2017 Medicaid & CHIP Supplemental Improper Payment Data

November 2017

List of Sections

Section 1: Historical Medicaid Cycle-Specific and National Rolling Improper Payment Rates 3
Section 2: 2017 Supplemental Medicaid Improper Payment Data 5
Section 3: Historical CHIP Cycle-Specific and National Rolling Improper Payment Rates 33
Section 4: 2017 Supplemental CHIP Improper Payment Data 35
Section 5: Error Codes 63

Note: Sections 2 and 4 contain their own Supplemental Information Table of Contents.

Section 1: Historical Medicaid Cycle-Specific and National Rolling Improper Payment Rates

Table A1. States in Each Cycle

Cycle 1	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2	**Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia**
Cycle 3	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

Note: States measured in the most recent cycle for the 2017 improper payment rate (i.e., Cycle 2) are in **bold**.

Table A2. Inception to Date Cycle-Specific Medicaid Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2007 - Cycle 1	4.7%			
2008 - Cycle 2	8.9%	3.1%	2.9%	**10.5%**
2009 - Cycle 3	2.6%	0.1%	6.7%	**8.7%**
2010 - Cycle 1	1.9%	0.1%	7.6%	**9.0%**
2011 - Cycle 2	3.6%	0.5%	4.0%	**6.7%**
2012 - Cycle 3	3.3%	0.3%	3.3%	**5.8%**
2013 - Cycle 1	3.4%	0.2%	3.3%	**5.7%**
2014 - Cycle 2	8.8%	0.1%	2.3%	**8.2%**
2015 - Cycle 3	18.6%	0.1%	N/A*	**N/A***
2016 - Cycle 1	9.8%	0.5%	N/A*	**N/A***
2017 - Cycle 2	10.5%	0.4%	N/A*	**N/A***

*For the 2015-2017 measurements, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed from these rates.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled.

Table A3. National Rolling Medicaid Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility	Overall**
2010 Rolling Rates	4.4%	1.0%	5.9%	**9.4%**
2011 Rolling Rates	2.7%	0.3%	6.0%	**8.1%**
2012 Rolling Rates	3.0%	0.3%	4.9%	**7.1%**
2013 Rolling Rates	3.6%	0.3%	3.3%	**5.8%**
2014 Rolling Rates	5.1%	0.2%	3.1%	**6.7%**
2015 Rolling Rates	10.6%	0.1%	3.1%*	**9.8%**
2016 Rolling Rates	12.4%	0.3%	3.1%*	**10.5%**
2017 Rolling Rates	12.9%	0.3%	3.1%*	**10.1%**

*Rolling eligibility component statistics for 2015-2017 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze.

**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions.

Section 2: 2017 Supplemental Medicaid Improper Payment Data

CMS reported a rolling improper payment rate for Medicaid in 2017 based on the 51 states reviewed from 2015-2017. Unless otherwise noted, all tables and figures in Section 2 are based on the rolling rate. There was no eligibility component review from 2015-2017 and eligibility results from the most recent cycles prior to 2015 are used as a proxy in the overall improper payment rate calculation.

Table S1. Summary of Medicaid Projected Improper Payments 6
Table S2. Medicaid Improper Payment Rate Applied to Projected Paid Amount (2017 Total Expenditures) and the Federal Share........ 6
Table S3. Medicaid Improper Payments by Type of Improper Payment and Cause of Improper Payment . 7
Table S4. Summary of Projected Medicaid Overpayments 7
Table S5. Summary of Projected Medicaid Underpayments........ 8
Table S6. Medicaid FFS Improper Payments by Service Type 9
Table S7. Summary of Medicaid FFS Projected Dollars by Type of Error 11
Table S8. Summary of Medicaid FFS Medical Review Overall Errors........ 12
Table S9. Summary of Medicaid FFS Medical Review Overpayments 12
Table S10. Summary of Medicaid FFS Medical Review Underpayments 13
Table S11. Medicaid FFS Specific Causes of Document(s) Absent from Record Error (MR2) 13
Table S12. Medicaid FFS Specific Types of Document(s) Absent from Record 15
Table S13. Medicaid FFS Specific Provider Types with Document(s) Absent from Record........ 17
Table S14. Medicaid FFS Specific Causes of No Documentation Error (MR1) 17
Table S15. Medicaid FFS Medical Review Errors by Service Type 19
Table S16. Summary of Medicaid FFS Data Processing Overall Improper Payments........ 21
Table S17. Summary of Medicaid FFS Data Processing Overpayments........ 21
Table S18. Summary of Medicaid FFS Data Processing Underpayments........ 22
Table S19. Specific Causes of Medicaid Provider Information/Enrollment Error (DP10)........ 22
Table S20. 2017 Cycle 2 DP10 Medicaid FFS Errors: NPI Required But Not Listed on Claim Breakdown 23
Table S21. 2017 Cycle 2 DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown23
Table S22. 2017 Cycle 2 DP10 Medicaid FFS Errors: Provider Not Enrolled Breakdown........ 24
Table S23. Specific Causes of Medicaid FFS Non-covered Service/Beneficiary Error (DP2)........ 24
Table S24. Specific Causes of Medicaid FFS Administrative/Other Error (DP12)........ 24
Table S25. Medicaid FFS Data Processing Errors by Service Type 25
Table S26. Summary of Medicaid Managed Care Data Processing Projected Dollars by Type of Error ... 27
Table S27. Summary of Medicaid Managed Care Data Processing Overpayments 27
Table S28. Summary of Medicaid Managed Care Data Processing Underpayments 28
Table S29. Specific Causes of Medicaid Managed Care Non-covered Service/Beneficiary Error (DP2) .. 28
Table S30. Specific Causes of Medicaid Managed Care Administrative/Other Error (DP12) 28
Table S31. State-Specific Improper Payment Rates for the States Measured in 2015 Cycle 3, 2016 Cycle 1, and 2017 Cycle 2 29

Medicaid Overpayments and Underpayments

Table S1. Summary of Medicaid Projected Improper Payments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	4,488	30,930	$10,856,712.7	$658,367,845.4	$41,185.9	$319,995.2	12.9%	12.0% - 13.7%
FFS Medical Review	918	30,930*	$1,402,373.9	$658,367,845.4	$7,429.7	$319,995.2	2.3%	1.9% - 2.7%
FFS Data Processing	3,774	30,930	$9,648,548.2	$658,367,845.4	$35,429.5	$319,995.2	11.1%	10.3% - 11.9%
Managed Care	52	9,889	$38,882.1	$10,508,998.1	$780.7	$261,860.8	0.3%	0.2% - 0.4%
Eligibility	*1,054*	*25,914*	*$419,948.2*	*$13,922,896.8*	*$18,078.1*	*$581,856.0*	*3.1%*	*2.2% - 4.0%*
Total	**5,594**	**66,733**	**$11,315,542.9**	**$682,799,740.4**	**$58,740.8**	**$581,856.0**	**10.1%**	**9.1% - 11.1%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.
*Data Processing review is performed on all sampled FFS claims. However, not all sampled FFS claims receive a Medical Review as certain exceptions apply where Medical Review is not able to be performed (Medicare Part A and Part B premiums, primary care case management payments, aggregate payments, other fixed payments, denied claims, and zero-paid claims).

Table S2. Medicaid Improper Payment Rate Applied to Projected Paid Amount (2017 Total Expenditures) and the Federal Share

Component	Projected Paid Amount (billions)	Projected Improper Payments (billions)	Lower 95% Confidence Limit (billions)	Upper 95% Confidence Limit (billions)
FFS Total	$320.0	$41.2	$38.5	$43.9
Federal Share	$192.6	$24.8	$23.2	$26.4
Managed Care Total	$261.9	$0.8	$0.5	$1.0
Federal Share	$171.2	$0.5	$0.3	$0.7
*Eligibility Total**	*$581.9*	*$18.1*	*$12.7*	*$23.5*
*Federal Share**	*$363.8*	*$11.3*	*$7.9*	*$14.7*
National Total**	**$581.9**	**$58.7**	**$53.1**	**$64.4**
Federal Share**	**$363.8**	**$36.7**	**$33.2**	**$40.3**

*Eligibility reviews are suspended for the current measurement cycle while CMS implements a new eligibility review methodology. The eligibility rates used as a proxy in the 2017 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.

Table S3. Medicaid Improper Payments by Type of Improper Payment and Cause of Improper Payment

Type of Improper Payment	Cause of Improper Payment	Improper Payments (billions)	Percentage of Improper Payments
Monetary Loss	Provider Not Enrolled	$2.66	7.3%
	Other Monetary Loss	$1.12	3.1%
Unknown	No or Insufficient Medical Documentation	$3.16	8.6%
	Non-Compliance with Provider Screening and NPI Requirements	$17.13	46.6%
	Other Unknown	$1.22	3.3%
Proxy Eligibility Estimate		$11.43	31.1%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Unknown" represents payments where therewas no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Table S4. Summary of Projected Medicaid Overpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	4,454	30,930	$10,851,069.3	$658,367,845.4	$41,174.3	$319,995.2	12.9%	12.0% - 13.7%
FFS Medical Review	918	30,930	$1,402,373.9	$658,367,845.4	$7,429.7	$319,995.2	2.3%	1.9% - 2.7%
FFS Data Processing	3,738	30,930	$9,642,900.9	$658,367,845.4	$35,417.7	$319,995.2	11.1%	10.3% - 11.8%
Managed Care	48	9,889	$38,821.3	$10,508,998.1	$779.4	$261,860.8	0.3%	0.2% - 0.4%
Eligibility	*1,009*	*25,914*	*$414,366.4*	*$13,922,896.8*	*$17,603.5*	*$581,856.0*	*3.0%*	*2.1% - 4.0%*
Total	**5,511**	**66,733**	**$11,304,257.1**	**$682,799,740.4**	**$58,288.0**	**$581,856.0**	**10.0%**	**9.0% - 11.0%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.

Table S5. Summary of Projected Medicaid Underpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	36	30,930	$5,647.3	$658,367,845.4	$11.8	$319,995.2	0.0%	(0.0%) - 0.0%
FFS Medical Review	0	30,930	$0.0	$658,367,845.4	$0.0	$319,995.2	0.0%	0.0% - 0.0%
FFS Data Processing	36	30,930	$5,647.3	$658,367,845.4	$11.8	$319,995.2	0.0%	(0.0%) - 0.0%
Managed Care	4	9,889	$60.8	$10,508,998.1	$1.3	$261,860.8	0.0%	(0.0%) - 0.0%
Eligibility	*45*	*25,914*	*$5,581.7*	*$13,922,896.8*	*$474.6*	*$581,856.0*	*0.1%*	*0.0% - 0.2%*
Total	**85**	**66,733**	**$11,289.8**	**$682,799,740.4**	**$487.7**	**$581,856.0**	**0.1%**	**0.0% - 0.2%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.

Medicaid FFS Component Improper Payment Rate

Table S6. Medicaid FFS Improper Payments by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Nursing Facility, Intermediate Care Facilities (ICF)	771	4,533	$2,372,157.2	$19,911,946.0	$9,201.3	$56,670.7	16.2%	14.3% - 18.1%
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	924	5,760	$650,415.2	$8,343,853.6	$8,795.1	$56,761.2	15.5%	13.0% - 18.0%
Prescribed Drugs	757	3,790	$886,981.2	$6,456,285.5	$5,604.1	$34,193.9	16.4%	12.7% - 20.1%
ICF for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	371	971	$4,012,619.3	$11,372,001.6	$4,415.5	$10,456.4	42.2%	37.4% - 47.1%
Personal Support Services	300	1,487	$90,721.6	$619,260.8	$3,210.9	$19,845.0	16.2%	13.0% - 19.3%
Inpatient and Outpatient Hospital Services	270	3,672	$1,790,892.9	$50,459,176.4	$2,139.7	$46,217.1	4.6%	3.6% - 5.7%
Psychiatric, Mental Health, and Behavioral Health Services	239	1,829	$688,450.2	$6,951,554.9	$1,790.0	$17,878.4	10.0%	6.6% - 13.4%
Physicians and Other Licensed Practitioner Services	126	1,190	$33,171.3	$317,106.7	$1,013.4	$11,507.4	8.8%	2.7% - 14.9%
Dental and Oral Surgery Services	188	771	$26,043.3	$111,639.1	$808.6	$4,975.4	16.3%	12.3% - 20.2%
Home Health Services	108	522	$28,281.3	$317,191.6	$808.0	$6,925.5	11.7%	8.5% - 14.8%
Hospice Services	18	155	$68,004.3	$575,038.1	$778.5	$2,230.7	34.9%	22.8% - 47.0%
Clinic Services	67	605	$47,048.7	$276,443.3	$758.7	$8,725.0	8.7%	5.1% - 12.3%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	77	313	$57,472.2	$261,323.0	$526.2	$2,961.7	17.8%	14.4% - 21.1%
Physical Therapy (PT), Occupational Therapy (OT), Respiratory Therapy (RT); Speech Language Pathology (SLP), Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	60	252	$2,869.0	$20,611.7	$452.9	$2,078.0	21.8%	14.8% - 28.8%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Laboratory, X-ray and Imaging Services	86	359	$5,401.7	$42,117.6	$381.9	$2,071.5	18.4%	12.6% - 24.2%
Crossover Claims	74	942	$83,556.5	$731,942.1	$299.0	$6,029.5	5.0%	3.1% - 6.8%
Capitated Care/Fixed Payments	24	3,186	$7,480.1	$551,523,608.4	$117.1	$28,927.5	0.4%	0.1% - 0.7%
Transportation and Accommodations	26	201	$5,138.4	$76,744.9	$84.4	$1,540.2	5.5%	3.3% - 7.6%
Denied Claims	2	392	$8.3	$0.0	$0.7	$0.0	N/A	N/A
Total	**4,488**	**30,930**	**$10,856,712.7**	**$658,367,845.4**	**$41,185.9**	**$319,995.2**	**12.9%**	**12.0% - 13.7%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

Medicaid FFS Improper Payments by Type of Error

Table S7. Summary of Medicaid FFS Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	2,886	$8,827,982.3	$31,639.4	$29,102.4	$34,176.5
Document(s) Absent from Record (MR2)	461	$811,663.2	$4,048.7	$3,160.7	$4,936.8
No Documentation Error (MR1)	328	$537,619.3	$2,485.9	$1,538.0	$3,433.8
Administrative/Other Error (DP12)	105	$301,997.8	$1,259.4	$369.7	$2,149.2
Non-covered Service/Beneficiary Error (DP2)	115	$228,980.7	$604.2	$389.0	$819.4
Procedure Coding Error (MR3)	12	$3,099.8	$284.2	-$25.1	$593.5
Number of Unit(s) Error (MR6)	49	$27,951.8	$233.5	$119.2	$347.8
Third-Party Liability Error (DP4)	10	$11,063.9	$220.9	-$35.3	$477.1
Improperly Completed Documentation (MR9)	19	$17,949.7	$217.4	$43.1	$391.8
Pricing Error (DP5)	83	$67,626.2	$98.2	$44.9	$151.6
Duplicate Claim Error (DP1)	1	$9,595.5	$49.0	N/A	N/A
Data Entry Error (DP7)	14	$3,881.0	$14.3	$3.5	$25.0
Policy Violation Error (MR8)	3	$7,182.1	$12.1	-$8.7	$32.8
Administrative/Other Error (MR10)	1	$24.8	$10.7	N/A	N/A
System Logic Edit Error (DP6)	2	$83.0	$5.9	-$4.3	$16.2
Unbundling Error (MR5)	3	$9.7	$1.8	-$0.8	$4.4
Claim Filed Untimely Error (DP11)	1	$2.0	$0.2	N/A	N/A
Data Processing Technical Deficiency (DTD)	364	$0.0	$0.0	$0.0	$0.0
Medical Technical Deficiency (MTD)	31	$0.0	$0.0	$0.0	$0.0
Total	**4,488**	**$10,856,712.7**	**$41,185.9**	**$38,200.4**	**$44,171.4**

Note: Details do not always sum to the total due to rounding. This table removes the overlap found in claims with both a Medical Review and Data Processing review to avoid double counting of errors. Therefore, these numbers will not necessarily match other tables in this report that are separated by review type. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Medicaid FFS Medical Review Improper Payments

Table S8. Summary of Medicaid FFS Medical Review Overall Errors

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	461	$811,663.2	$4,048.7	$3,160.7	$4,936.8
No Documentation Error (MR1)	328	$537,619.3	$2,485.9	$1,538.0	$3,433.8
Procedure Coding Error (MR3)	12	$3,099.8	$284.2	-$25.1	$593.5
Improperly Completed Documentation (MR9)	19	$17,949.7	$217.4	$43.1	$391.8
Number of Unit(s) Error (MR6)	49	$24,495.7	$205.8	$96.7	$314.9
Administrative/Other Error (MR10)	3	$354.5	$173.7	-$146.5	$493.9
Policy Violation Error (MR8)	3	$7,182.1	$12.1	-$8.7	$32.8
Unbundling Error (MR5)	3	$9.7	$1.8	-$0.8	$4.4
Medical Technical Deficiency (MTD)	40	$0.0	$0.0	$0.0	$0.0
Total	**918**	**$1,402,373.9**	**$7,429.7**	**$6,046.5**	**$8,812.8**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S9. Summary of Medicaid FFS Medical Review Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	461	$811,663.2	$4,048.7	$3,160.7	$4,936.8
No Documentation Error (MR1)	328	$537,619.3	$2,485.9	$1,538.0	$3,433.8
Procedure Coding Error (MR3)	12	$3,099.8	$284.2	-$25.1	$593.5
Improperly Completed Documentation (MR9)	19	$17,949.7	$217.4	$43.1	$391.8
Number of Unit(s) Error (MR6)	49	$24,495.7	$205.8	$96.7	$314.9
Administrative/Other Error (MR10)	3	$354.5	$173.7	-$146.5	$493.9
Policy Violation Error (MR8)	3	$7,182.1	$12.1	-$8.7	$32.8
Unbundling Error (MR5)	3	$9.7	$1.8	-$0.8	$4.4
Medical Technical Deficiency (MTD)	40	$0.0	$0.0	$0.0	$0.0
Total	**918**	**$1,402,373.9**	**$7,429.7**	**$6,046.5**	**$8,812.8**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S10. Summary of Medicaid FFS Medical Review Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
No Documentation Error (MR1)	0	$0.0	$0.0	$0.0	$0.0
Procedure Coding Error (MR3)	0	$0.0	$0.0	$0.0	$0.0
Unbundling Error (MR5)	0	$0.0	$0.0	$0.0	$0.0
Number of Unit(s) Error (MR6)	0	$0.0	$0.0	$0.0	$0.0
Policy Violation Error (MR8)	0	$0.0	$0.0	$0.0	$0.0
Improperly Completed Documentation (MR9)	0	$0.0	$0.0	$0.0	$0.0
Administrative/Other Error (MR10)	0	$0.0	$0.0	$0.0	$0.0
Document(s) Absent from Record (MR2)	0	$0.0	$0.0	$0.0	$0.0
Medical Technical Deficiency (MTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Medical Review Improper Payments: Document(s) Absent from Record Error (MR2)

Table S11. Medicaid FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	105	$81,130.0	$797.1	$417.0	$1,177.1
Provider did not submit required progress notes applicable to the sampled Date Of Service (DOS)	81	$187,025.9	$721.1	$452.5	$989.8
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	54	$31,783.1	$693.4	$103.7	$1,283.1
Provider did not submit the service plan	66	$106,307.4	$572.8	$287.3	$858.3
Multiple documents are missing from the record that are required to support payment	77	$192,409.8	$465.6	$254.6	$676.7

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Individual plan (Individual Service Plan [ISP], Individual Family Service Plan (ISFP), Individual Education Plan [IEP], or Plan Of Care [POC]) was present, but not applicable to the sampled DOS	45	$97,012.1	$365.9	$150.9	$581.0
Record does not include a physician's order for the sampled service	15	$30,924.3	$244.7	$60.5	$428.8
Provider did not submit sufficient documentation to support the claim	10	$17,893.7	$137.6	-$2.8	$278.0
No proof of delivery in the record provided	1	$394.8	$24.2	N/A	N/A
Provider did not submit the required physician certification/recertification of services	4	$66,457.7	$17.6	-$9.6	$44.8
Provider did not submit the test result	1	$33.3	$4.9	N/A	N/A
Provider did not submit the required signed timesheet	1	$247.9	$3.7	N/A	N/A
Provider did not submit a valid prescription	1	$43.2	$0.0	N/A	N/A
Total	**461**	**$811,663.2**	**$4,048.7**	**$3,160.7**	**$4,936.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Table S12. Medicaid FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
Progress Notes for All Disciplines/Departments	105
Member Pharmacy Signature Log/Proof of Delivery	90
POC/Service/Treatment Plan and Goals	83
Physician Orders	49
IEP; Individual Program Plan (IPP); ISP; IFSP	43
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records	42
Proof of Acceptance or Refusal of Counseling	24
Medication Administration Record (MAR)	11
Physician Certification/Recertification/Form 485 POC	10
Encounter/Office Visit/Clinic Record & Notes	9
PT, OT, SLP, Audiology, Vision, and RT: Evaluation and Re-evaluation/Notes	9
Mental Health Progress/Therapy Notes/Daily Attendance Logs	9
Timesheet, Completed & Signed	8
Treatment Administration Record/Notes	7
Documentation of Daily Patient Presence	7
Case Management Care Plan/Updates & Notes	5
Ground Mileage/Pick-up & Drop-off Details	5
Other	4
Dental or Orthodontic Clinical Notes	4
Procedure Record/Notes	3
Orders	3
Initial Intake Assessment/Reassessment	3
Physician Orders & Progress Notes	2
Beneficiary’s Signature/Proof of Service Receipt	2
Evaluation & Management (E&M)/Counseling Notes	2
Dialysis Treatment Records and Notes	2
Member Profile with Refill History for the Sampled Medication	2
Nursing Assessments and Notes	2
Psychological Testing, Mental Health Counseling Notes, Treatment Plan, & Progress Toward Goals	1
Home Health Aide Notes/Worksheets	1
Nursing Care Plan/Treatment Care Plan	1
Laboratory & Diagnostic Tests/Reports	1
Nursing Flowsheets/Notes	1
Physician’s Physical Exam Notes	1
Goals/Timelines/Outcome Measures (with Description of Services Approved & Provided)	1
Transportation Schedule for Requested DOS	1
Service Logs	1

Documentation Type	Total Count
Annual Physical Exam	1
Total Time Spent for Units Billed	1
Copy of Prescription	1
Invoice for Services (Dated)	1
Emergency Department Record/Notes	1
DME/Supplies Prescription	1
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Table S13. Medicaid FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Total Count
Nursing Facility, Chronic Care Services or ICF	162
Prescribed Drugs	114
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs & School Based Services	100
Personal Support Services	64
Psychiatric, Mental & Behavioral Health	38
ICF/IID and ICF/Group Homes	26
Physicians & Other Licensed Practitioners Services	9
PT, OT, RT, SLP, Audiology & Rehabilitation Services, Ophthalmology, Optometry & Optical Services Necessary Supplies & Equipment	9
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	8
Clinic Services	8
Home Health Services	6
Dental and Oral Surgery Services	5
Inpatient Hospital Services	4
Outpatient Hospital Services	4
Transportation and Accommodations	3
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Medical Review Improper Payments: No Documentation Error (MR1)

Table S14. Medicaid FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	188	$226,298.5	$947.3	$698.5	$1,196.1
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	41	$246,357.0	$895.0	$8.0	$1,782.0
Provider responded that he or she did not have the beneficiary on file or in the system	16	$12,340.9	$141.3	$25.7	$257.0
Provider billed in error	12	$4,161.4	$112.3	$13.1	$211.5
Provider responded with a statement that records cannot be located	9	$1,782.6	$87.0	-$28.7	$202.8
Provider is under fraud investigation	27	$4,470.9	$85.7	$44.2	$127.2
Provider responded with a statement that he or she billed for the wrong beneficiary	5	$967.6	$60.6	-$6.9	$128.0
State could not locate the provider	12	$4,155.4	$60.2	$6.5	$113.9
Provider responded that he or she is no longer operating business/practice and the record is unavailable	8	$3,410.0	$53.4	-$7.7	$114.6
Other	6	$1,013.3	$21.2	-$2.4	$44.8

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider submitted a record for wrong DOS	2	$31,501.0	$17.0	-$10.8	$44.7
Provider did not submit medical records, only billing information	1	$81.3	$4.0	N/A	N/A
Provider did not submit medical records, only the PERM coversheet	1	$1,079.4	$0.9	N/A	N/A
Total	**328**	**$537,619.3**	**$2,485.9**	**$1,538.0**	**$3,433.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Medicaid FFS Medical Review Errors by Service Type

Table S15. Medicaid FFS Medical Review Errors by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	192	5,760	$165,705.6	$8,343,853.6	$1,730.3	$56,761.2	3.0%	2.0% - 4.1%
Nursing Facility, ICF	156	4,533	$455,027.4	$19,911,946.0	$1,349.5	$56,670.7	2.4%	1.7% - 3.1%
Prescribed Drugs	167	3,790	$181,292.7	$6,456,285.5	$1,173.1	$34,193.9	3.4%	2.0% - 4.9%
Personal Support Services	110	1,487	$36,240.0	$619,260.8	$721.4	$19,845.0	3.6%	2.8% - 4.5%
Physicians and Other Licensed Practitioner Services	47	1,190	$22,435.7	$317,106.7	$689.9	$11,507.4	6.0%	0.0% - 12.0%
Inpatient and Outpatient Hospital Services	38	3,672	$211,593.0	$50,459,176.4	$613.8	$46,217.1	1.3%	0.9% - 1.8%
Psychiatric, Mental Health, and Behavioral Health Services	62	1,829	$38,024.5	$6,951,554.9	$235.5	$17,878.4	1.3%	0.7% - 1.9%
Home Health Services	37	522	$7,694.0	$317,191.6	$209.1	$6,925.5	3.0%	1.9% - 4.1%
ICF/IID and ICF/Group Homes	25	971	$265,841.2	$11,372,001.6	$190.2	$10,456.4	1.8%	1.1% - 2.5%
Dental and Oral Surgery Services	20	771	$3,830.4	$111,639.1	$162.5	$4,975.4	3.3%	1.5% - 5.0%
Clinic Services	12	605	$6,432.0	$276,443.3	$142.0	$8,725.0	1.6%	0.3% - 2.9%
Laboratory, X-ray and Imaging Services	15	359	$323.6	$42,117.6	$77.4	$2,071.5	3.7%	1.0% - 6.4%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	18	313	$6,474.6	$261,323.0	$63.5	$2,961.7	2.1%	0.9% - 3.4%
PT OT, RT; SLP, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	10	252	$582.6	$20,611.7	$52.0	$2,078.0	2.5%	0.6% - 4.4%
Transportation and Accommodations	9	201	$876.6	$76,744.9	$19.6	$1,540.2	1.3%	1.1% - 1.5%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Capitated Care/Fixed Payments	0	3,186	$0.0	$551,523,608.4	$0.0	$28,927.5	0.0%	0.0% - 0.0%
Crossover Claims	0	942	$0.0	$731,942.1	$0.0	$6,029.5	0.0%	0.0% - 0.0%
Denied Claims	0	392	$0.0	$0.0	$0.0	$0.0	N/A	N/A
Hospice Services	0	155	$0.0	$575,038.1	$0.0	$2,230.7	0.0%	0.0% - 0.0%
Total	**918**	**30,930**	**$1,402,373.9**	**$658,367,845.4**	**$7,429.7**	**$319,995.2**	**2.3%**	**1.9% - 2.7%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

Medicaid FFS Data Processing Improper Payments

Table S16. Summary of Medicaid FFS Data Processing Overall Improper Payments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	3,029	$8,965,361.8	$33,001.0	$30,420.8	$35,581.2
Administrative/Other Error (DP12)	112	$352,834.1	$1,286.8	$397.1	$2,176.5
Non-covered Service/Beneficiary Error (DP2)	125	$233,393.4	$678.1	$452.7	$903.6
Third-Party Liability Error (DP4)	10	$11,063.9	$220.9	-$35.3	$477.1
Pricing Error (DP5)	102	$72,333.5	$173.4	$107.3	$239.4
Duplicate Claim Error (DP1)	1	$9,595.5	$49.0	N/A	N/A
Data Entry Error (DP7)	14	$3,881.0	$14.3	$3.5	$25.0
System Logic Edit Error (DP6)	2	$83.0	$5.9	-$4.3	$16.2
Claim Filed Untimely Error (DP11)	1	$2.0	$0.2	N/A	N/A
Data Processing Technical Deficiency (DTD)	378	$0.0	$0.0	$0.0	$0.0
Total	**3,774**	**$9,648,548.2**	**$35,429.5**	**$32,686.6**	**$38,172.4**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S17. Summary of Medicaid FFS Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	3,029	$8,965,361.8	$33,001.0	$30,420.8	$35,581.2
Administrative/Other Error (DP12)	112	$352,834.1	$1,286.8	$397.1	$2,176.5
Non-covered Service/Beneficiary Error (DP2)	125	$233,393.4	$678.1	$452.7	$903.6
Third-Party Liability Error (DP4)	10	$11,063.9	$220.9	-$35.3	$477.1
Pricing Error (DP5)	69	$66,884.3	$162.4	$97.8	$227.1
Duplicate Claim Error (DP1)	1	$9,595.5	$49.0	N/A	N/A
Data Entry Error (DP7)	12	$3,685.1	$14.1	$3.4	$24.9
System Logic Edit Error (DP6)	1	$80.8	$5.2	N/A	N/A
Claim Filed Untimely Error (DP11)	1	$2.0	$0.2	N/A	N/A
Data Processing Technical Deficiency (DTD)	378	$0.0	$0.0	$0.0	$0.0
Total	**3,738**	**$9,642,900.9**	**$35,417.7**	**$32,674.8**	**$38,160.6**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S18. Summary of Medicaid FFS Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	33	$5,449.2	$10.9	-$2.5	$24.4
System Logic Edit Error (DP6)	1	$2.2	$0.7	N/A	N/A
Data Entry Error (DP7)	2	$195.9	$0.1	-$0.1	$0.4
Duplicate Claim Error (DP1)	0	$0.0	$0.0	$0.0	$0.0
Non-covered Service/Beneficiary Error (DP2)	0	$0.0	$0.0	$0.0	$0.0
Provider Information/Enrollment Error (DP10)	0	$0.0	$0.0	$0.0	$0.0
Claim Filed Untimely Error (DP11)	0	$0.0	$0.0	$0.0	$0.0
Administrative/Other Error (DP12)	0	$0.0	$0.0	$0.0	$0.0
Third-Party Liability Error (DP4)	0	$0.0	$0.0	$0.0	$0.0
Data Processing Technical Deficiency (DTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**36**	**$5,647.3**	**$11.8**	**-$1.7**	**$25.4**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Data Processing Improper Payments: Provider Information/Enrollment Error (DP10)

Table S19. Specific Causes of Medicaid Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
National Provider Identifier (NPI)	Attending or rendering provider NPI required but not listed on claim	1,041	$4,719,684.3	$17,748.4	$15,857.3	$19,639.6
	Referring/Ordering provider NPI required, but not listed on the claim	629	$333,308.3	$4,634.2	$3,466.3	$5,802.0
	Billing provider NPI required but not listed on claim	16	$23,670.7	$92.9	$9.5	$176.3
Provider Screening	Provider not appropriately screened using risk based criteria prior to enrollment	854	$1,108,170.0	$5,975.5	$4,934.7	$7,016.2
Provider Enrollment	Provider not enrolled in Medicaid	464	$2,717,571.8	$4,383.9	$3,552.5	$5,215.4
Provider License/Certification	Provider license not current for DOS	15	$44,730.2	$75.0	$17.1	$132.9
	CLIA certification not current for DOS	1	$41.3	$43.3	N/A	N/A
Other		9	$18,185.3	$47.7	$14.5	$81.0
Total		**3,029**	**$8,965,361.8**	**$33,001.0**	**$30,420.8**	**$35,581.2**

Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S20. 2017 Cycle 2 DP10 Medicaid FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Count of Errors
Attending	No NPI on the claim	57
	Type 2 NPI on the claim, but Type 1 is required	103
Referring/Ordering	No NPI on the claim	157
	Type 2 NPI on the claim, but Type 1 is required	16
Billing	No NPI on the claim	9
Rendering	Type 2 NPI on the claim, but Type 1 is required	1
Note: These error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.		

Table S21. 2017 Cycle 2 DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Count of Errors
Screening Elements Not Completed	No required databases were checked	303
	System for Award Management (SAM) or Excluded Parties List System (EPLS) not checked	53
	On-site visit not conducted	47
	Social Security Death Master File (SSDMF) was not checked	31
	National Plan and Provider Enumeration System (NPPES) not checked	32
	Office of Inspector General's List of Excluded Individuals and Entities (OIG LEIE) database was not checked	23
Provider Enrollment Status	Newly enrolled provider	211
	Provider not notified of revalidation requirement and revalidation not complete	193
	Revalidated provider	9
	Re-enrolled provider	1
Provider Risk Level	Low risk provider	352
	Moderate risk provider	38
	High Risk provider	24
Note: It is possible for one claim to have multiple sub-causes for error, so one claim may be counted multiple times in this table. Additionally, these error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.		

Table S22. 2017 Cycle 2 DP10 Medicaid FFS Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Count of Errors
Billing	97
Ordering and Referring Physicians and other professionals (ORP)	69
Attending	1
Rendering	1
Note: These error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.	

Data Processing Improper Payments: Non-covered Service/Beneficiary Error (DP2)

Table S23. Specific Causes of Medicaid FFS Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Financial system reflected incorrect beneficiary eligibility status	40	$142,870.3	$311.0	$119.3	$502.8
Other	61	$77,755.5	$244.4	$156.1	$332.8
Non-covered based on missing or invalid authorization	22	$12,275.8	$109.7	$32.7	$186.8
Capitation payment made for a beneficiary not enrolled in Managed Care Organization (MCO)	1	$457.5	$7.6	N/A	N/A
Non-covered based on beneficiary's benefit plan	1	$34.2	$5.3	N/A	N/A
Total	**125**	**$233,393.4**	**$678.1**	**$452.7**	**$903.6**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Administrative/Other Error (DP12)

Table S24. Specific Causes of Medicaid FFS Administrative/Other Error (DP12)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
State did not provide documentation needed to complete the review	112	$352,834.1	$1,286.8	$397.1	$2,176.5
Total	**112**	**$352,834.1**	**$1,286.8**	**$397.1**	**$2,176.5**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Medicaid FFS Data Processing Errors by Service Type

Table S25. Medicaid FFS Data Processing Errors by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Nursing Facility, ICF	643	4,533	$1,968,952.7	$19,911,946.0	$8,102.9	$56,670.7	14.3%	12.5% - 16.1%
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	752	5,760	$494,472.3	$8,343,853.6	$7,244.6	$56,761.2	12.8%	10.5% - 15.0%
Prescribed Drugs	628	3,790	$766,710.3	$6,456,285.5	$4,799.8	$34,193.9	14.0%	10.4% - 17.6%
ICF/IID and ICF/Group Homes	355	971	$3,781,962.6	$11,372,001.6	$4,359.7	$10,456.4	41.7%	36.9% - 46.5%
Personal Support Services	251	1,487	$77,426.7	$619,260.8	$2,831.7	$19,845.0	14.3%	11.1% - 17.4%
Inpatient and Outpatient Hospital Services	235	3,672	$1,579,523.4	$50,459,176.4	$1,772.3	$46,217.1	3.8%	2.9% - 4.8%
Psychiatric, Mental Health, and Behavioral Health Services	188	1,829	$659,515.5	$6,951,554.9	$1,583.3	$17,878.4	8.9%	5.5% - 12.2%
Hospice Services	18	155	$68,004.3	$575,038.1	$778.5	$2,230.7	34.9%	22.8% - 47.0%
Dental and Oral Surgery Services	176	771	$22,628.9	$111,639.1	$668.1	$4,975.4	13.4%	9.8% - 17.0%
Clinic Services	57	605	$41,169.3	$276,443.3	$642.3	$8,725.0	7.4%	4.0% - 10.7%
Home Health Services	78	522	$21,639.8	$317,191.6	$613.6	$6,925.5	8.9%	6.1% - 11.7%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	68	313	$52,973.0	$261,323.0	$493.4	$2,961.7	16.7%	13.5% - 19.8%
PT, OT, RT; SLP, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	53	252	$2,371.8	$20,611.7	$409.9	$2,078.0	19.7%	12.7% - 26.7%
Laboratory, X-ray and Imaging Services	75	359	$5,136.8	$42,117.6	$323.9	$2,071.5	15.6%	10.1% - 21.1%
Physicians and Other Licensed Practitioner Services	79	1,190	$10,735.6	$317,106.7	$323.5	$11,507.4	2.8%	1.0% - 4.6%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Crossover Claims	74	942	$83,556.5	$731,942.1	$299.0	$6,029.5	5.0%	3.1% - 6.8%
Capitated Care/Fixed Payments	24	3,186	$7,480.1	$551,523,608.4	$117.1	$28,927.5	0.4%	0.1% - 0.7%
Transportation and Accommodations	18	201	$4,280.2	$76,744.9	$65.2	$1,540.2	4.2%	2.1% - 6.4%
Denied Claims	2	392	$8.3	$0.0	$0.7	$0.0	N/A	N/A
Total	**3,774**	**30,930**	**$9,648,548.2**	**$658,367,845.4**	**$35,429.5**	**$319,995.2**	**11.1%**	**10.3% - 11.9%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

Medicaid Managed Care Component Improper Payment Rate

Medicaid Managed Care Errors by Type of Error

Table S26. Summary of Medicaid Managed Care Data Processing Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	18	$18,259.8	$385.8	$166.8	$604.8
Administrative/Other Error (DP12)	15	$10,667.8	$299.5	$170.3	$428.6
Provider Information/Enrollment Error (DP10)	2	$1,265.0	$38.9	-$15.3	$93.1
Managed Care Payment Error (DP9)	10	$469.4	$27.0	$8.1	$45.9
Duplicate Claim Error (DP1)	2	$7,267.6	$17.2	-$10.0	$44.4
Managed Care Rate Cell Error (DP8)	2	$952.6	$12.4	-$11.0	$35.7
Data Processing Technical Deficiency (DTD)	3	$0.0	$0.0	$0.0	$0.0
Total	**52**	**$38,882.1**	**$780.7**	**$517.6**	**$1,043.8**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Medicaid Managed Care Data Processing Improper Payments

Table S27. Summary of Medicaid Managed Care Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	18	$18,259.8	$385.8	$166.8	$604.8
Administrative/Other Error (DP12)	15	$10,667.8	$299.5	$170.3	$428.6
Provider Information/Enrollment Error (DP10)	2	$1,265.0	$38.9	-$15.3	$93.1
Managed Care Payment Error (DP9)	7	$423.9	$26.2	$7.3	$45.0
Duplicate Claim Error (DP1)	2	$7,267.6	$17.2	-$10.0	$44.4
Managed Care Rate Cell Error (DP8)	1	$937.3	$11.9	N/A	N/A
Data Processing Technical Deficiency (DTD)	3	$0.0	$0.0	$0.0	$0.0
Total	**48**	**$38,821.3**	**$779.4**	**$516.3**	**$1,042.6**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table S28. Summary of Medicaid Managed Care Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Managed Care Payment Error (DP9)	3	$45.5	$0.8	-$0.5	$2.2
Managed Care Rate Cell Error (DP8)	1	$15.3	$0.5	N/A	N/A
Duplicate Claim Error (DP1)	0	$0.0	$0.0	$0.0	$0.0
Non-covered Service/Beneficiary Error (DP2)	0	$0.0	$0.0	$0.0	$0.0
Provider Information/Enrollment Error (DP10)	0	$0.0	$0.0	$0.0	$0.0
Administrative/Other Error (DP12)	0	$0.0	$0.0	$0.0	$0.0
Data Processing Technical Deficiency (DTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**4**	**$60.8**	**$1.3**	**-$0.3**	**$2.9**
Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Non-covered Service/Beneficiary Error(DP2)

Table S29. Specific Causes of Medicaid Managed Care Non-covered Service/BeneficiaryError (DP2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Financial system reflected incorrect beneficiary eligibility status	15	$12,732.6	$318.4	$120.7	$516.2
Claim/Capitation payment paid for coverage period or DOS after beneficiary's date of death	2	$4,699.8	$59.4	-$33.5	$152.2
Capitation payment made for a beneficiary not enrolled in MCO	1	$827.4	$8.0	N/A	N/A
Total	**18**	**$18,259.8**	**$385.8**	**$166.8**	**$604.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Administrative/Other Error (DP12)

Table S30. Specific Causes of Medicaid Managed Care Administrative/Other Error (DP12)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
State did not provide documentation needed to complete the review	15	$10,667.8	$299.5	$170.3	$428.6
Total	**15**	**$10,667.8**	**$299.5**	**$170.3**	**$428.6**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Table S31. State-Specific Improper Payment Rates for the States Measured in 2015 Cycle 3, 2016 Cycle 1, and 2017 Cycle 2

Considerations for viewing state-specific PERM rates:

- What is included in PERM rates and represented in this table
  - **Three components** – PERM measures Fee-For-Service (FFS) payments made to providers, managed care capitation payments made to Managed Care Organizations (MCOs), and beneficiary eligibility determinations made by state agencies and combines them to form the overall rate per state. The overall improper payment rate is computed by proportionally combining the FFS and managed care components based on expenditures for each component (the claims rate), then adding the eligibility component and subtracting out the overlap between the claims and eligibility component. Because of this, you cannot simply average the three components to reach the overall rate.
  - **Three cycles** – PERM measures on a three-year, 17 state rotation cycle, meaning that each state is measured once every three years and each PERM cycle measurement includes one third of all states. The most recent three cycles combine to form each year's overall national rate.
  - **Sample vs projection** –
    - *Sample improper payments* – The improper payments associated with the actual reviewed sample of claims. These are then extrapolated out to represent the entire universe of claims (the projected improper payments). The federal share of the sampled overpayments is the only portion that CMS has the authority to recover from the FFS and managed care universes.
    - *Projected improper payments* – The estimated improper payments used for national reporting to represent the entire Medicaid program (derived by projecting out the actual sampled improper payments to represent all Medicaid improper payments).
  - **Insufficient Documentation vs Monetary Loss Errors** – please note that the concept of monetary loss errors was not implemented until 2017, so data on monetary loss percentage is not available for 2015 and 2016.
    - *Insufficient Documentation Errors* – Improper payments also include instances where there is insufficient or no documentation to support the payment as proper or improper. A majority of Medicaid improper payments were due to instances where information required for payment or eligibility determination was missing from the claim or state systems (e.g., not properly saving documentation after verification) and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or ineligible beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable.
    - *Monetary Loss Errors* – Instances of monetary loss errors occur when CMS has sufficient information to determine that the Medicaid payment should not have occurred or should have been made in a different amount. Monetary loss errors represent a smaller proportion of Medicaid improper payments.
- **State-specific Improper Payment Rates Are Not Comparable**

States have flexibility to design their policies and operate their programs to meet the individual needs of the state, such as establishing a managed care delivery system rather than relying on FFS. Variation between states and the resulting methodological differences between states' PERM rates makes it impossible to accurately compare state-specific PERM rates between states. Additional reasons include:

- *State-level precision/confidence interval* – The national PERM rate is established by capturing a statistically valid random sample representative of all Medicaid payments matched with federal funds. The national PERM improper payment rate meets a precision requirement where CMS is 95 percent confident that the Medicaid improper payment rate is within +/- 3 percentage points. The PERM program was not designed to produce that level of precision at the state level. Therefore, state-level precision can vary, leading to wider confidence intervals in some states.
- *Program structure* – PERM has historically seen a lower instance of improper payments in managed care than FFS, based on differences in the review standards that apply to claims from the two service delivery models. Due to the differing review methodology, states' rates are often not comparable due to the varying distribution between FFS and managed care expenditures.
  - The definition of a FFS delivery system used below includes states' direct payment to providers for each service rendered to individual beneficiaries. Managed care is a delivery system in which a state makes a risk-based monthly capitated payment to a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan, which is responsible for managing beneficiary care. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to a data processing review.
- *State Policies* – Policies vary by state, which leads to differences in the states' specific Medicaid rates. These varying policies may include medical documentation and coverage requirements, integration and coordination of payment and eligibility systems, and prioritization of resources based on budget limitation.

- **Other Considerations**
  - In light of changes to the way states adjudicate beneficiary eligibility for Medicaid, for 2015 through 2018, CMS did not conduct the eligibility measurement component of PERM. During the pause of the PERM program's eligibility measurement component, CMS required states to implement pilots to ensure effective oversight and monitoring of Medicaid eligibility determinations. These Eligibility Review Pilots provided states with more targeted, detailed information on the accuracy of eligibility determinations 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. Unlike during the normal PERM process, where states are measured once every three years, the eligibility pilots occurred every year for every state. To compute the overall national improper payment rate, the Medicaid eligibility component improper payment rate was held constant at the 2014 national rate between 2015 and 2018. Therefore, there is no eligibility component data for 2015-2017.
  - This information does not include situations where documentation was received or findings disputes were requested after the cycle cutoff date. However, these instances may be eligible for continued processing and may result in a recalculation of a state's improper payment rate after the officially reported rate.
  - Some states rely solely on FFS and do not have a managed care program at all (those states are marked with "--" in the managed care columns).

State	Overall					Fee-For-Service						
	Projected IP Rate	Projected Monetary Loss IP Rate	Projected Confidence Interval	Projected IP ($ mil)	Sampled IP	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	% of Total Projected Expenditures	Sampled Expenditures
Alabama	6.3%		1.9% - 10.7%	$290.0	$17,386.9	6.30%		$290.0	$17,386.9	$4,603.6	100.0%	$1,077,981.1
Arkansas	18.7%		16.4% - 21.0%	$961.5	$350,998.1	18.67%		$961.5	$350,998.1	$5,149.7	100.0%	$869,138.7
Colorado	7.8%	0.8%	5.4% - 10.3%	$548.5	$56,951.2	8.77%	0.8%	$527.0	$56,466.5	$6,011.4	85.9%	$1,511,968.0
Delaware	2.9%		1.8% - 3.9%	$55.0	$261,846.6	12.70%		$55.0	$261,846.6	$432.6	22.5%	$2,573,304.9
District of Columbia	21.8%		19.0% - 24.7%	$434.1	$986,655.1	29.84%		$434.1	$986,655.1	$1,454.8	73.2%	$4,346,355.2
Florida	9.8%		6.4% - 13.2%	$1,827.0	$667,283.4	16.05%		$1,809.6	$664,065.0	$11,275.2	60.3%	$5,010,203.2
Georgia	15.9%	4.3%	10.0% - 21.8%	$1,524.9	$608,583.9	22.46%	10.5%	$1,296.3	$598,385.9	$5,771.1	60.1%	$4,068,179.5
Hawaii	1.9%		1.2% - 2.7%	$30.5	$96,557.7	12.71%		$26.3	$93,597.2	$206.6	13.1%	$566,547.6
Idaho	5.4%		3.0% - 7.9%	$93.7	$106,163.1	6.06%		$93.7	$106,163.1	$1,544.2	89.6%	$1,369,638.8
Illinois	4.9%		2.7% - 7.0%	$721.2	$50,766.5	6.90%		$638.1	$49,292.4	$9,240.7	62.3%	$1,768,070.4
Indiana	10.7%		6.1% - 15.4%	$917.1	$86,019.1	13.81%		$917.1	$86,019.1	$6,639.2	77.8%	$885,260.6
Iowa	8.7%		5.9% - 11.6%	$318.6	$293,223.2	9.87%		$318.6	$293,223.2	$3,227.6	88.6%	$1,158,002.9
Kansas	2.0%		1.8% - 2.2%	$60.5	$1,471,507.9	23.89%		$60.5	$1,471,507.9	$253.3	8.4%	$2,648,792.9
Kentucky	2.7%	2.2%	0.6% - 4.8%	$261.8	$177,945.4	9.47%	2.2%	$261.8	$177,945.4	$2,765.0	28.5%	$2,748,633.8
Louisiana	9.5%		6.4% - 12.6%	$542.9	$183,889.8	12.84%		$526.0	$176,775.1	$4,098.0	71.8%	$723,419.1
Maine	18.0%		11.4% - 24.6%	$436.3	$146,383.8	17.97%		$436.3	$146,383.8	$2,428.2	100.0%	$3,791,727.7
Maryland	3.9%	2.8%	2.2% - 5.5%	$415.7	$76,528.2	6.62%	0.7%	$382.1	$74,440.3	$5,768.0	53.8%	$1,824,966.3
Massachusetts	4.9%	0.2%	3.5% - 6.4%	$817.4	$47,492.3	8.04%	0.6%	$817.4	$47,492.3	$10,173.1	61.4%	$3,993,380.7
Michigan	3.5%		2.5% - 4.5%	$523.4	$67,871.5	10.38%		$523.4	$67,871.5	$5,044.8	34.0%	$100,652,945.7
Minnesota	4.9%		2.6% - 7.3%	$539.5	$52,985.7	6.78%		$378.8	$49,634.5	$5,584.5	51.1%	$611,722.7
Mississippi	10.3%		6.1% - 14.5%	$424.9	$159,729.8	12.90%		$424.9	$159,729.8	$3,294.5	80.0%	$1,057,266.8
Missouri	25.0%		20.8% - 29.2%	$2,277.2	$552,592.7	28.60%		$2,277.2	$552,592.7	$7,961.0	87.5%	$1,550,735.7
Montana	5.8%		2.9% - 8.8%	$63.6	$75,044.4	5.81%		$63.6	$75,044.4	$1,094.2	100.0%	$895,989.0
Nebraska	3.7%	1.2%	2.6% - 4.8%	$73.9	$144,886.8	5.59%	1.7%	$73.9	$144,886.8	$1,321.7	66.0%	$8,589,873.7
Nevada	13.8%		10.7% - 16.9%	$248.2	$583,110.5	18.59%		$248.2	$583,110.5	$1,335.2	74.3%	$3,512,204.6
New Hampshire	10.1%	0.3%	8.7% - 11.6%	$174.7	$138,453.3	18.52%	0.5%	$174.7	$138,453.3	$943.3	54.8%	$1,535,330.3
New Jersey	1.2%	0.0%	-0.6% - 3.0%	$157.0	$3,237.0	3.17%	0.0%	$157.0	$3,237.0	$4,947.9	37.2%	$1,973,290.1
New Mexico	1.1%		0.7% - 1.5%	$53.5	$51,177.1	7.17%		$53.5	$51,177.1	$747.0	15.4%	$460,324.1
New York	6.0%		3.9% - 8.1%	$2,841.9	$142,196.5	10.69%		$2,841.9	$142,196.5	$26,575.2	56.1%	$1,404,177.9
North Carolina	4.0%	0.5%	2.1% - 6.0%	$474.8	$24,077.0	4.89%	0.9%	$471.8	$23,095.8	$9,638.8	81.7%	$524,604.7
North Dakota	12.8%		9.6% - 16.0%	$142.9	$558,044.8	16.15%		$142.9	$558,044.8	$884.7	79.3%	$3,033,672.6
Ohio	2.2%		1.3% - 3.0%	$456.3	$11,539.8	4.56%		$420.9	$7,899.0	$9,226.7	44.0%	$708,901.0
Oklahoma	5.0%		2.6% - 7.4%	$213.1	$37,002.9	4.99%		$213.1	$37,002.9	$4,269.8	100.0%	$524,385.4
Oregon	4.7%		2.2% - 7.2%	$230.3	$112,795.4	8.80%		$221.0	$111,858.1	$2,512.6	50.8%	$1,009,438.6
Pennsylvania	3.2%		1.3% - 5.0%	$694.2	$48,938.2	7.55%		$694.2	$48,938.2	$9,198.2	41.9%	$1,359,402.2
Rhode Island	3.8%	0.0%	2.4% - 5.2%	$93.6	$428,350.4	8.71%	0.0%	$81.6	$427,053.3	$936.0	38.1%	$8,711,749.1
South Carolina	3.9%	0.2%	2.7% - 5.2%	$217.8	$167,273.1	7.40%	0.2%	$206.7	$166,214.1	$2,793.3	50.3%	$20,574,019.0
South Dakota	30.7%		23.7% - 37.7%	$236.0	$288,409.3	30.69%		$236.0	$288,409.3	$768.8	100.0%	$1,059,969.5

Tennessee	2.4%	1.1%	1.9% - 3.0%	$227.5	$19,965.7	8.27%	1.6%	$227.5	$19,965.7	$2,749.9	29.6%	$3,145,787.6
Texas	23.9%		20.9% - 27.0%	$6,755.4	$379,185.8	46.16%		$6,755.4	$379,185.8	$14,635.9	51.8%	$951,586.6
Utah	1.9%	0.3%	1.0% - 2.9%	$41.6	$21,619.5	3.92%	0.1%	$41.6	$21,619.5	$1,061.3	49.6%	$4,714,639.7
Vermont	3.8%	0.4%	1.7% - 6.0%	$66.8	$26,579.7	3.84%	1.5%	$66.8	$26,579.7	$1,741.6	100.0%	$2,327,022.3
Virginia	6.9%		3.3% - 10.5%	$535.8	$45,159.8	10.81%		$508.9	$44,873.6	$4,705.9	60.2%	$1,068,766.3
Washington	6.3%		4.3% - 8.3%	$469.9	$93,912.3	10.58%		$469.9	$93,912.3	$4,441.4	59.6%	$885,573.3
West Virginia	13.6%	0.4%	-0.6% - 27.9%	$495.5	$206,521.0	22.20%	0.8%	$495.5	$206,521.0	$2,232.4	61.5%	$2,693,219.0
Wisconsin	0.3%		-0.2% - 0.8%	$28.7	$75.3	0.57%		$28.7	$75.3	$4,989.9	57.2%	$923,281.3
Wyoming	16.6%		11.8% - 21.4%	$87.9	$346,173.9	16.56%		$87.9	$346,173.9	$530.9	100.0%	$1,047,128.0

State	Managed Care			
	Projected IP Rate	Projected IP Rate	Projected IP ($ mil)	Projected Expenditures ($ mil)
Alabama	6.3%	--	--	--
Arkansas	18.7%	--	--	--
Colorado	7.8%	2.2%	$21.5	$988.6
Delaware	2.9%	0.0%	$0.0	$1,491.0
District of Columbia	21.8%	0.0%	$0.0	$534.0
Florida	9.8%	0.2%	$17.3	$7,413.0
Georgia	15.9%	6.0%	$228.7	$3,829.1
Hawaii	1.9%	0.3%	$4.3	$1,365.6
Idaho	5.4%	0.0%	$0.0	$178.5
Illinois	4.9%	1.5%	$83.1	$5,581.4
Indiana	10.7%	0.0%	$0.0	$1,898.5
Iowa	8.7%	0.0%	$0.0	$413.9
Kansas	2.0%	0.0%	$0.0	$2,768.4
Kentucky	2.7%	0.0%	$0.0	$6,939.7
Louisiana	9.5%	1.0%	$16.9	$1,611.4
Maine	18.0%	--	--	--
Maryland	3.9%	0.7%	$33.6	$4,951.2
Massachusetts	4.9%	0.0%	$0.0	$6,405.7
Michigan	3.5%	0.0%	$0.0	$9,807.7
Minnesota	4.9%	3.0%	$160.7	$5,334.9
Mississippi	10.3%	0.0%	$0.0	$824.4
Missouri	25.0%	0.0%	$0.0	$1,142.3
Montana	5.8%	--	--	--
Nebraska	3.7%	0.0%	$0.0	$681.0
Nevada	13.8%	0.0%	$0.0	$462.0
New Hampshire	10.1%	0.0%	$0.0	$778.7
New Jersey	1.2%	0.0%	$0.0	$8,368.7
New Mexico	1.1%	0.0%	$0.0	$4,096.8
New York	6.0%	0.0%	$0.0	$20,815.1
North Carolina	4.0%	0.1%	$3.0	$2,156.4
North Dakota	12.8%	0.0%	$0.0	$231.5
Ohio	2.2%	0.3%	$35.4	$11,749.2
Oklahoma	5.0%	--	--	--
Oregon	4.7%	0.4%	$9.3	$2,429.8

Pennsylvania	3.2%	0.0%	$0.0	$12,739.5
Rhode Island	3.8%	0.8%	$12.1	$1,520.5
South Carolina	3.9%	0.4%	$11.1	$2,756.0
South Dakota	30.7%	--	--	--
Tennessee	2.4%	0.0%	$0.0	$6,550.3
Texas	23.9%	0.0%	$0.0	$13,612.5
Utah	1.9%	0.0%	$0.0	$1,077.5
Vermont	3.8%	--	--	--
Virginia	6.9%	0.9%	$27.0	$3,107.8
Washington	6.3%	0.0%	$0.0	$3,009.2
West Virginia	13.6%	0.0%	$0.0	$1,399.2
Wisconsin	0.3%	0.0%	$0.0	$3,730.7
Wyoming	16.6%	--	--	--

Section 3: Historical CHIP Cycle-Specific and National Rolling Improper Payment Rates

Table B1. States in Each Cycle

Cycle 1	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2	**Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia**
Cycle 3	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

Note: States measured in the most recent cycle for the 2017 improper payment rate (i.e., Cycle 2) are in **bold**.

Table B2. Inception to Date Cycle-Specific CHIP Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2012 - Cycle 3	6.9%	0.1%	5.7%	**8.2%**
2013 - Cycle 1	6.1%	0.5%	4.4%	**6.8%**
2014 - Cycle 2	6.2%	0.0%	2.6%	**4.8%**
2015 - Cycle 3	13.1%	0.6%	N/A*	**N/A***
2016 - Cycle 1	14.0%	3.7%	N/A*	**N/A***
2017 - Cycle 2	7.7%	1.7%	N/A*	**N/A***

*For the 2015-2017 measurements, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed from these rates.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled.

Table B3. National Rolling CHIP Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility	Overall**
2013 Rolling Rates	5.7%	0.2%	5.1%	**7.1%**
2014 Rolling Rates	6.2%	0.2%	4.2%	**6.5%**
2015 Rolling Rates	7.3%	0.4%	4.2%*	**6.8%**
2016 Rolling Rates	10.2%	1.0%	4.2%*	**8.0%**
2017 Rolling Rates	10.3%	1.6%	4.2%*	**8.6%**

*Rolling eligibility component statistics for 2015-2017 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. It is important to note that the 2013 rolling rate for CHIP represents 2 cycles since only 34 states had been sampled at the time.

Section 4: 2017 Supplemental CHIP Improper Payment Data

CMS reported a rolling improper payment rate for CHIP in 2017 based on the 51 states reviewed from 2015-2017. Unless otherwise noted, all tables and figures in Section 4 are based on the rolling rate. There was no eligibility component review from 2015-2017 and eligibility results from the most recent cycles prior to 2015 are used as a proxy in the overall improper payment rate calculation.

Table T1. Summary of CHIP Projected Improper Payments ... 36
Table T2. CHIP Improper Payment Rate Applied to Projected Paid Amount (2017 Total Expenditures) and the Federal Share ... 36
Table T3. CHIP Improper Payments by Type of Improper Payment and Cause of Improper Payment ... 37
Table T4. Summary of Projected CHIP Overpayments ... 37
Table T5. Summary of Projected CHIP Underpayments ... 38
Table T6. CHIP FFS Improper Payments by Service Type ... 41
Table T7. Summary of CHIP FFS Projected Dollars by Type of Error ... 43
Table T8. Summary of CHIP FFS Medical Review Overall Errors ... 44
Table T9. Summary of CHIP FFS Medical Review Overpayments ... 44
Table T10. Summary of CHIP FFS Medical Review Underpayments ... 45
Table T11. CHIP FFS Specific Causes of Document(s) Absent from Record Error (MR2) ... 45
Table T12. CHIP FFS Specific Types of Document(s) Absent from Record ... 47
Table T13. CHIP FFS Specific Provider Types with Document(s) Absent from Record ... 49
Table T14. CHIP FFS Specific Causes of No Documentation Error (MR1) ... 49
Table T15. CHIP FFS Medical Review Errors by Service Type ... 51
Table T16. Summary of CHIP FFS Data Processing Overall Improper Payments ... 53
Table T17. Summary of CHIP FFS Data Processing Overpayments ... 53
Table T18. Summary of CHIP FFS Data Processing Underpayments ... 54
Table T19. Specific Causes of CHIP Provider Information/Enrollment Error (DP10) ... 54
Table T20. 2017 Cycle 2 DP10 CHIP FFS Errors: NPI Required But Not Listed on Claim Breakdown ... 55
Table T21. 2017 Cycle 2 DP10 CHIP Errors: Provider Not Appropriately Screened Breakdown ... 55
Table T22. 2017 Cycle 2 DP10 CHIP Errors: Provider Not Enrolled Breakdown ... 56
Table T23. Specific Causes of CHIP FFS Non-covered Service/Beneficiary Error (DP2) ... 56
Table T24. Specific Causes of CHIP FFS Administrative/Other Error (DP12) ... 56
Table T25. CHIP FFS Data Processing Errors by Service Type ... 57
Table T26. Summary of CHIP Managed Care Data Processing Projected Dollars by Type of Error ... 61
Table T27. Summary of CHIP Managed Care Data Processing Overpayments ... 61
Table T28. Summary of CHIP Managed Care Data Processing Underpayments ... 62
Table T29. Specific Causes of CHIP Managed Care Non-covered Service/Beneficiary Error (DP2) ... 62
Table T30. Specific Causes of CHIP Managed Care Payment Error (DP9) ... 62

CHIP Overpayments and Underpayments

Table T1. Summary of CHIP Projected Improper Payments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	4,078	22,808	$4,001,875.2	$72,096,254.7	$636.6	$6,187.4	10.3%	9.6% - 11.0%
FFS Medical Review	758	22,808*	$510,697.3	$72,096,254.7	$134.8	$6,187.4	2.2%	1.9% - 2.5%
FFS Data Processing	3,462	22,808	$3,554,134.5	$72,096,254.7	$523.6	$6,187.4	8.5%	7.8% - 9.1%
Managed Care	250	9,642	$159,201.1	$2,155,092.4	$190.5	$11,727.6	1.6%	1.3% - 2.0%
Eligibility	*1,841*	*25,358*	*$240,621.1*	*$5,617,602.3*	*$755.8*	*$17,915.0*	*4.2%*	*3.7% - 4.8%*
Total	**6,169**	**57,808**	**$4,401,697.4**	**$79,868,949.4**	**$1,548.0**	**$17,915.0**	**8.6%**	**8.0% - 9.2%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.
*Data Processing review is performed on all sampled FFS claims. However, not all sampled FFS claims receive a Medical Review as certain exceptions apply where Medical Review is not able to be performed (Medicare Part A and Part B premiums, primary care case management payments, aggregate payments, other fixed payments, denied claims, and zero-paid claims).

Table T2. CHIP Improper Payment Rate Applied to Projected Paid Amount (2017 Total Expenditures) and the Federal Share

Component	Projected Paid Amount (billions)	Projected Improper Payments (billions)	Lower 95% Confidence Limit (billions)	Upper 95% Confidence Limit (billions)
FFS Total	$6.2	$0.6	$0.6	$0.7
Federal Share	$5.1	$0.5	$0.5	$0.6
Managed Care Total	$11.7	$0.2	$0.1	$0.2
Federal Share	$9.2	$0.1	$0.1	$0.2
*Eligibility Total**	*$17.9*	*$0.8*	*$0.7*	*$0.9*
*Federal Share**	*$14.3*	*$0.6*	*$0.5*	*$0.7*
National Total**	**$17.9**	**$1.5**	**$1.4**	**$1.7**
Federal Share**	**$14.3**	**$1.2**	**$1.1**	**$1.3**

*Eligibility reviews are suspended for the current measurement cycle while CMS implements a new eligibility review methodology. The eligibility rates used as a proxy in the 2017 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.

Table T3. CHIP Improper Payments by Type of Improper Payment and Cause of Improper Payment

Type of Improper Payment	Cause of Improper Payment	Improper Payments (billions)	Percentage of Improper Payments
Monetary Loss	Non-Covered Beneficiary	$0.16	13.1%
	Provider Not Enrolled	$0.04	2.9%
	Other Monetary Loss	$0.02	1.6%
Unknown	No or Insufficient Medical Documentation	$0.08	6.8%
	Non-Compliance with Provider Screening and NPI Requirements	$0.34	27.8%
	Other Unknown	$0.03	2.3%
Proxy Eligibility Estimate		$0.56	45.5%

Note: The table provides information on CHIP improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Unknown" represents payments where there was no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Table T4. Summary of Projected CHIP Overpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	4,011	22,808	$4,000,045.9	$72,096,254.7	$635.6	$6,187.4	10.3%	9.6% - 11.0%
FFS Medical Review	757	22,808	$510,681.5	$72,096,254.7	$134.6	$6,187.4	2.2%	1.9% - 2.5%
FFS Data Processing	3,394	22,808	$3,552,321.0	$72,096,254.7	$522.8	$6,187.4	8.5%	7.8% - 9.1%
Managed Care	175	9,642	$159,179.3	$2,155,092.4	$190.5	$11,727.6	1.6%	1.3% - 2.0%
Eligibility	*1,753*	*25,358*	*$238,406.1*	*$5,617,602.3*	*$747.8*	*$17,915.0*	*4.2%*	*3.6% - 4.7%*
Total	**5,939**	**57,808**	**$4,397,631.3**	**$79,868,949.4**	**$1,539.5**	**$17,915.0**	**8.6%**	**8.0% - 9.2%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.

Table T5. Summary of Projected CHIP Underpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	69	22,808	$1,829.3	$72,096,254.7	$0.9	$6,187.4	0.0%	0.0% - 0.0%
FFS Medical Review	1	22,808	$15.8	$72,096,254.7	$0.1	$6,187.4	0.0%	(0.0%) - 0.0%
FFS Data Processing	68	22,808	$1,813.5	$72,096,254.7	$0.8	$6,187.4	0.0%	0.0% - 0.0%
Managed Care	75	9,642	$21.8	$2,155,092.4	$0.0	$11,727.6	0.0%	(0.0%) - 0.0%
Eligibility	*88*	*25,358*	*$2,215.0*	*$5,617,602.3*	*$7.9*	*$17,915.0*	*0.0%*	*0.0% - 0.1%*
Total	**232**	**57,808**	**$4,066.2**	**$79,868,949.4**	**$8.8**	**$17,915.0**	**0.0%**	**0.0% - 0.1%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate.

CHIP FFS Component Improper Payment Rate

Table T6. CHIP FFS Improper Payments by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Dental and Oral Surgery Services	1,150	3,641	$135,031.7	$617,543.2	$188.5	$1,069.7	17.6%	15.3% - 20.0%
Prescribed Drugs	1,083	4,160	$1,077,494.9	$5,622,176.8	$153.2	$1,068.7	14.3%	12.3% - 16.3%
Psychiatric, Mental Health, and Behavioral Health Services	262	2,317	$589,611.3	$5,402,469.0	$66.1	$1,163.3	5.7%	4.4% - 6.9%
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	418	1,728	$48,481.3	$1,085,080.9	$64.2	$212.5	30.2%	26.0% - 34.4%
Inpatient and Outpatient Hospital Services	394	4,267	$1,971,351.5	$50,241,762.5	$55.5	$1,157.1	4.8%	4.1% - 5.5%

Physicians and Other Licensed Practitioner Services	244	2,146	$47,918.8	$523,935.8	$40.2	$604.0	6.6%	4.9% - 8.4%
PT, OT, RT; SLP, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	109	483	$8,811.5	$32,611.9	$26.5	$223.8	11.9%	9.1% - 14.7%
Clinic Services	133	1,113	$26,672.6	$230,273.1	$18.4	$265.1	6.9%	5.0% - 8.9%
Personal Support Services	109	581	$36,417.8	$246,169.2	$9.5	$68.0	13.9%	9.5% - 18.4%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	49	179	$18,677.6	$107,290.0	$6.7	$56.3	11.9%	9.4% - 14.4%
Laboratory, X-ray and Imaging Services	63	420	$11,476.0	$91,795.3	$4.0	$47.4	8.5%	5.3% - 11.8%
Home Health Services	36	239	$16,978.9	$171,360.3	$3.1	$19.3	16.1%	8.6% - 23.6%
Transportation and Accommodations	12	140	$12,739.4	$103,096.1	$0.4	$26.1	1.6%	1.1% - 2.2%
Capitated Care/Fixed Payments	3	984	$5.0	$6,893,434.5	$0.1	$202.1	0.0%	(0.0%) - 0.1%
Denied Claims	1	315	$15.0	$0.0	$0.1	$0.0	N/A	N/A
Crossover Claims	12	45	$191.9	$10,328.3	$0.0	$0.1	58.8%	52.6% - 65.0%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Hospice Services	0	7	$0.0	$10,890.9	$0.0	$0.8	0.0%	0.0% - 0.0%
ICF/IID and ICF/Group Homes	0	43	$0.0	$706,036.8	$0.0	$3.0	0.0%	0.0% - 0.0%
Total	**4,078**	**22,808**	**$4,001,875.2**	**$72,096,254.7**	**$636.6**	**$6,187.4**	**10.3%**	**9.6% - 11.0%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

CHIP FFS Improper Payments by Type of Error

Table T7. Summary of CHIP FFS Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	1,864	$2,597,208.9	$441.3	$396.3	$486.2
Document(s) Absent from Record (MR2)	396	$232,808.7	$81.3	$66.3	$96.3
Non-covered Service/Beneficiary Error (DP2)	638	$566,505.6	$41.2	$32.9	$49.5
No Documentation Error (MR1)	217	$229,299.5	$39.0	$30.2	$47.9
Administrative/Other Error (DP12)	232	$244,516.7	$13.1	$10.5	$15.7
Procedure Coding Error (MR3)	20	$10,877.3	$5.9	$0.4	$11.4
Improperly Completed Documentation (MR9)	17	$3,196.4	$3.7	$0.9	$6.5
Number of Unit(s) Error (MR6)	33	$31,291.7	$3.5	$0.6	$6.3
Pricing Error (DP5)	102	$23,690.7	$2.2	$0.7	$3.7
Data Entry Error (DP7)	26	$16,357.4	$1.5	$0.1	$2.9
Administrative/Other Error (MR10)	8	$2,410.6	$1.4	$0.2	$2.6
Third-Party Liability Error (DP4)	5	$1,022.4	$1.1	-$1.1	$3.4
Duplicate Claim Error (DP1)	4	$42,032.8	$0.7	-$0.2	$1.6
FFS Payment for a Managed Care Service Error (DP3)	1	$130.5	$0.2	N/A	N/A
Medically Unnecessary Service Error (MR7)	1	$95.0	$0.2	N/A	N/A
Unbundling Error (MR5)	1	$180.0	$0.1	N/A	N/A
Claim Filed Untimely Error (DP11)	1	$30.6	$0.1	N/A	N/A
Policy Violation Error (MR8)	1	$66.6	$0.1	N/A	N/A
Diagnosis Coding Error (MR4)	1	$153.8	$0.0	N/A	N/A
Data Processing Technical Deficiency (DTD)	460	$0.0	$0.0	$0.0	$0.0
Medical Technical Deficiency (MTD)	50	$0.0	$0.0	$0.0	$0.0
Total	**4,078**	**$4,001,875.2**	**$636.6**	**$587.7**	**$685.5**

Note: Details do not always sum to the total due to rounding. This table removes the overlap found in claims with both a Medical Review and Data Processing review to avoid double counting of errors. Therefore, these numbers will not necessarily match other tables in this report that are separated by review type. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

CHIP FFS Medical Review Improper Payments

Table T8. Summary of CHIP FFS Medical Review Overall Errors

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	396	$232,775.1	$80.9	$66.0	$95.9
No Documentation Error (MR1)	217	$229,299.5	$39.0	$30.2	$47.9
Procedure Coding Error (MR3)	20	$10,877.3	$5.9	$0.4	$11.4
Improperly Completed Documentation (MR9)	17	$3,196.4	$3.7	$0.9	$6.5
Number of Unit(s) Error (MR6)	33	$30,643.0	$3.4	$0.6	$6.2
Administrative/Other Error (MR10)	9	$3,410.6	$1.4	$0.2	$2.6
Medically Unnecessary Service Error (MR7)	1	$95.0	$0.2	N/A	N/A
Unbundling Error (MR5)	1	$180.0	$0.1	N/A	N/A
Policy Violation Error (MR8)	1	$66.6	$0.1	N/A	N/A
Diagnosis Coding Error (MR4)	1	$153.8	$0.0	N/A	N/A
Medical Technical Deficiency (MTD)	62	$0.0	$0.0	$0.0	$0.0
Total	**758**	**$510,697.3**	**$134.8**	**$116.2**	**$153.4**
Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Table T9. Summary of CHIP FFS Medical Review Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	396	$232,775.1	$80.9	$66.0	$95.9
No Documentation Error (MR1)	217	$229,299.5	$39.0	$30.2	$47.9
Procedure Coding Error (MR3)	19	$10,861.5	$5.8	$0.3	$11.2
Improperly Completed Documentation (MR9)	17	$3,196.4	$3.7	$0.9	$6.5
Number of Unit(s) Error (MR6)	33	$30,643.0	$3.4	$0.6	$6.2
Administrative/Other Error (MR10)	9	$3,410.6	$1.4	$0.2	$2.6
Medically Unnecessary Service Error (MR7)	1	$95.0	$0.2	N/A	N/A
Unbundling Error (MR5)	1	$180.0	$0.1	N/A	N/A
Policy Violation Error (MR8)	1	$66.6	$0.1	N/A	N/A
Diagnosis Coding Error (MR4)	1	$153.8	$0.0	N/A	N/A
Medical Technical Deficiency (MTD)	62	$0.0	$0.0	$0.0	$0.0
Total	**757**	**$510,681.5**	**$134.6**	**$116.1**	**$153.2**
Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Table T10. Summary of CHIP FFS Medical Review Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Procedure Coding Error (MR3)	1	$15.8	$0.1	N/A	N/A
No Documentation Error (MR1)	0	$0.0	$0.0	$0.0	$0.0
Diagnosis Coding Error (MR4)	0	$0.0	$0.0	$0.0	$0.0
Unbundling Error (MR5)	0	$0.0	$0.0	$0.0	$0.0
Number of Unit(s) Error (MR6)	0	$0.0	$0.0	$0.0	$0.0
Medically Unnecessary Service Error (MR7)	0	$0.0	$0.0	$0.0	$0.0
Policy Violation Error (MR8)	0	$0.0	$0.0	$0.0	$0.0
Improperly Completed Documentation (MR9)	0	$0.0	$0.0	$0.0	$0.0
Administrative/Other Error (MR10)	0	$0.0	$0.0	$0.0	$0.0
Document(s) Absent from Record (MR2)	0	$0.0	$0.0	$0.0	$0.0
Medical Technical Deficiency (MTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**1**	**$15.8**	**$0.1**	**N/A**	**N/A**
Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Medical Review Improper Payments: Document(s) Absent from Record Error (MR2)

Table T11. CHIP FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	216	$99,203.3	$43.1	$33.0	$53.2
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	62	$25,878.7	$18.0	$8.8	$27.3
Provider did not submit the service plan	27	$2,668.0	$6.8	$2.4	$11.2
Provider did not submit required progress notes applicable to the sampled DOS	22	$8,697.1	$4.1	$1.7	$6.5
Individual plan (ISP, ISFP, IEP, or POC) was present, but not applicable to the sampled DOS	30	$3,183.8	$2.8	$1.3	$4.4
Provider did not submit sufficient documentation to support the claim	11	$15,576.5	$2.4	$0.4	$4.4
Multiple documents are missing from the record that are required to support payment	16	$59,041.5	$1.7	$0.3	$3.1

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
No proof of delivery in the record provided	2	$412.7	$1.0	-$0.8	$2.8
Record does not include a physician's order for the sampled service	7	$3,111.3	$0.7	$0.1	$1.4
Provider did not submit a valid prescription	2	$13,002.8	$0.3	-$0.2	$0.7
Provider did not submit the test result	1	$1,999.5	$0.0	N/A	N/A
Total	**396**	**$232,775.1**	**$80.9**	**$66.0**	**$95.9**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Table T12. CHIP FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
Member Pharmacy Signature Log/Proof of Delivery	194
POC/Service/Treatment Plan and Goals	51
Proof of Acceptance or Refusal of Counseling	34
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records	18
Encounter/Office Visit/Clinic Record & Notes	16
PT, OT, SLP, Audiology, Vision, and RT: Evaluation and Re-evaluation/Notes	13
Dental or Orthodontic Clinical Notes	10
Copy of Prescription	9
Mental Health Progress/Therapy Notes/Daily Attendance Logs	9
Physician Orders & Progress Notes	9
Member Profile with Refill History for the Sampled Medication	9
Procedure Record/Notes	8
IEP; IPP; ISP; IFSP	7
Timesheet, Completed & Signed	6
Laboratory & Diagnostic Tests/Reports	6
Name of Drug, Dose, Route, Number Dispensed, & Number of Refills	5
Progress Notes for All Disciplines/Departments	4
MAR	4
Initial Intake Assessment/Reassessment	4
E&M/Counseling Notes	4
Case Management Care Plan/Updates & Notes	3
Ground Mileage/Pick-up & Drop-off Details	3
NDC Number	2
Physician Order Sheet	2
Other	2
Optometry and Optical Visit Notes	2
Itemized Billing Sheet (If Required Based on Payment Method)	1
Psychiatric Evaluation/Testing	1
Dental X-Ray Notes	1
Home Health Aide Notes/Worksheets	1
Eyeglass/Optician Invoices	1
Orders	1
Treatment Administration Records/Notes	1
Goals/Timelines/Outcome Measures (with Description pf Services Approved & Provided)	1
Documentation Reflecting Medical Necessity for Transportation	1
Physician Certification/Recertification/Form 485 POC	1
Psychological Testing, Mental Health Counseling Notes, Treatment Plan, & Progress Toward Goals	1
Admission History & Physical	1

Documentation Type	Total Count
Radiology/Imaging Report/Results & Interpretation	1
Discharge Summary	1
Total Time Spent for Units Billed	1
Documentation of Daily Patient Presence	1
Nursing Assessment and Notes	1
Anesthesia (Pre and Post-op) & Peri-operative Record/Notes (with Start and Stop Times)	1
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Table T13. CHIP FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Total Count
Prescribed Drugs	251
Psychiatric, Mental & Behavioral Health	46
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs & School Based Services	40
Personal Support Services	27
Physicians & Other Licensed Practitioners Services	18
Clinic Services	16
Inpatient Hospital Services	15
Dental and Oral Surgery Services	15
Outpatient Hospital Services	10
PT, OT, RT, SLP, Audiology & Rehabilitation Services, Ophthalmology, Optometry & Optical Services Necessary Supplies & Equipment	5
Laboratory, X-Ray and Imaging Services	4
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	2
Home Health Services	2
Transportation and Accommodations	1
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Medical Review Improper Payments: No Documentation Error (MR1)

Table T14. CHIP FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	105	$91,375.0	$17.5	$12.0	$23.0
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	33	$11,492.4	$6.1	$2.6	$9.6
Provider billed in error	19	$5,994.9	$4.1	$0.3	$7.9
Provider responded that he or she did not have the beneficiary on file or in the system	21	$110,793.4	$3.6	$1.5	$5.7
Other	4	$466.0	$1.8	-$0.4	$4.0
Provider submitted a record for the wrong beneficiary	3	$517.4	$1.8	-$1.0	$4.6
Provider responded with a statement that records cannot be located	11	$2,225.5	$1.2	$0.1	$2.3
State could not locate the provider	10	$994.9	$1.2	-$0.3	$2.7

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider responded with a statement that the record is lost or destroyed due to an unforeseeable and uncontrollable event such as fire, flood, or earthquake	1	$115.2	$0.5	N/A	N/A
Provider submitted a record for wrong DOS	1	$29.6	$0.5	N/A	N/A
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	6	$5,106.0	$0.4	$0.0	$0.7
Provider is under fraud investigation	1	$157.0	$0.2	N/A	N/A
Provider did not submit medical records, only billing information	1	$27.1	$0.0	N/A	N/A
Provider responded with a statement that he or she billed for the wrong beneficiary	1	$4.9	$0.0	N/A	N/A
Total	**217**	**$229,299.5**	**$39.0**	**$30.2**	**$47.9**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

CHIP FFS Medical Review Errors by Service Type

Table T15. CHIP FFS Medical Review Errors by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Prescribed Drugs	275	4,160	$201,315.2	$5,622,176.8	$52.3	$1,068.7	4.9%	3.9% - 5.9%
Psychiatric, Mental Health, and Behavioral Health Services	90	2,317	$28,946.1	$5,402,469.0	$17.9	$1,163.3	1.5%	1.0% - 2.1%
Dental and Oral Surgery Services	63	3,641	$3,765.8	$617,543.2	$15.7	$1,069.7	1.5%	0.6% - 2.3%
Physicians and Other Licensed Practitioner Services	81	2,146	$30,049.5	$523,935.8	$11.5	$604.0	1.9%	1.0% - 2.8%
Clinic Services	38	1,113	$15,374.3	$230,273.1	$11.4	$265.1	4.3%	2.7% - 5.9%
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	65	1,728	$13,607.6	$1,085,080.9	$9.1	$212.5	4.3%	2.5% - 6.0%
Inpatient and Outpatient Hospital Services	51	4,267	$180,920.3	$50,241,762.5	$8.0	$1,157.1	0.7%	0.4% - 0.9%
PT, OT, RT; SLP, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	24	483	$2,435.2	$32,611.9	$3.9	$223.8	1.7%	0.4% - 3.0%
Laboratory, X-ray and Imaging Services	17	420	$3,652.3	$91,795.3	$1.6	$47.4	3.5%	1.9% - 5.0%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	7	179	$4,916.1	$107,290.0	$1.4	$56.3	2.5%	2.2% - 2.7%
Personal Support Services	36	581	$9,867.1	$246,169.2	$1.3	$68.0	1.9%	0.2% - 3.6%
Home Health Services	7	239	$3,730.5	$171,360.3	$0.6	$19.3	3.1%	(1.0%) - 7.2%
Transportation and Accommodations	4	140	$12,117.5	$103,096.1	$0.1	$26.1	0.3%	(0.1%) - 0.6%
Capitated Care/Fixed Payments	0	984	$0.0	$6,893,434.5	$0.0	$202.1	0.0%	0.0% - 0.0%
Crossover Claims	0	45	$0.0	$10,328.3	$0.0	$0.1	0.0%	0.0% - 0.0%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Denied Claims	0	315	$0.0	$0.0	$0.0	$0.0	N/A	N/A
Hospice Services	0	7	$0.0	$10,890.9	$0.0	$0.8	0.0%	0.0% - 0.0%
ICF/IID and ICF/Group Homes	0	43	$0.0	$706,036.8	$0.0	$3.0	0.0%	0.0% - 0.0%
Total	**758**	**22,808**	**$510,697.3**	**$72,096,254.7**	**$134.8**	**$6,187.4**	**2.2%**	**1.9% - 2.5%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

CHIP FFS Data Processing Improper Payments

Table T16. Summary of CHIP FFS Data Processing Overall Improper Payments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	1,949	$2,653,087.2	$460.0	$414.6	$505.4
Non-covered Service/Beneficiary Error (DP2)	663	$572,783.3	$44.3	$35.9	$52.8
Administrative/Other Error (DP12)	234	$244,651.3	$13.2	$10.6	$15.8
Pricing Error (DP5)	105	$23,690.7	$2.2	$0.7	$3.7
Data Entry Error (DP7)	30	$16,703.2	$1.7	$0.2	$3.1
Third-Party Liability Error (DP4)	5	$1,022.4	$1.1	-$1.1	$3.4
Duplicate Claim Error (DP1)	4	$42,032.8	$0.7	-$0.2	$1.6
FFS Payment for a Managed Care Service Error (DP3)	1	$130.5	$0.2	N/A	N/A
Claim Filed Untimely Error (DP11)	2	$33.2	$0.1	-$0.1	$0.3
Data Processing Technical Deficiency (DTD)	469	$0.0	$0.0	$0.0	$0.0
Total	**3,462**	**$3,554,134.5**	**$523.6**	**$477.4**	**$569.9**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table T17. Summary of CHIP FFS Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	1,948	$2,653,072.2	$459.9	$414.5	$505.3
Non-covered Service/Beneficiary Error (DP2)	663	$572,783.3	$44.3	$35.9	$52.8
Administrative/Other Error (DP12)	233	$244,640.6	$13.2	$10.6	$15.8
Data Entry Error (DP7)	25	$16,680.3	$1.7	$0.2	$3.1
Pricing Error (DP5)	46	$21,975.0	$1.5	$0.2	$2.9
Third-Party Liability Error (DP4)	3	$973.1	$1.1	-$1.1	$3.4
Duplicate Claim Error (DP1)	4	$42,032.8	$0.7	-$0.2	$1.6
FFS Payment for a Managed Care Service Error (DP3)	1	$130.5	$0.2	N/A	N/A
Claim Filed Untimely Error (DP11)	2	$33.2	$0.1	-$0.1	$0.3
Data Processing Technical Deficiency (DTD)	469	$0.0	$0.0	$0.0	$0.0
Total	**3,394**	**$3,552,321.0**	**$522.8**	**$476.6**	**$569.1**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table T18. Summary of CHIP FFS Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	59	$1,715.7	$0.7	$0.0	$1.4
Provider Information/Enrollment Error (DP10)	1	$15.0	$0.1	N/A	N/A
Administrative/Other Error (DP12)	1	$10.7	$0.0	N/A	N/A
Data Entry Error (DP7)	5	$22.9	$0.0	$0.0	$0.0
Third-Party Liability Error (DP4)	2	$49.3	$0.0	$0.0	$0.0
Duplicate Claim Error (DP1)	0	$0.0	$0.0	$0.0	$0.0
Non-covered Service/Beneficiary Error (DP2)	0	$0.0	$0.0	$0.0	$0.0
Claim Filed Untimely Error (DP11)	0	$0.0	$0.0	$0.0	$0.0
FFS Payment for a Managed Care Service Error (DP3)	0	$0.0	$0.0	$0.0	$0.0
Data Processing Technical Deficiency (DTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**68**	**$1,813.5**	**$0.8**	**$0.1**	**$1.5**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Data Processing Improper Payments: Provider Information/Enrollment Error (DP10)

Table T19. Specific Causes of CHIP Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Screening	Provider not appropriately screened using risk based criteria prior to enrollment	923	$835,956.9	$266.6	$232.3	$300.9
National Provider Identifier (NPI)	Referring/Ordering provider Type 1 NPI required, but not listed on the claim	711	$379,648.1	$121.3	$104.6	$138.0
	Attending or rendering provider NPI required but not listed on claim	95	$634,486.4	$27.8	$5.6	$50.0
	Billing provider NPI required but not listed on claim	4	$679.8	$0.5	-$0.2	$1.2
Provider Enrollment	Provider not enrolled in CHIP	208	$798,910.2	$43.2	$31.3	$55.1
Provider License	Provider license not current for DOS	7	$3,390.8	$0.5	$0.0	$1.0
Other		1	$15.0	$0.1	N/A	N/A
Total		**1,949**	**$2,653,087.2**	**$460.0**	**$414.6**	**$505.4**

Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table T20. 2017 Cycle 2 DP10 CHIP FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Count of Errors
Attending	No NPI on the claim	3
	Type 2 NPI on the claim, but Type 1 is required	20
Referring/Ordering	No NPI on the claim	194
	Type 2 NPI on the claim, but Type 1 is required	1
Billing	No NPI on the claim	4
Note: These error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.		

Table T21. 2017 Cycle 2 DP10 CHIP Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Count of Errors
Screening Elements Not Completed	No required databases were checked	302
	SAM or EPLS not checked	84
	SSDMF was not checked	94
	OIG LEIE database was not checked	55
	NPPES not checked	41
	On-site visit not conducted	2
Provider Enrollment Status	Newly enrolled provider	351
	Provider not notified of revalidation requirement and revalidation not complete	104
	Revalidated provider	6
	Re-enrolled provider	9
Provider Risk Level	Low risk provider	466
	Moderate risk provider	2
	High risk provider	2
Note: It is possible for one claim to have multiple sub-causes for error, so one claim may be counted multiple times in this table. Additionally, these error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.		

Table T22. 2017 Cycle 2 DP10 CHIP Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Count of Errors
ORP	41
Billing	13
Rendering	5
Attending	4
Note: These error sub-causes are for the most recent Cycle 2 measurement only, not all three cycles used in the rolling data. Therefore, the counts in this table will not add to the totals above.	

Data Processing Improper Payments: Non-covered Service/Beneficiary Error (DP2)

Table T23. Specific Causes of CHIP FFS Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Financial system reflects incorrect beneficiary eligibility status	190	$474,069.7	$24.3	$17.0	$31.7
Other	460	$92,646.1	$17.1	$13.4	$20.9
Non-covered based on missing or invalid authorization	10	$4,794.2	$1.8	$0.5	$3.1
Non-covered based on beneficiary's benefit plan	3	$1,273.3	$1.0	-$0.4	$2.5
Total	**663**	**$572,783.3**	**$44.3**	**$35.9**	**$52.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Administrative/Other Error (DP12)

Table T24. Specific Causes of CHIP FFS Administrative/Other Error (DP12)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
State did not provide documentation needed to complete the review	234	$244,651.3	$13.2	$10.6	$15.8
Total	**234**	**$244,651.3**	**$13.2**	**$10.6**	**$15.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

CHIP FFS Data Processing Errors by Service Type

Table T25. CHIP FFS Data Processing Errors by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Dental and Oral Surgery Services	1,108	3,641	$131,890.8	$617,543.2	$173.7	$1,069.7	16.2%	14.0% - 18.5%
Prescribed Drugs	878	4,160	$921,881.1	$5,622,176.8	$113.8	$1,068.7	10.6%	8.8% - 12.5%
Day Habilitation, Adult Day Care, Foster Care and Waiver Programs, School Based Services	365	1,728	$35,612.9	$1,085,080.9	$57.8	$212.5	27.2%	23.1% - 31.3%
Psychiatric, Mental Health, and Behavioral Health Services	187	2,317	$568,389.8	$5,402,469.0	$50.1	$1,163.3	4.3%	3.2% - 5.4%
Inpatient and Outpatient Hospital Services	347	4,267	$1,790,901.6	$50,241,762.5	$47.5	$1,157.1	4.1%	3.4% - 4.8%
Physicians and Other Licensed Practitioner Services	167	2,146	$18,141.4	$523,935.8	$29.2	$604.0	4.8%	3.3% - 6.3%
PT, OT, RT; SLP, Audiology; Ophthalmology, Optometry, and Optical Services & Rehabilitation Services, Necessary Supplies & Equipment	88	483	$6,870.2	$32,611.9	$24.5	$223.8	10.9%	8.2% - 13.7%
Personal Support Services	75	581	$27,707.3	$246,169.2	$8.3	$68.0	12.1%	8.0% - 16.3%
Clinic Services	101	1,113	$12,325.7	$230,273.1	$7.7	$265.1	2.9%	1.7% - 4.1%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	43	179	$14,761.5	$107,290.0	$5.3	$56.3	9.5%	7.1% - 11.9%
Laboratory, X-ray and Imaging Services	48	420	$8,623.1	$91,795.3	$2.6	$47.4	5.4%	2.6% - 8.2%
Home Health Services	31	239	$16,195.3	$171,360.3	$2.5	$19.3	13.1%	6.3% - 19.9%
Transportation and Accommodations	8	140	$621.9	$103,096.1	$0.3	$26.1	1.3%	0.9% - 1.8%
Capitated Care/Fixed Payments	3	984	$5.0	$6,893,434.5	$0.1	$202.1	0.0%	(0.0%) - 0.1%
Denied Claims	1	315	$15.0	$0.0	$0.1	$0.0	N/A	N/A

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Crossover Claims	12	45	$191.9	$10,328.3	$0.0	$0.1	58.8%	52.6% - 65.0%
Hospice Services	0	7	$0.0	$10,890.9	$0.0	$0.8	0.0%	0.0% - 0.0%
ICF/IID and ICF/Group Homes	0	43	$0.0	$706,036.8	$0.0	$3.0	0.0%	0.0% - 0.0%
Total	**3,462**	**22,808**	**$3,554,134.5**	**$72,096,254.7**	**$523.6**	**$6,187.4**	**8.5%**	**7.8% - 9.1%**

Note: Details do not always sum to the total due to rounding. Additionally, for denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim.

CHIP Managed Care Component Improper Payment Rate

CHIP Managed Care Errors by Type of Error

Table T26. Summary of CHIP Managed Care Data Processing Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	123	$86,910.1	$178.1	$137.2	$219.0
Managed Care Payment Error (DP9)	109	$54,282.6	$7.0	$2.2	$11.8
Third-Party Liability Error (DP4)	2	$229.2	$2.3	-$1.3	$5.8
Administrative/Other Error (DP12)	1	$150.1	$2.1	N/A	N/A
Managed Care Rate Cell Error (DP8)	7	$11,768.8	$0.8	$0.1	$1.4
Duplicate Claim Error (DP1)	3	$5,860.4	$0.4	-$0.1	$0.8
Data Processing Technical Deficiency (DTD)	5	$0.0	$0.0	$0.0	$0.0
Total	**250**	**$159,201.1**	**$190.5**	**$149.0**	**$232.1**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

CHIP Managed Care Data Processing Improper Payments

Table T27. Summary of CHIP Managed Care Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	123	$86,910.1	$178.1	$137.2	$219.0
Managed Care Payment Error (DP9)	35	$54,260.8	$6.9	$2.1	$11.8
Third-Party Liability Error (DP4)	2	$229.2	$2.3	-$1.3	$5.8
Administrative/Other Error (DP12)	1	$150.1	$2.1	N/A	N/A
Managed Care Rate Cell Error (DP8)	6	$11,768.7	$0.8	$0.1	$1.4
Duplicate Claim Error (DP1)	3	$5,860.4	$0.4	-$0.1	$0.8
Data Processing Technical Deficiency (DTD)	5	$0.0	$0.0	$0.0	$0.0
Total	**175**	**$159,179.3**	**$190.5**	**$149.0**	**$232.1**

Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.

Table T28. Summary of CHIP Managed Care Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Managed Care Payment Error (DP9)	74	$21.8	$0.0	$0.0	$0.0
Managed Care Rate Cell Error (DP8)	1	$0.1	$0.0	N/A	N/A
Duplicate Claim Error (DP1)	0	$0.0	$0.0	$0.0	$0.0
Non-covered Service/Beneficiary Error (DP2)	0	$0.0	$0.0	$0.0	$0.0
Administrative/Other Error (DP12)	0	$0.0	$0.0	$0.0	$0.0
Third-Party Liability Error (DP4)	0	$0.0	$0.0	$0.0	$0.0
Data Processing Technical Deficiency (DTD)	0	$0.0	$0.0	$0.0	$0.0
Total	**75**	**$21.8**	**$0.0**	**$0.0**	**$0.0**
Note: Details do not always sum to the total due to rounding. Additionally, for error types with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Non-covered Service/Beneficiary Error (DP2)

Table T29. Specific Causes of CHIP Managed Care Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Financial system reflects incorrect beneficiary eligibility status	123	$86,910.1	$178.1	$137.2	$219.0
Total	**123**	**$86,910.1**	**$178.1**	**$137.2**	**$219.0**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Data Processing Improper Payments: Managed Care Payment Error (DP9)

Table T30. Specific Causes of CHIP Managed Care Payment Error (DP9)

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Incorrect rate cell used for DOS	38	$54,281.9	$7.0	$2.1	$11.8
Other	71	$0.7	$0.0	$0.0	$0.0
Total	**109**	**$54,282.6**	**$7.0**	**$2.2**	**$11.8**
Note: Details do not always sum to the total due to rounding. Additionally, for error causes with fewer than two claims per sample stratum, a confidence interval is not calculated.					

Section 5: Error Codes

Table C1. Medical Review Error Codes

Error Code	Error	Definition
MR1	No Documentation Error	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.
MR2	Document(s) Absent from Record	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. Additional documentation was not submitted.
MR3	Procedure Coding Error	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.
MR4	Diagnosis Coding Error	According to the medical record, the principal diagnosis code was incorrect or the DRG paid was incorrect and resulted in a payment error.
MR5	Unbundling Error	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 as individual services.
MR6	Number of Unit(s) Error	An incorrect number of units was billed.
MR7	Medically Unnecessary Service Error	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.
MR8	Policy Violation Error	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.
MR9	Improperly Completed Documentation	Required forms and documents are present, but are inadequately completed to verify that the services were provided in accordance with policy or regulation.
MR10	Administrative/Other Error	Medical review determined a payment error, but does not fit into one of the other medical review error categories.
MTD	Medical Technical Deficiency	Medical review determined a deficiency that did not result in a payment error. DOS billing errors are included as deficiencies when the DOS on the record is less than 7 days prior to or after the DOS on the claim.

Table C2. Data Processing Error Codes

Error Code	Error	Definition
DP1	Duplicate Claim Error	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.
DP2	Non-covered Service/Beneficiary Error	The state's policy indicates that the service billed on the sampled claim is not payable by the Medicaid program or CHIP and/or the financial system reflects incorrect beneficiary eligibility status for the coverage category for the service.
DP3	FFS Payment for a Managed Care Service Error	The beneficiary is enrolled in an MCO that includes the service on the sampled claim under capitated benefits, but the state inappropriately paid for the sampled service.
DP4	Third-Party Liability Error	Medicaid/CHIP paid the service on the sampled claim as the primary payer, but a third-party carrier should have paid for the service.
DP5	Pricing Error	The payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.
DP6	System Logic Edit Error	The system did not contain the edit that was necessary to properly administer state policy or the system edit was in place, but was not working correctly and the sampled line item/claim was paid inappropriately.
DP7	Data Entry Error	The sampled line item/claim was paid in error due to clerical errors in the data entry of the claim.
DP8	Managed Care Rate Cell Error	The beneficiary was enrolled in managed care on the sampled DOS and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell.
DP9	Managed Care Payment Error	The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.
DP10	Provider Information/Enrollment Error	The provider was not enrolled in Medicaid/CHIP according to federal regulations and state policy or required provider information was missing from the sampled claim.
DP11	Claim Filed Untimely Error	The sampled claim was not filed in accordance with the timely filing requirements defined by state policy.
DP12	Administrative/Other Error	A payment error was discovered during data processing review, but the error was not a DP1 – DP11 error.
DTD	Data Processing Technical Deficiency	A deficiency was found during data processing review that did not result in a payment error.

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2017 HHS AFR.