% of the time if CMS repeated the study many times.

TABLE 5.8. 2016 CHIP IMPROPER PAYMENT RATE APPLIED TO TOTAL EXPENDITURES AND THE FEDERAL SHARE (DOLLARS IN BILLIONS)

Component	2016 Expenditures ($billions)	Projected Improper Payments ($billions)	Lower 90% Confidence Limit ($billions)	Upper 90% Confidence Limit ($billions)
FFS Total	$4.3	$0.4	$0.4	$0.5
Federal Share	$3.0	$0.3	$0.3	$0.3
Managed Care Total	$9.1	$0.1	$0.1	$0.1
Federal Share	$6.2	$0.1	$0.0	$0.1
*Eligibility Total**	*$13.3*	*$0.6*	*$0.5*	*$0.6*
*Federal Share**	*$9.2*	*$0.4*	*$0.3*	*$0.4*
National Total**	**$13.3**	**$1.1**	**$1.0**	**$1.1**
Federal Share**	**$9.2**	**$0.7**	**$0.7**	**$0.8**

*Eligibility reviews are suspended for the current measurement cycle while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2016 improper payment rate were the same eligibility rates reported in the 2014 improper payment rate.

**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.

2016 Cycle-Specific Improper Payment Rate

A cycle rate is an improper payment rate based on the 17 states measured in a cycle. Unlike the rolling rate, the cycle improper payment rate does not reflect findings from the entire nation, but provides a snapshot of the results specific to the states participating in a given cycle. Table 5.9, below, lists the cycle rates from the three most recent PERM cycles that are the measurements included in the 2016 rolling rate.

TABLE 5.9. 2014 – 2016 MEDICAID AND CHIP IMPROPER PAYMENT CYCLE RATES[17]

Program	2014 Cycle 2	2015 Cycle 3	2016 Cycle 1
Medicaid Improper Payment Rate*	8.1%	14.2%	8.8%
CHIP Improper Payment Rate*	4.7%	9.0%	12.4%

*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 2016 Cycle 1 rate and the 2015 Cycle 3 rate, the 2013 Cycle 1 eligibility component rate and the 2012 Cycle 3 eligibility component rate (the most recent eligibility measurements prior to the current measurement cycle) are used as proxies in the overall 2016 Cycle 1 and 2015 Cycle 3 improper payment rate calculations, respectively. Since these cycle rates are used for the national rolling rate, eligibility is included in this table. In addition, the 2014 Cycle 2 and 2015 Cycle 3 rates include state-level improper payment rate recalculations.

As seen in Table 5.9, the 2016 Medicaid Cycle 1 improper payment rate is 8.8%. The 2016 CHIP Cycle 1 improper payment rate is 12.4%. The Cycle 1 states reviewed in 2016 were the same states reviewed in 2013 and 2010. The 2016 Medicaid Cycle 1 improper payment rate increased from the 2013 Cycle 1 improper payment rate of 5.7% for these states and the CHIP rate increased from the 2013 Cycle 1 rate of 6.8%. The Medicaid and CHIP rates increased in Cycle 1 due to state difficulties coming into compliance with new requirements. The increase in the Medicaid Cycle 1 improper payment rate caused the rolling improper payment rate to increase from 9.8% in 2015 to 10.5% in 2016.

Table 5.10, below, shows the Medicaid Cycle 1 rates by component in 2010 and 2013 compared to the current cycle rates in 2016.

[17] Cycle 1 and Cycle 2 rates include state-level improper payment rate recalculations.

TABLE 5.10. 2010 - 2016 MEDICAID CYCLE RATES BY COMPONENT

Component	2010 Cycle 1 Improper Payment Rate	2013 Cycle 1 Improper Payment Rate	2016 Cycle 1 Improper Payment Rate
FFS	1.9%	3.5%	9.8%
Managed Care	0.1%	0.2%	0.5%
Cycle	**1.4%**	**2.4%**	**5.7%**
Note: For the current measurement cycle, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed from the cycle rates in this table for comparison purposes. The 2010 and 2013 rates include state-level improper payment rate recalculations and the 17-state cycle rates were previously not reported.			

Table 5.11 shows the CHIP Cycle 1 rates by component in 2013 and 2016 since there were no CHIP rates prior to 2011.

TABLE 5.11. 2016 CHIP CYCLE RATES BY COMPONENT

Component	2013 Cycle 1 Improper Payment Rate	2016 Cycle 1 Improper Payment Rate
FFS	5.2%	14.0%
Managed Care	0.5%	3.7%
Cycle	**2.8%**	**8.2%**
Note: For the current measurement cycle, 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 5.10, the 2013 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 6.1. CMS continuously reviews the causes of errors and implements national and state-focused activities to decrease Medicaid and CHIP improper payments.

TABLE 6.1. IMPROPER PAYMENT RATE TARGETS

Program	2017	2018	2019
Medicaid Improper Payment Rate	9.6%	6.7%	5.5%
CHIP Improper Payment Rate	7.4%	7.1%	6.2%

State difficulties coming into compliance with new requirements is the driver of the Medicaid and CHIP improper payment rates. The targets take into account these changes in policies and compliance, and although all states are included in the improper payment rates, CMS reviews only 17 states each year. In 2014, CMS reported a rate reflecting the first 17 states measured under the new requirements. The 2015 improper payment rates reflected the second group of 17 states subject to new requirements for a total of 34 states. In 2016, CMS reports a rate that reflects the measurement of the final group of 17 states under the new requirements and is 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 are sections providing 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 the effectiveness of their CAPs.

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 each state submits its CAP for each cycle. These 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.

CMS Program Improvements

CMS is committed to reducing improper payments in all of its programs, as evidenced by improper payment reduction efforts contained in the FY 2018 President's Budget. In addition, CMS' new leadership will be re-examining the existing corrective actions and exploring new and innovative approaches to reducing improper payments while minimizing burden for our partners.

The following are brief descriptions of some of CMS' key efforts to prevent and reduce improper payments in the Medicaid program.

- State-Specific Corrective Action Plans: CMS works closely with all states to develop state-specific CAPs. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from CMS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns. For example, because the Medicaid improper payment rate was primarily driven by state errors bringing

systems into compliance with new requirements, state CAPs focus on systems or process changes to reduce these errors. Specific actions include implementing new claims processing edits, converting to a more sophisticated claims processing system, and implementing a new provider enrollment process to make it easier for referring providers to enroll in the program.

- State Medicaid Provider Screening and Enrollment: CMS shares Medicare data to assist states with meeting Medicaid screening and enrollment requirements. Specifically, CMS shares the Medicare provider enrollment record via the Provider Enrollment, Chain and Ownership System (PECOS) administrative interface and via data extracts from the PECOS system. CMS also shares Office of the Inspector General (OIG) exclusion data with states.

- Enhanced Assistance on State Medicaid Provider Screening and Enrollment: CMS provides ongoing guidance, education, and outreach (site visits and technical assistance) to states on federal requirements for Medicaid enrollment and screening. In addition, CMS published the Medicaid Provider Enrollment Compendium, which is sub-regulatory guidance designed to assist states in applying the regulatory requirements.

- Medicaid Integrity Institute: CMS offers training, technical assistance, and support to state Medicaid program integrity officials through the Medicaid Integrity Institute. Some sessions have focused exclusively on complying with the provider screening and enrollment requirements.

- Additional Support: CMS aligned state Program Integrity Reviews with off-cycle improper payment reviews to assist states that were previously reviewed to continuously correct errors. For example, CMS collects the status of the state-specific CAPs, assesses states' CAP status, and provides feedback to states on actions needed to complete their CAP.

Additional information on these and other corrective actions can also be found in the Department of Health and Human Services' FY 2016 AFR.

Eligibility Review Pilots

The ACA 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 continue to identify vulnerabilities in processes and systems. States then take action to address these vulnerabilities, which is essential to preventing future improper payments and improving verification processes. In the most recent round of pilots, states continued to identify vulnerabilities related to caseworkers or systems not properly establishing income level, although these vulnerabilities did not necessarily always lead to eligibility determination errors. States also identified issues related to failures in sending appropriate notices, delays in processing eligibility determinations, and failing to follow verification plans that outline each state's verification policies and procedures. 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 Claim (DP1)** - The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid. Services on a sampled claim conflict with services on another claim during the same DOS.

- **Non-covered Service/Beneficiary (DP2)** - The state's policy indicates that the service being billed is not payable by Medicaid or CHIP and/or the beneficiary is ineligible for the coverage category for that service.

- **FFS Payment for a Managed Care Service (DP3)** - The beneficiary is enrolled in a managed care organization (MCO) that should have covered the service, but the state inappropriately paid for the sampled service.

- **Third-party Liability Error (DP4)** - Medicaid or CHIP paid for the service as the primary payer, but a third-party carrier should have paid for the service.

- **Pricing Error (DP5)** - The payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.

- **System Logic Edit Error (DP6)** - The system did not contain the edit that was necessary to follow state policy or the system edit was in place, but was not working correctly and the line item/claim was paid inappropriately.

- **Data Entry Error (DP7)** - A line item/claim was paid in error due to clerical errors in the data entry of the claim.

- **Managed Care Rate Cell Error (DP8)** - 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 (DP9)** - The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.

- **Provider Information/Enrollment Error (DP10)** - The provider was not enrolled in Medicaid or CHIP according to federal regulations and state policy or required provider information was missing from the claim.

- **Claim Filed Untimely (DP11)** - The claim was not filed within timely filing requirements for the date of service in accordance with federal regulations and state guidelines.

- **Administrative/Other (DP12)** - A payment error was discovered during data processing review, but the error was not a DP1 – DP11 error.

- **Data Processing Technical Deficiency (DTD)** - A deficiency was found during data processing review that did not result in a payment error.

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

- **No Documentation (MR1)** - The provider failed to respond to requests for the medical records or the provider responded that he or she did not have the requested documentation. The provider did not send any documentation related to the sampled payment.

- **Incomplete Documentation (MR2)** - Claim errors are placed into this category when the submitted medical documentation is missing required information, making the record insufficient to support payment for the services billed. The provider submitted some documentation, but the documentation is inconclusive to support the billed service. Based on the medical records provided, the reviewer could not conclude that some of the allowed services were provided at the level billed and/or medically necessary. The additional documentation needed was not submitted.

- **Procedure Coding Error (MR3)** - The reviewer determines that the medical service, treatment, and/or equipment was medically necessary and was provided at a proper level of care, but billed and paid based on a wrong procedure code.

- **Diagnosis Coding Error (MR4)** - According to the medical record, the principal diagnosis code was incorrect or the Diagnosis-Related Group paid was incorrect and resulted in a payment error.

- **Unbundling (MR5)** - Unbundling includes instances where a set of medical services was provided and billed as separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set, rather than individual services.

- **Number of Unit(s) Error (MR6)** - An incorrect number of unit(s) was billed.

- **Medically Unnecessary Service (MR7)** - There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary. There is affirmative evidence that shows there was an improper diagnosis or deficient treatment plan reasonably connected to the provision of unnecessary medical services or treatment plan for an illness/injury not applicable to improving a patient's condition.

- **Policy Violation (MR8)** - A policy is in place regarding the service or procedure performed, and medical review indicates that the service or procedure in the record is inconsistent with the documented policy.

- **Inadequate Documentation (MR9)** - Required forms and documents are present, but are inadequately completed to verify that the services were provided in accordance with policy or regulation.

- **Administrative/Other (MR10)** - Medical review determined a payment error, but does not fit into one of the other medical review error categories.

- **Medical Technical Deficiency (MTD)** - Medical review determined a deficiency that did not result in a payment error. DOS billing errors are included as deficiencies when the date of service on the record is less than 7 days prior to or after the DOS on the claim.

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 error findings.

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

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 Federal Financial Participation. 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.

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 improper payment 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

- Agency Financial Report (AFR)
- Centers for Medicare & Medicaid Services (CMS)
- Children's Health Insurance Program (CHIP)
- Corrective Action Plan (CAP)
- Code of Federal Regulations (CFR)
- Date of Service (DOS)
- Fiscal Year (FY)
- Fee-For-Service (FFS)
- Health Insurance Portability and Accountability Act (HIPAA)
- 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 Management Information System (MMIS)
- Managed Care Organization (MCO)
- National Provider Identifier (NPI)
- Program Integrity Board of CMS (PI Board)
- Patient Protection and Affordable Care Act (PPACA or ACA)
- Payment Error Rate Measurement (PERM)
- Medicaid Recovery Audit Contractor (RAC)
- Transformed Medicaid Statistical Information System (T-MSIS)