# Medicaid and CHIP 2014 Improper Payments Report

## I. EXECUTIVE SUMMARY

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

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

Medicaid and the Children's Health Insurance Program (CHIP) have been identified as programs at risk for significant erroneous payments.

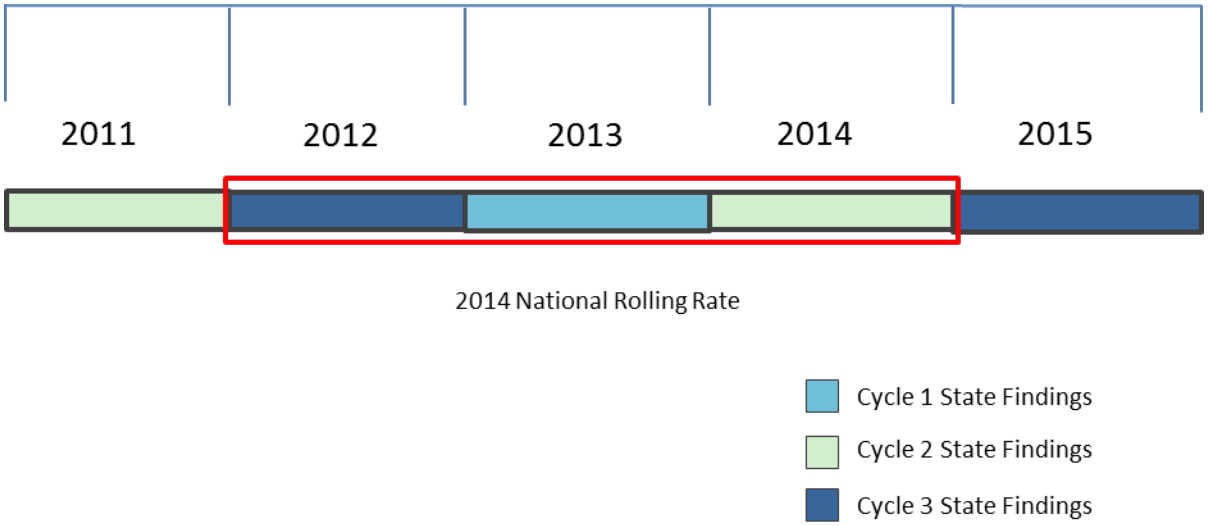
The Centers for Medicare & Medicaid Services (CMS) measures Medicaid and CHIP improper payments annually through the **Payment Error Rate Measurement (PERM)** program. The PERM program reviews three groups of payments, known as components:

1) Fee-for-service (FFS) claims;
2) Managed care capitation payments; and
3) The payments resulting from eligibility determinations.

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

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

**FIGURE 1. 2014 NATIONAL IMPROPER PAYMENT RATE COMBINES THE THREE MOST RECENT CYCLE MEASUREMENT FINDINGS**



## *MEDICAID – 6.7 PERCENT IMPROPER PAYMENT RATE*

Correct Payments + Improper Payments = Total Medicaid Payments[2]

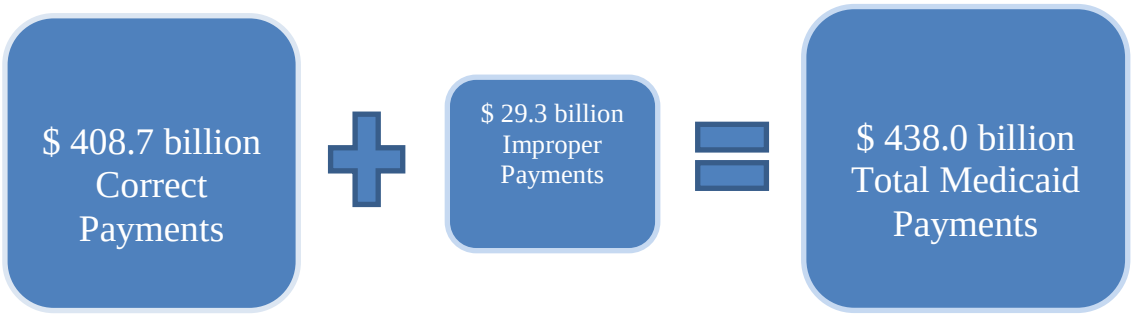



Table 1.1 summarizes the 2014 national Medicaid improper payment rate findings and projected improper payments by component.

**TABLE 1.1. 2014 NATIONAL MEDICAID IMPROPER PAYMENT RATES**

| Component | Improper Payment Rate | Total Projected Improper Payments ($billions) | Federal Share Projected Improper Payments ($billions) |
|---|---|---|---|
| **MEDICAID** | | | |
| FFS | 5.1% | $15.9 | $9.5 |
| Managed Care | 0.2% | $0.3 | $0.2 |
| Eligibility | 3.1% | $13.6 | $8.1 |
| **Overall**[3] | **6.7%** | **$29.3** | **$17.5** |

- **Medicaid FFS improper payments are primarily caused by one or more of the following issues:**
  - States' systems non-compliance with new provider information and enrollment requirements;
  - Insufficient provider documentation to support the claims; and
  - Processing systems where either logic edits were not in place to stop payments or edits in place were not working properly.
- **The majority of Medicaid errors and improper payments related to the eligibility component were due to states enrolling people that were not eligible for Medicaid.**

[2] Payments include both the State and Federal share.

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

## *CHIP – 6.5 PERCENT IMPROPER PAYMENT RATE*

Correct Payments + Improper Payments = Total CHIP Payments[4]

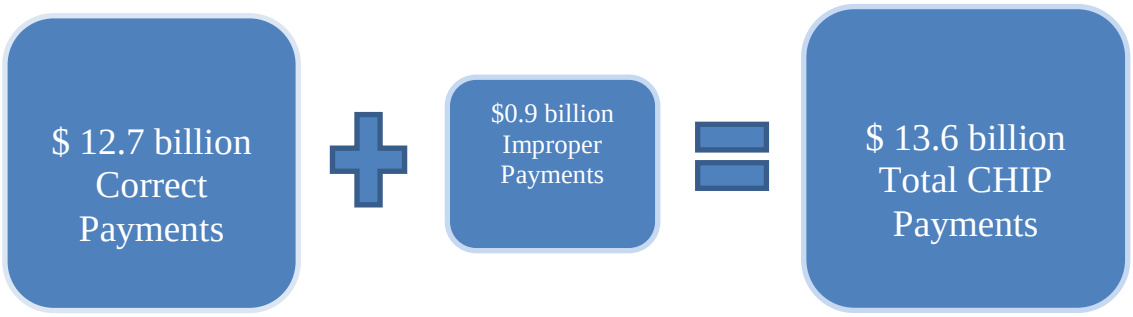



Table 1.2 summarizes the 2014 national CHIP improper payment rate findings and projected improper payments by component.

**TABLE 1.2. 2014 NATIONAL CHIP IMPROPER PAYMENT RATES**

| Component | Improper Payment Rate | Total Projected Improper Payments ($billions) | Federal Share Projected Improper Payments ($billions) |
|---|---|---|---|
| **CHIP** | | | |
| FFS | 6.2% | $0.3 | $0.2 |
| Managed Care | 0.2% | $0.0 | $0.0 |
| Eligibility | 4.2% | $0.6 | $0.4 |
| **Overall** | **6.5%** | **$0.9** | **$0.6** |

- **CHIP FFS improper payments are primarily caused by one or more of the following issues:**
  - States' systems non-compliance with new provider information and enrollment requirements;
  - Pharmacy providers failing to maintain records of patient counseling for medications and/or proof of delivery of medications required by states' policies; and
  - Insufficient or no provider documentation maintained to support the claims.
- **The majority of CHIP errors and improper payments related to the eligibility component were due to states enrolling people that were not eligible for CHIP.**

[4] Payments include both the State and Federal share.

## *Overall PERM Findings*

- **Overpayments constituted the overwhelming majority of improper payments:** Underpayments accounted for just 4.2% of all improper Medicaid payments and 1.6% of all improper CHIP payments.
- **Managed care was less prone to PERM errors:** The managed care component continued to be the smallest contributor to the overall improper payment rate. For PERM, managed care reviews only examine the capitation payments made by states to managed care organizations, not payments made by the plans to providers. Far fewer processing errors were identified for managed care payments than FFS payments.

The Medicaid improper payment rate increased from 5.8% in 2013 to 6.7% in 2014. The increase was due to state difficulties getting systems into compliance with new requirements. In particular, all referring or ordering providers providing services under a state plan or waiver must now be enrolled in Medicaid, states are required to screen providers under a risk-based screening process prior to enrollment, and the attending provider National Provider Identifier (NPI) must be included on all electronically filed institutional claims. While these requirements will strengthen the integrity of the program, they require systems changes that many states had not fully implemented during the period of measurement. The 2014 Medicaid improper payment rate would be 5.4% if these systems errors did not occur, meaning that improvement was made in all other aspects of review.

The 2014 CHIP improper payment rate reflects the first measurement of all 50 states and DC and is the first baseline improper payment rate for CHIP. The 2014 CHIP improper payment rate is lower than the 2013 rate of 7.1%. However, this does not necessarily represent a reduction in improper payments. Rather, CMS has incorporated the final cycle of states into the estimate. Once states have been measured for a second time beginning in 2015, we can attribute changes in the rolling rate to improvements or regressions from the last time a cycle of states was measured.

# Table of Contents

# Index of Tables

# II. PERM PROGRAM BACKGROUND

The Improper Payments Information Act (IPIA) of 2002[5] requires federal agencies to annually review programs that they administer in order to:

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

Medicaid and the Children's Health Insurance Program (CHIP) have been identified as programs at risk for significant erroneous payments.

The Centers for Medicare & Medicaid Services (CMS) measures Medicaid and CHIP improper payments annually through the **Payment Error Rate Measurement (PERM)** program.

## Overview of Medicaid Program and CHIP

The Social Security Act established the Medicaid program in 1965 and CHIP in 1997. Both programs provide health care coverage for low-income individuals and families. Under this federal authority, each state partners with the federal government to enact a Medicaid program and CHIP for its population. The federal government is the primary source of funding for these programs, and CMS is the federal agency responsible for interpreting and implementing the federal Medicaid and CHIP statutes and ensuring that federal funds are appropriately spent. Both programs, however, are administered at the state level with significant state financing, and states have a statutory obligation and fiscal interest in assuring program integrity.

While every state has operated both Medicaid and CHIP for many years, the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, more commonly known as the Affordable Care Act (ACA), significantly affected each program by adding new requirements, expanded eligibility, and additional federal funding. Along with implementing the provisions of the ACA over several years, states are planning and implementing major changes to their Medicaid programs and CHIP to comply with the new law and to improve accountability and quality of care.

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

## PERM Program Objectives

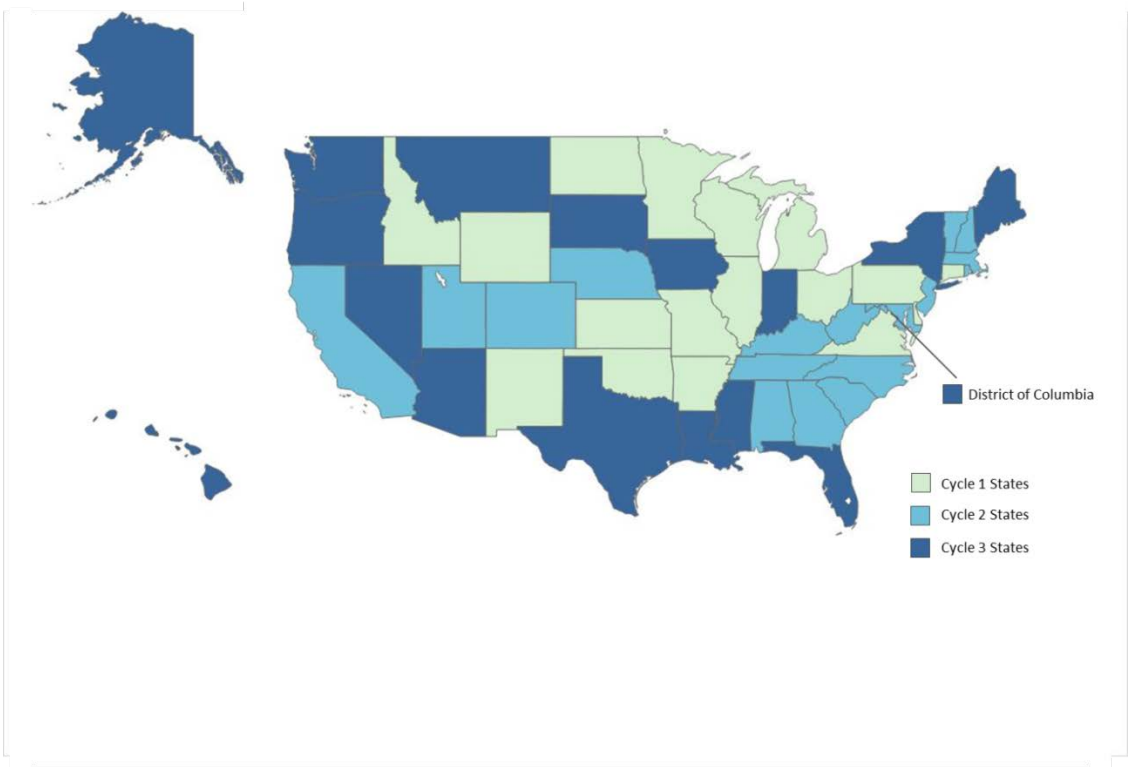
The PERM program is a joint effort between CMS and the states to calculate Medicaid and CHIP improper payment rates. To meet this objective, the PERM program uses a 17-state, three-year rotation cycle for measuring improper payments. This means that each fiscal year, CMS measures a third of the states and all states are reviewed once every three years. The states in each cycle are shown in Table 2.1 below as well as in Figure 2, which provides the state cycle information graphically.

**TABLE 2.1. STATES IN EACH CYCLE**

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

Note: States measured in the most recent cycle for the 2014 improper payment rate (i.e., cycle 2) are in **bold**.

**FIGURE 2. STATES IN EACH CYCLE**

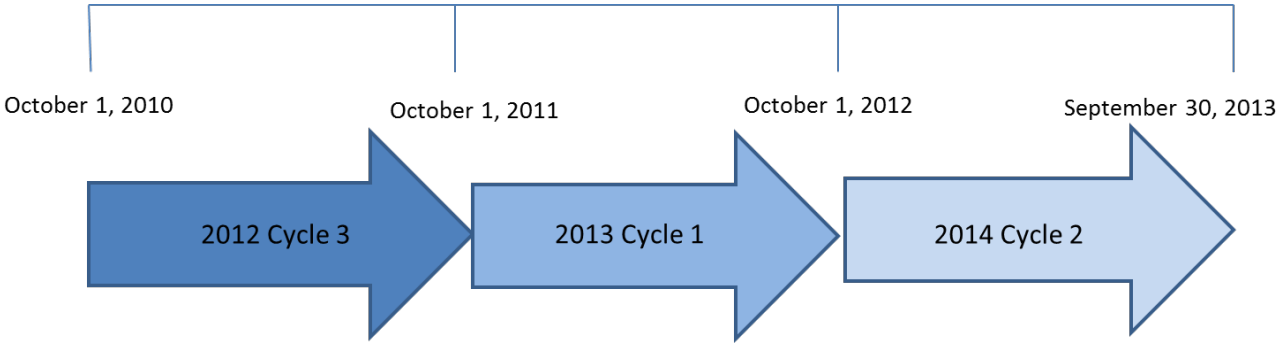


# III. PERM METHODOLOGY

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

It is important to note that, given the time necessary to complete reviews and calculate rates, the 2014 Medicaid and CHIP improper payment rates represent a review period (i.e., the time period from which the sampled claims were actually paid) spanning fiscal year (FY) 2011 through FY 2013. See Figure 3, below.

**FIGURE 3. PERIOD UNDER REVIEW FOR THE 2014 PERM MEDICAID AND CHIP NATIONAL IMPROPER PAYMENT RATES**




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

1. Fee for service (FFS) claims;
2. Managed care payments[6]; and
3. Eligibility determinations.

CMS uses federal contractors to review a random sample of FFS and managed care payments, while the states are responsible for conducting eligibility reviews on randomly sampled cases according to CMS' review guidelines. The section below describes each step of the calculation process and presents high-level review findings for the 2014 Medicaid and CHIP improper payment rates.

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

## Sample Selection

The first step in the PERM process is the selection of a random sample for each component. The federal statistical contractor (SC) takes random samples of FFS and managed care payment data that states submit on a quarterly basis.[7] For the eligibility reviews, states select monthly random samples of active and negative cases.

- ***Active cases*** contain information on a recipient who is enrolled in the Medicaid program or CHIP in the sample month.
- ***Negative cases*** contain information on a recipient who applied for benefits and was denied or whose program benefits were terminated in the sample month.

This sampling methodology follows the guidance and meets all requirements from the Office of Management and Budget (OMB). State-specific sample sizes are calculated for each program (Medicaid and CHIP) and component (FFS, managed care, and eligibility) based on the results from the state's previous PERM cycle using the state-specific improper payment rate and standard error.[8] The maximum sample size is set at 1,000 for each component in each state. Table 3.1 presents sample sizes from all 17 states in the most recent cycle years.

**TABLE 3.1. SAMPLE SIZES BY CYCLE AND CLAIM TYPE[9]**

| Claim Type | 2012 Cycle 3 | 2013 Cycle 1 | 2014 Cycle 2 |
|---|---|---|---|
| **MEDICAID** | | | |
| FFS | 6,562 | 6,696 | 6,119 |
| Managed Care | 2,917 | 3,214 | 3,390 |
| Eligibility Active | 7,834 | 8,286 | 9,794 |
| **Overall** | **17,313** | **18,196** | **19,303** |

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

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

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

| Claim Type | 2012 Cycle 3 | 2013 Cycle 1 | 2014 Cycle 2 |
|---|---|---|---|
| **CHIP** | | | |
| FFS | 7,599 | 7,993 | 7,779 |
| Managed Care | 3,391 | 3,906 | 2,869 |
| Eligibility Active | 8,469 | 8,621 | 8,268 |
| **Overall** | **19,459** | **20,520** | **18,916** |

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

# Data Processing Reviews

A federal contractor conducts data processing reviews on each sampled FFS claim and managed care payment. A **data processing error** is a payment error that results in an overpayment or underpayment and could be avoided through the state's Medicaid Management Information System (MMIS) or other payment system. Claims not processed through a state's MMIS are subject to validation through a paper audit trail, state summary or other proof of payment. Below, both FFS and managed care data processing reviews are discussed in more detail.

## ***FFS Data Processing Reviews***

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

- For the correct amount;
- For the correct and eligible recipient; and
- To the correct and eligible provider.

During the data processing FFS review, the following items are examined for each sampled claim by reviewing information in the states' systems or paper records:

- The aid category and eligibility of the recipient for the date of service to ensure the recipient had an approved eligibility span that covered the date of service of the payment under review;
- Whether the service should have been covered by a managed care plan;

- Whether any other type of insurance, including Medicare, should have paid for the service;
- Re-pricing each claim manually to verify the payment was for the correct amount;
- Checking for adjustments to the payment under review and making sure the payment is not a duplicate of a previously paid claim;
- Whether the billing, servicing, and referring/ordering providers were Medicaid/CHIP participants and had valid medical licenses (when required); and
- For providers newly enrolled after March 24, 2011, if risk-based screening was conducted.

## ***Managed Care Data Processing Reviews***

Capitation payments made to at-risk managed care health plans are also sampled for data processing reviews. Managed care payments are fully and partially capitated payments, which include:

- Premiums for "full risk" indemnity insurance, including payments to Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), and Health Insurance Organizations (HIOs);
- Premiums for partial risk insurance contracts, such as Pre-paid Inpatient Health Plans (PIHPs) and Pre-paid Ambulatory Health Plans (PAHPS);
- Payments to service-specific providers paid on a capitated/at-risk basis (e.g., pharmacy, mental health);
- Condition-specific managed care payments for special needs beneficiaries (e.g., at-risk payments for HIV/AIDS); and
- Certain non-capitated, recipient-specific payments made to managed care organizations such as delivery supplemental payments or "kick" payments which are paid at a negotiated rate.

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

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

Rate cells may be based on:

- Age;

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

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

## Medical Reviews

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

- Zero paid claims;
- Fixed payments;
- Medicare premium payments;
- Medicare crossover claims; and
- Denied claims, which do not receive a medical review[10].

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

[10] Fifty-six FFS claims sampled in the 2012 measurement and four FFS claims sampled in the 2013 measurement inadvertently did not get medical review. This issue affected 23 out of approximately 13,200 sampled Medicaid FFS claims and 37 out of approximately 15,800 sampled CHIP FFS claims from those two measurements. CMS elected to drop the claims from the Medicaid and CHIP samples. Dropping the affected claims did not bias the improper payment rates since the claims were randomly distributed across states and so few claims were affected. Calling the claims correctly paid would have understated the improper payment rate and determining them to be in error would have overstated the improper payment rate. Dropping the claims from the sample allowed the remaining sampled claims that were fully reviewed to estimate the correct improper payment rate. The HHS Office of the Inspector General (OIG) also presented the option of imputing a medical review improper payment rate on these claims which resulted in the same improper payment rate as dropping the claims. CMS has put steps in place to prevent these errors from occuring in future cycles. For 2014 measurement, all claims sampled that required medical review were appropriately reviewed.

documentation is received within 14 days of the first request, the claim is cited as an improper payment due to an "insufficient documentation error."

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

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

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

These reviews are conducted to ensure the following:

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

## Difference Resolution and Appeals Process

If the federal contractor identifies an error, the state is notified and given an opportunity to review the documentation associated with the payment. If the state does not agree with the contractor's conclusion, the state may dispute the error finding. The federal contractor performs an independent difference resolution review to consider the state's information and to make a final determination.
If the state does not agree with the federal contractor's findings after the independent difference resolution review, the state can then appeal to CMS.

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

# IV. FEE-FOR-SERVICE RESULTS

Fee for service reviews include: 1) payments by claims processing systems, and 2) documentation in the medical records to support claims as billed.

## Data Processing Reviews

### *MEDICAID*

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

**TABLE 4.1. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF FFS DATA PROCESSING ERRORS IN MEDICAID**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($Millions) | % of Projected Dollars in Error |
| **Medicaid** | | | | |
| Non-covered Service | 460 | 72.0% | $7,891.6 | 72.9% |
| Logic Edit | 22 | 3.4% | $1,968.5 | 18.2% |
| Data Entry Error | 2 | 0.3% | $339.7 | 3.1% |
| Pricing Error | 110 | 17.2% | $287.9 | 2.7% |
| Third-party Liability | 10 | 1.6% | $142.1 | 1.3% |
| FFS Claim for Managed Care Service | 15 | 2.3% | $134.7 | 1.2% |
| Admin/Other | 11 | 1.7% | $47.4 | 0.4% |
| Duplicate Item | 9 | 1.4% | $19.2 | 0.2% |
| MC Payment Error | 0 | 0.0% | $0.0 | 0.0% |
| Rate Cell Error | 0 | 0.0% | $0.0 | 0.0% |
| **Total** | **639** | **100.0%** | **$10,831.3** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

For Medicaid claims sampled, the most prevalent error types, representing 93.8% of the total Medicaid FFS data processing projected improper payments and 92.6% of the total Medicaid FFS data processing count of error, are:

- Non-covered Service;
- Logic Edit; and
- Pricing.

## *Non-Covered Service Errors*

PERM cites a Non-covered Service error when the recipient is not eligible for the service or the provider is not eligible to bill, provide, or order the service, or has not been enrolled using risk-based screening criteria if newly enrolled after March 24, 2011. The majority of non-covered service errors were provider related. Examples of the main reasons for non-covered service errors follow.

***Attending or rendering provider required but not listed on the institutional claim***

**Example**: A Medicaid provider submitted a claim for nursing facility room and board for the month of May 2013. The Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standard requires the submission of the attending provider's National Provider Identifier (NPI) on all electronically filed institutional claims other than non-scheduled transportation claims. This requirement was effective beginning July 1, 2012. The attending provider information was not submitted on the claim, but the claim was paid, resulting in an overpayment error.

***Referring/ordering provider required but not listed on the claim***

**Example**: A Medicaid provider submitted a claim for independent laboratory services. Laboratory services require a physician or other provider's authorization. Federal regulations (42 CFR § 455.440 National Provider Identifier) state that the state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The ordering provider NPI was not listed on the claim, which resulted in an overpayment error.

***Referring/ordering provider not enrolled***

**Example**: A Medicaid provider submitted a prescribed drug claim. A prescription must be written or electronically submitted for all pharmacy claims and the prescribing provider must be listed on the claim and enrolled with the Medicaid/CHIP agency. Federal regulations (42 CFR § 455.410) state that the state Medicaid agency must require all ordering or referring physicians, or other professionals providing services under the state plan or under a waiver of the plan, to be enrolled as participating providers. A search of the state MMIS revealed that the provider was not enrolled as of the date of service, resulting in an overpayment error.

***New provider not enrolled using risk-based screening criteria***

**Example:** A Medicaid provider submitted a claim for dental services. The dental provider on the claim had submitted an application for enrollment with the state on September 1, 2012. Federal regulations (42 CFR § 455.450 Screening Levels for Medicaid Providers) require a state Medicaid agency to screen all new applications for enrollment after March 24, 2011, based on a categorical

risk level of limited, moderate, or high. Dental providers should be screened at the limited risk level unless subject to an adjustment of risk level under 42 CFR § 455.450(e). This screening includes the checking of Federal databases including the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the Excluded Parties List System (EPLS)[11], and OIG's List of Excluded Individuals and Entities (LEIE) pursuant to 42 CFR § 455.436. The state checked for the current license, OIG Exclusion List, and NPI number of the provider, but did not check all of the federal databases as required such as the Death Master file and the EPLS. This claim is cited as an error because not all of the required data base checks were completed.

## *Logic Edit Errors*

Logic Edit errors occur either when a system edit was not in place, or was in place but not working correctly, and the line item/claim was incorrectly paid (for example, incompatibility between gender and procedure). Each state's payment system is programmed with state-specific rules and policies for paying claims. Errors can occur when these edits are either ineffective because they were not coded properly or the edits were turned off.

***System edit should have stopped payment***

**Example**: A Medicaid provider submitted a prescribed drug claim that was paid October 26, 2012. State guidelines require that National Drug Code (NDC) information is needed, including dosage and quantity, before claims can be paid. The NDC information was not submitted; therefore, a system edit should have stopped payment, which resulted in an overpayment error.

## *Pricing Errors*

A Pricing error can occur for several reasons, including:

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

[11] EPLS is now part of the General Services Administration's System for Award Management (SAM).

**Example:** A hospital claim was submitted for a pregnant woman who presented at the emergency room and was later admitted to the hospital and delivered. Federal regulation (42 CFR 447.53(b)(2)) does not allow charging a co-pay to pregnant women with Medicaid when a service related to the pregnancy is provided. And, per the regulations, co-pays are not to be deducted from this category of beneficiary. A $40.00 co-pay was incorrectly deducted from this hospital claim payment resulting in an underpayment of $40.00.

## ***CHIP***

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

**TABLE 4.2. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF FFS DATA PROCESSING ERRORS IN CHIP**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($Millions) | % of Projected Dollars in Error |
| **CHIP** | | | | |
| Non-covered Service | 554 | 56.0% | $131.1 | 76.6% |
| Admin/Other | 71 | 7.2% | $20.0 | 11.7% |
| Pricing Error | 237 | 23.9% | $7.7 | 4.5% |
| FFS Claim for Managed Care Service | 19 | 1.9% | $4.3 | 2.5% |
| Third-party Liability | 34 | 3.4% | $3.1 | 1.8% |
| Logic Edit | 24 | 2.4% | $2.9 | 1.7% |
| Duplicate Item | 14 | 1.4% | $1.0 | 0.6% |
| Data Entry Error | 37 | 3.7% | $1.0 | 0.6% |
| MC Payment Error | 0 | 0.0% | $0.0 | 0.0% |
| Rate Cell Error | 0 | 0.0% | $0.0 | 0.0% |
| **Total** | **990** | **100.0%** | **$171.2** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

For CHIP claims sampled, 92.8% of the total CHIP FFS data processing projected improper payments are for the following three error types:

- Non-covered Service;
- Admin/Other; and
- Pricing.

## *Non-Covered Service Errors*

PERM cites a Non-covered Service error when the recipient is not eligible for the service or the provider is not eligible to bill, provide, or order the service, or has not been enrolled using risk-based screening criteria if newly enrolled after March 24, 2011. The majority of non-covered service errors were provider related. Examples of non-covered service errors follow.

***Attending or rendering provider required but not listed on the institutional claim***

**Example**: A CHIP provider submitted a hospital claim electronically for a child covered under CHIP. The HIPAA transaction standard requires that the attending provider's NPI be cited on all electronically submitted institutional claims other than non-scheduled transportation claims beginning July 2012. The attending provider's NPI was not cited on the claim and the claim was paid without the required information, resulting in an overpayment error.

***Referring/ordering provider required but not listed on the claim***

**Example**: A CHIP provider submitted a claim for laboratory services for a child covered under CHIP. Laboratory services must be ordered by a physician or other provider allowed to authorize services. Federal regulations (42 CFR § 455.440 National Provider Identifier[12]) state that the state agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The ordering provider NPI was not listed on the claim, which resulted in an overpayment error.

***Referring/ordering provider not enrolled***

**Example**: A CHIP provider filed a prescribed drug claim for a child covered under CHIP. Federal regulations (42 CFR § 455.410(b)) provide that the state agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers. The pharmacy prescriber was identified on the claim but was not enrolled in the state's CHIP or Medicaid program on the date of service. The referring provider is not an enrolled provider on the date of service billed resulting in an overpayment error.

[12] Pursuant to 42 CFR 457.990, the provisions in Part 455, Subpart E apply equally to CHIP as they do to Medicaid.

***New provider not enrolled using ACA risk-based criteria***

**Example**: A CHIP provider submitted a claim for clinic services. The billing provider was enrolled in March 2012. Federal regulations (42 CFR § 455.410) require that a state Medicaid/CHIP agency must screen all new provider applications for enrollment after March 24, 2011 based on a categorical risk level of limited, moderate, or high. These regulations also specify that the state agency may rely on the results of the provider screening performed by Medicare. The required screening includes Federal database checks using the Social Security Administration's Death Master File, National Plan and Provider Enumeration System (NPPES), the Excluded Parties List System (EPLS)[13], and OIG's List of Excluded Individuals and Entities (LEIE), pursuant to 42 CFR § 455.436. The enrollment packet supplied by the state for the provider showed that not all of the required checks were completed at enrollment. The provider was also not listed in the Medicare provider enrollment system. The failure to conduct all required database checks resulted in an overpayment error.

## *Administrative/Other Errors*

The Administrative/Other type of error is used when the error does not accurately fit within the other error types.

***Claim filed untimely***

**Example**: A CHIP provider submitted a claim for waiver services. The claim had a date of service of November 20, 2009 and was filed on April 10, 2011. State policy requires all claims to be submitted within 180 days of the date of service. The claim was submitted 507 days after the date of service and a good cause reason for late filing was not documented by the state. The claim should have been denied, resulting in an overpayment error.

## *Pricing Errors*

A Pricing error can occur for several reasons, including:

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

***System calculation incorrect***

**Example**: A psychiatric hospital submits a claim for an inpatient stay of 26 days. Under certain circumstances, some hospitals are eligible for add-on payments to the calculated diagnosis-related

[13] EPLS is now part of the General Services Administration's System for Award Management (SAM).

group (DRG) amount. The add-on amount for this in-patient psychiatric claim was incorrectly calculated as $2,324.44 but should have been $360.02, resulting in an overpayment. The state reported this was due to incorrect programming logic in the claims processing system for the add-on calculation. After the state discovered this problem, they reviewed all claims processed using this faulty logic and made adjustments as warranted.

# Medical Reviews

## ***MEDICAID***

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

**TABLE 4.3. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF FFS MEDICAL REVIEW ERRORS IN MEDICAID**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| **Medicaid** | | | | |
| Insufficient Documentation | 197 | 41.4% | $2,322.0 | 41.4% |
| Policy Violation | 66 | 13.9% | $1,079.9 | 19.3% |
| No Documentation | 109 | 22.9% | $970.5 | 17.3% |
| Number of Unit(s) Error | 48 | 10.1% | $578.8 | 10.3% |
| Admin/Other | 22 | 4.6% | $389.5 | 6.9% |
| Diagnosis Coding Error | 20 | 4.2% | $199.7 | 3.6% |
| Procedure Coding Error | 9 | 1.9% | $61.7 | 1.1% |
| Medically Unnecessary | 4 | 0.8% | $5.2 | 0.1% |
| Unbundling | 1 | 0.2% | $1.4 | 0.0% |
| **Total** | **476** | **100.0%** | **$5,608.8** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

The top three error types, representing 78.0% of the total Medicaid FFS medical review projected improper payments are:

- Insufficient Documentation;
- Policy Violation; and
- No Documentation.

## *Insufficient Documentation Errors*

Insufficient Documentation means there is not enough documentation to support the service billed. Errors are cited when the provider does not supply enough documentation to determine the medical necessity of the claim, or the medical records do not document the tasks performed on the date of service (DOS) billed.

**Example**: A Medicaid provider submitted an inpatient psychiatric claim. To support the claim, the provider submitted a discharge summary, a psychological evaluation, and billing statement record. However, the provider did not submit documentation of daily presence to support 2 units of all inclusive room and board for the sampled dates of service. The documentation submitted was insufficient to support the claim and resulted in an overpayment.

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

**TABLE 4.4. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2014 MEDICAID IMPROPER PAYMENT RATE SAMPLE**

| Documentation Type | Total Count |
|---|---|
| Treatment Plan/Plan of Care | 40 |
| Physicians' Orders | 35 |
| Progress Notes | 29 |
| Flowsheets and Worksheets | 20 |
| Attendance Logs | 19 |
| Initial Intake Assessment/Reassessment | 16 |
| Encounter/Office Visit Notes | 13 |
| Procedure Record | 13 |
| Pharmacy Signature Log/Proof of Delivery | 13 |
| Laboratory/Diagnostic Tests and Reports | 12 |
| Start and Stop Times | 11 |
| Timesheets | 8 |
| Medication Administration Record | 7 |
| Recipient Signature/Proof of Service Receipt | 6 |
| Copy of Valid Prescription | 5 |
| Immunization Record | 4 |
| Physician Certification/Re-Certification | 4 |

| Documentation Type | Total Count |
|---|---|
| Dental Chart | 3 |
| Evaluation and Management/Counseling Notes | 2 |
| Case Management Care Plan | 1 |
| Psychiatric Certification for Admission | 1 |
| Psychological Testing | 1 |
| Note: Multiple documents could have been missing for the same medical record. | |

## *Policy Violation Errors*

Policy violation errors are cited when the medical documentation submitted does not comply with state policy documentation requirements. In other words, documentation was submitted but after review it was determined that records were not maintained in compliance with specific policies as required to qualify for reimbursement.

**Example**: A Medicaid provider submitted a prescribed drug claim for a prescription for amoxicillin powder for suspension. State policy required a copy of the original prescription that identifies the recipient, date of birth, name of drug and NDC code billed, refill history, documentation of acceptance or refusal of patient counseling, and signature of receipt of the prescribed medication. The provider sent a copy of the prescription and refill history, but did not submit proof of recipient/representative acceptance or refusal of patient counseling, as required by state policy. This claim resulted in an overpayment error.

## *No Documentation Errors*

No Documentation Errors are cited when either the provider or supplier fails to respond to repeated attempts to obtain the supporting documentation or the provider or supplier states that they do not have the requested records.

**Example**: A Medicaid provider submitted a claim for a laboratory test. The provider did not respond to repeated requests to supply an order for the test and the test result. This claim resulted in an overpayment error.

## ***CHIP***

Table 4.5 identifies the medical review errors found by error type and the associated projected dollars in error for CHIP FFS.

**TABLE 4.5. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF FFS MEDICAL REVIEW ERRORS IN CHIP**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($Millions) | % of Projected Dollars in Error |
| **CHIP** | | | | |
| Policy Violation | 164 | 23.3% | $65.6 | 41.2% |
| Insufficient Documentation | 232 | 32.9% | $40.6 | 25.5% |
| No Documentation | 163 | 23.1% | $31.2 | 19.6% |
| Admin/Other | 37 | 5.2% | $7.4 | 4.6% |
| Number of Unit(s) Error | 60 | 8.5% | $6.1 | 3.8% |
| Procedure Coding Error | 30 | 4.3% | $4.1 | 2.6% |
| Diagnosis Coding Error | 14 | 2.0% | $3.8 | 2.4% |
| Medically Unnecessary | 4 | 0.6% | $0.5 | 0.3% |
| Unbundling | 1 | 0.1% | $0.0 | 0.0% |
| **Total** | **705** | **100.0%** | **$159.3** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

The top three error types, representing 86.3% of all CHIP FFS medical review projected improper payments are as follows:

- Policy Violation;
- Insufficient Documentation; and
- No Documentation.

### *Policy Violation Errors*

Policy Violation Errors are cited when medical documentation submitted does not comply with state policy documentation requirements, such as when records were not maintained in compliance with specific policies as required to qualify for reimbursement.

**Example**: A CHIP provider submitted a prescribed drug claim for nystatin. State policy required a copy of the original prescription that identifies the recipient, date of birth, name of drug and NDC code billed, refill history, documentation of acceptance or refusal of patient counseling, and signature of receipt of the prescribed medication. The provider did not supply documentation to

support the representative/recipient's acceptance or refusal of counseling for the prescribed drug. Therefore, this claim resulted in an overpayment error.

### *Insufficient Documentation Errors*

Insufficient Documentation means there is not enough documentation to support the service billed. Errors are cited when the provider does not supply enough documentation to determine the medical necessity of the claim, or the medical records do not document the tasks performed on the date of service (DOS) billed.

**Example**: A CHIP provider submitted a claim for an in-office blood test. The provider submitted physician progress notes and the order for the test. However, in order to bill for the service, the result of the in-office blood test is necessary to confirm that the test was performed. After an additional documentation request was sent, the provider did not submit the requested test results for the sampled procedure. This claim was determined to be an overpayment error.

Table 4.6 identifies the types of documents that are most commonly missing when insufficient documentation errors are cited in CHIP.

**TABLE 4.6. COUNT OF MISSING DOCUMENTATION TYPES IN THE 2014 CHIP IMPROPER PAYMENT RATE SAMPLE**

| Documentation Type | Total Count |
|---|---|
| Treatment Plan/Plan of Care | 46 |
| Physicians' Orders | 39 |
| Progress Notes | 39 |
| Procedure Record | 20 |
| Flowsheets and Worksheets | 18 |
| Evaluation & Management/Counseling Notes | 14 |
| Laboratory/Diagnostic Tests and Reports | 13 |
| Start and Stop Times | 13 |
| Attendance Logs | 12 |
| Encounter/Office Visit Notes | 11 |
| Medication Administration Record | 11 |
| Pharmacy Signature Log/Proof of Delivery | 9 |
| Copy of Valid Prescription | 8 |
| Immunization Record | 8 |
| Recipient Signature/Proof of Service Receipt | 7 |

| Documentation Type | Total Count |
|---|---|
| Dental Chart | 6 |
| Initial Intake Assessment/Reassessment | 6 |
| Authorization for Transportation | 3 |
| Case Management Care Plan | 2 |
| Physician Certification/Re-Certification | 1 |
| Psychiatric Certification for Admission | 1 |
| Psychological Testing | 1 |
| Note: Multiple documents could have been missing for the same medical record. | |

### *No Documentation Errors*

No Documentation Errors are cited when either the provider or supplier fails to respond to repeated attempts to obtain the supporting documentation or the provider or supplier states that they do not have the requested records.

**Example**: A CHIP provider submitted a claim for Level 2 Adult Day Care. The state could not locate the provider to request medical records for review. This claim was determined to be an overpayment error.

## Service Type Analysis

An analysis by service type compares medical review and data processing errors by covered service categories, and may show services and providers at greater risk for error in each program.

### ***Medicaid***

Table 4.7 shows the FFS improper payment rate and projected improper payments broken down by service type for Medicaid. The table shows the top 10 service types in projected dollars in error and combines the remaining service types. It includes both data processing and medical review errors.

**TABLE 4.7. FFS IMPROPER PAYMENT RATE AND PROJECTED IMPROPER PAYMENTS BY SERVICE TYPE IN MEDICAID**

| Service Type | Number of Sample Payment Errors | | Projected Dollars in Error | | Improper Payment Rate |
|---|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error | |
| **Medicaid** | | | | | |
| Nursing Facility, Intermediate Care Facilities | 131 | 12.0% | $3,051.5 | 19.2% | 4.7% |
| Prescribed Drugs | 143 | 13.0% | $2,783.0 | 17.5% | 9.1% |
| Personal Support Services | 76 | 6.9% | $2,251.5 | 14.1% | 6.3% |
| Outpatient Hospital Services and Clinics | 63 | 5.7% | $1,370.9 | 8.6% | 10.4% |
| Psychiatric, Mental Health, and Behavioral Health Services | 62 | 5.7% | $1,184.9 | 7.4% | 6.9% |
| Inpatient and Outpatient Hospital | 140 | 12.8% | $812.9 | 5.1% | 2.0% |
| Denied Claims | 4 | 0.4% | $756.3 | 4.7% | N/A |
| Habilitation and Waiver Programs, School Services | 117 | 10.7% | $664.8 | 4.2% | 2.3% |
| Dental and Other Oral Surgery Services | 52 | 4.7% | $587.9 | 3.7% | 8.4% |
| ICF for the Mentally Retarded and Group Homes | 27 | 2.5% | $578.0 | 3.6% | 5.3% |
| All Other Service Types | 281 | 25.6% | $1,884.4 | 11.8% | 2.8% |
| **Total** | **1,096** | **100.0%** | **$15,926.1** | **100.0%** | **5.1%** |

Note: Details do not always sum to the total due to rounding. In addition, the improper payment rates by service type are calculated using the projected dollars in error within each service and the total paid amount in each service (not shown). The total improper payment rate should be the same as the FFS component improper payment rate.

Nine service types represented 84.5% of the total Medicaid FFS projected improper payments.

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

- Non-covered Service,
- Insufficient Documentation,
- No Documentation.

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

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

The predominant medical review errors for Nursing Facility, Chronic Care Services, and Intermediate Care Facilities were related to missing physician orders, lack of written progress notes, and unsigned orders. The general documentation requirements for these service types are:

certification, recertification, plans of care, physician orders, progress notes, and documentation to support daily presence for the dates billed.

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

## *Prescribed Drugs*

The primary medical review errors for Prescribed Drugs were related to lack of documentation of acceptance or refusal of patient counseling, and lack of documentation of patient receipt of their medications. Prescription documentation generally requires original prescriptions that identify the recipient, date of birth, name of drug, NDC code billed, refill history, documentation of acceptance or refusal of patient counseling, and signature of receipt of the prescribed medication.

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

## *Personal Support Services*

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

## *Clinics*

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

## *Psychiatric/Mental Health/Behavioral Health Services*

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

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

### *Inpatient/Outpatient Hospital*

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

### *Habilitation/Waiver Programs/School Services*

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

### *Dental/Other Oral Surgery Services*

Medical review errors were most often cited for Dental and Other Oral Surgery service due to the provider not responding to the request for documentation, insufficient documentation errors, and policy violations for signed orders and progress notes. Documentation requirements include dental progress notes, treatment plans, documentation of patient's age, dental condition, and treatment services rendered.

While data processing errors are often not related to a service category, it was noted that many states had enrolled a proportionately high percentage of new dental providers during this reporting period. Since some states had not fully implemented the risk-based screening requirements under federal regulations at time of enrollment, this resulted in a high number of errors for this service category.

## ***CHIP***

Table 4.8 shows the FFS improper payment rate and projected improper payments broken down by service type for CHIP. The table presents the top ten service types in terms of projected dollars in

error and combines the remaining service types. It includes both data processing and medical review errors.

**TABLE 4.8. FFS IMPROPER PAYMENT RATE AND PROJECTED IMPROPER PAYMENTS BY SERVICE TYPE IN CHIP**

| Service Type | Number of Sample Payment Errors | | Projected Dollars in Error | | Improper Payment Rate |
|---|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error | |
| **CHIP** | | | | | |
| Prescribed Drugs | 377 | 23.2% | $108.0 | 34.5% | 10.7% |
| Physicians and Other Licensed Practitioner Services | 154 | 9.5% | $40.6 | 13.0% | 7.3% |
| Psychiatric, Mental Health, and Behavioral Health Services | 214 | 13.2% | $37.2 | 11.9% | 5.9% |
| Dental and Other Oral Surgery Services | 127 | 7.8% | $35.3 | 11.3% | 4.3% |
| Outpatient Hospital Services and Clinics | 111 | 6.8% | $29.2 | 9.3% | 5.7% |
| Inpatient and Outpatient Hospital | 189 | 11.6% | $29.0 | 9.3% | 3.2% |
| Therapies, Hearing and Rehabilitation Services | 54 | 3.3% | $8.1 | 2.6% | 21.9% |
| Habilitation and Waiver Programs, School Services | 66 | 4.1% | $7.8 | 2.5% | 4.8% |
| Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices and Environmental Modifications | 30 | 1.8% | $3.6 | 1.1% | 12.0% |
| Personal Support Services | 44 | 2.7% | $3.2 | 1.0% | 4.1% |
| All Other Service Types | 261 | 16.0% | $11.1 | 3.5% | 4.1% |
| **Total** | **1,627** | **100.0%** | **$313.1** | **100.0%** | **6.2%** |
| Note: Details do not always sum to the total due to rounding. In addition, the improper payment rates by service type are calculated using the projected dollars in error within each service and the total paid amount in each service (not shown). The total improper payment rate should be the same as the FFS component improper payment rate. | | | | | |

Six service types represented 89.2% of the total CHIP FFS projected improper payments.

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

- Non-covered Service,
- Insufficient Documentation, and
- Policy Violation.

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

## *Prescribed Drugs*

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

This service category had a high number of data processing errors due to the requirement that the NPI and name of the prescribing provider be listed on claims submitted. In addition, the prescribing provider had to be enrolled with the CHIP or Medicaid agency.

## *Physicians/Other Licensed Practitioner Services*

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

## *Psychiatric, Mental Health, Behavioral Health Services*

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

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

## *Dental and Other Oral Surgery Services*

Medical review errors related to Dental and Other Oral Surgery Services were most often cited due to the provider not responding to the request for documentation, insufficient documentation errors (most commonly missing signatures), failure to name the provider who rendered the services, and policy violations, most commonly missing the unique patient identifier and date of birth.

Documentation requirements generally include dental progress notes, treatment plans, documentation of patient's age, dental condition, and treatment services rendered.

While data processing errors are often not related to a service category, many states had enrolled a proportionately high percentage of new dental providers during this reporting period. Since some states had not fully implemented the risk-based screening requirements under Federal regulations at time of enrollment, this resulted in a high number of errors for this service category.

## *Clinics*

The predominant medical review errors cited for claims by Clinics were insufficient documentation errors (mostly related to missing orders or results for billed tests), and no documentation errors due to the clinic not responding to the request for records. Documentation requirements generally include physician orders, progress notes, nursing notes, preventive and diagnostic test results, and immunization records.

## *Inpatient/Outpatient Hospital*

The primary medical review errors related to Inpatient and Outpatient Hospital Services were cited for insufficient documentation due to missing documentation of billed services and missing physician orders. Documentation requirements for this service type generally include physician orders, progress notes, surgical/anesthesia records, admission and discharge information, laboratory tests results, X-ray reports, medication administration records, etc.

While data processing errors are often not related to a service category, during this reporting period non-covered service errors represented most of the error types identified for Inpatient and Outpatient Hospital Services. The reasons for these errors were that the attending physicians' NPIs were not on the electronically filed institutional claims in accordance with the HIPAA transaction standards, risk based screening was either not completed or not documented for newly enrolled providers, and referring/ordering providers were either not on the claims or were not enrolled.

# V. MANAGED CARE

A managed care plan is paid a pre-determined, capitated amount for a specified time period (usually one month) for each enrolled recipient. The insurer is then responsible to pay for all covered medically necessary services for the enrollee. Because the amount of services that will be necessary in that time period are unknown, managed care plans are considered to be financially "at-risk."

Capitation payments made to managed care health plans that hold financial risk are also sampled for review in PERM. A number of elements are reviewed, including:

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

## MEDICAID

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

**TABLE 5.1. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF MANAGED CARE DATA PROCESSING ERRORS**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| **Medicaid** | | | | |
| Non-covered Service | 16 | 17.0% | $239.5 | 90.3% |
| Duplicate Item | 3 | 3.2% | $18.5 | 7.0% |
| MC Payment Error | 68 | 72.3% | $4.0 | 1.5% |
| Pricing Error | 6 | 6.4% | $3.1 | 1.2% |
| Rate Cell Error | 1 | 1.1% | $0.1 | 0.0% |
| Admin/Other | 0 | 0.0% | $0.0 | 0.0% |
| Data Entry Error | 0 | 0.0% | $0.0 | 0.0% |

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| FFS Claim for Managed Care Service | 0 | 0.0% | $0.0 | 0.0% |
| Logic Edit | 0 | 0.0% | $0.0 | 0.0% |
| Third-party Liability | 0 | 0.0% | $0.0 | 0.0% |
| **Total** | **94** | **100.0%** | **$265.2** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

The top error type, representing 90.3% of all Medicaid managed care projected improper payments is non-covered service. Additionally, managed care payment errors accounted for 72.3% of the total number of errors.

## ***Non-Covered Service Errors***

Managed care errors cited were mostly due to the recipient not being eligible for managed care. In some cases, the recipient was not eligible for managed care because the recipient no longer had active eligibility for Medicaid for the period under review, or had passed away prior to the capitation payment to the health plan.

**Example:** A managed care behavioral health capitation payment was made for April 2013. The Medicaid recipient had passed away in February 2013, two months before the payment was made. There is no evidence that the capitation payment was ever recovered, resulting in an overpayment error.

## ***Managed Care Payment Errors***

Managed Care Payment errors are identified when the wrong amount is paid for an eligible recipient who was enrolled in the managed care program or the recipient was eligible for Medicaid but not eligible to be enrolled in a managed care plan based on state policy regarding mandatory, voluntary or exclusions from enrollment for certain populations.

**Example:** A managed care payment was made for a Medicaid recipient who had coverage under another insurance policy. This state has a policy to exclude all beneficiaries from enrollment in managed care if the beneficiary has active third party liability for the month the payment covered. In this case, the other insurance was reported at the eligibility determination but was not considered when enrolling the recipient in the managed care program. The recipient was eligible for Medicaid but not eligible to be enrolled in a managed care plan based on state policy.

# CHIP

Table 5.2 shows the breakdown of data processing errors in managed care for CHIP. The reasons for overall frequency of the CHIP errors types were consistent with Medicaid managed care findings.

**TABLE 5.2. PERCENTAGE AND PROJECTED DOLLAR AMOUNT OF MANAGED CARE DATA PROCESSING ERRORS IN CHIP**

| Error Type | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| **CHIP** | | | | |
| Non-covered Service | 12 | 9.9% | $12.0 | 87.0% |
| Rate Cell Error | 3 | 2.5% | $1.6 | 11.4% |
| Pricing Error | 1 | 0.8% | $0.2 | 1.3% |
| MC Payment Error | 105 | 86.8% | $0.0 | 0.3% |
| Admin/Other | 0 | 0.0% | $0.0 | 0.0% |
| Data Entry Error | 0 | 0.0% | $0.0 | 0.0% |
| Duplicate Item | 0 | 0.0% | $0.0 | 0.0% |
| FFS Claim for Managed Care Service | 0 | 0.0% | $0.0 | 0.0% |
| Logic Edit | 0 | 0.0% | $0.0 | 0.0% |
| Third-party Liability | 0 | 0.0% | $0.0 | 0.0% |
| **Total** | **121** | **100.0%** | **$13.7** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

The top error type representing 87.0% of all CHIP managed care projected improper payments is Non-covered service. Rate cell errors accounted for the second most projected improper payments, however, only three errors were identified. Managed care payment errors accounted for 86.8% of the total number of errors.

## *Non-Covered Service Errors*

Managed care errors cited were mostly due to the recipient not being eligible for managed care. In some cases, the recipient was not eligible for managed care because the recipient no longer had active eligibility for CHIP for the period under review or had passed away prior to the capitation payment to the health plan.

**Example**: A dental health plan payment roster shows a capitation payment was made for a CHIP recipient for the month of November 2012 in the amount of $26.73. However, the eligibility system

screen prints show the eligibility span for the recipient was terminated on July 9, 2011, sixteen months prior to the coverage month paid. This resulted in an overpayment error.

## ***Managed Care Payment Errors***

Managed Care Payment errors are identified when the wrong amount is paid for an eligible recipient who was enrolled in the managed care program or the recipient was eligible for CHIP but not eligible to be enrolled in a managed care plan based on state policy regarding mandatory, voluntary or exclusions from enrollment for certain populations.

**Example:** The state paid a capitation rate of $5.41 on January 1, 2011 for the month of January. The rate was not approved by CMS and was paid under the state's assumption that the rate would receive CMS approval. However, CMS instead approved a rate of $5.24 on February 16, 2011 which the state implemented beginning with March 2011 payments. The approved rate on file at the time of the January payment was $6.78, which resulted in a $1.37 underpayment. The state did not go back and adjust the January 2011 payment until March 2012 which is not within the 60 day adjustment timeframe for PERM. This resulted in an underpayment.

# VI. ELIGIBILITY

While the federal contractor is conducting data processing and medical reviews, states are conducting eligibility reviews on each sampled case from the active and negative universes. The eligibility reviews verify that the caseworker made the appropriate decision on the case given the information available at the time the last action occurred. The appropriateness of the decision is based on the relevant state and federal eligibility policies.

2014 PERM improper payment rate findings reflect payments made through September 30, 2013, which occurred prior to the implementation of many of the Affordable Care Act required changes in Medicaid eligibility; therefore, these findings do not reflect eligibility determinations made under new Affordable Care Act requirements.

For each case sampled in the active case universe, states collect claims data for payments made on behalf of the recipient for services received in the sample month and paid in that month and in the four subsequent months. These payments constitute the universe of payments affected by the eligibility review of the sampled cases.

Please note that since states conduct the eligibility reviews, CMS has less detailed data on eligibility findings compared to FFS and managed care.

## MEDICAID

### *Active Cases*

PERM defines active eligibility cases as those cases containing information on a recipient who is enrolled in the Medicaid program in the month that eligibility is reviewed. Table 6.1 summarizes the number of sample payment errors and the associated projected dollars for active cases.

**TABLE 6.1. TOTAL NUMBER AND DOLLAR AMOUNTS OF ELIGIBILITY ERRORS FOR ACTIVE CASES IN MEDICAID**

| Review Finding | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| **Medicaid** | | | | |
| Not Eligible | 639 | 60.6% | $8,362.6 | 61.5% |
| Undetermined | 183 | 17.4% | $2,439.1 | 17.9% |
| Liability Understated | 138 | 13.1% | $1,969.8 | 14.5% |
| Liability Overstated | 45 | 4.3% | $403.8 | 3.0% |
| Eligible with Ineligible Services | 35 | 3.3% | $395.2 | 2.9% |

| Review Finding | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($millions) | % of Projected Dollars in Error |
| Managed Care Error, Ineligible for Managed Care | 5 | 0.5% | $22.6 | 0.2% |
| Managed Care Error, Eligible for Managed Care but Improperly Enrolled | 9 | 0.9% | $6.1 | 0.0% |
| **Total** | **1,054** | **100.0%** | **$13,599.3** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

In the 2013 measurement, CMS began collecting more detailed information on eligibility cases in order to further analyze the types of cases with payment errors and the reasons why those cases were found to be in error. Two critical elements were collected on each case: 1) eligibility category, or the basis by which an individual qualifies as a recipient, and 2) cause of error. Standardized values were available for selection for each element so that results could be analyzed and compared across states. This analysis is currently only available for the 34 Cycle 1 and Cycle 2 states measured in 2013 and 2014.

Three primary Medicaid eligibility categories each contributed over 36.0% of the total Medicaid eligibility projected improper payments for the 34 states:

- Aged, Blind & Disabled Categorically Needy;
- Nursing Home; and
- Families with Dependent Children (General).

The causes of error included the following:

- Agency Miscalculated Countable Assets, which was the reason for 25% of total Medicaid eligibility improper payments for the 34 states;
- Other Asset Related Error, which was the reason for 14% of total Medicaid eligibility improper payments; and
- Other State Procedure Error, which contributed 14% to the total Medicaid eligibility improper payments.

## ***Negative Cases***

PERM defines negative eligibility cases as those cases containing information on a recipient who applied for benefits and was denied or whose program benefits were terminated based on the state agency's eligibility determination. There are no claims data collected for negative cases, as there are

no claims or payments associated with a termination or denial of eligibility. Table 6.2 shows the number of negative cases found in error and the number found correct.

**TABLE 6.2. ELIGIBILITY REVIEW FINDINGS FOR NEGATIVE CASES IN MEDICAID**

| Negative Case Action | Number of Sample Cases in Error | Percentage of Sample Cases |
|---|---|---|
| **Medicaid** | | |
| Improper Termination | 651 | 5.4% |
| Improper Denial | 217 | 1.8% |
| Correct | 11,194 | 92.8% |
| **Total** | **12,062** | **100.0%** |
| Note: Due to rounding, the sum may not equal 100%. | | |

# CHIP

## *Active Cases*

PERM defines active eligibility cases as those cases containing information on a recipient who is enrolled in CHIP in the month that eligibility is reviewed. Table 6.3 summarizes the number of sample payment errors and the associated projected dollars for active cases.

**TABLE 6.3. TOTAL NUMBER AND DOLLAR AMOUNTS OF ELIGIBILITY ERRORS FOR ACTIVE CASES IN CHIP**

| Review Finding | Number of Sample Payment Errors | | Projected Dollars in Error | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | % of Total Number of Errors | Projected Dollars in Error ($Millions) | % of Projected Dollars in Error |
| **CHIP** | | | | |
| Not Eligible | 1,409 | 76.5% | $508.5 | 89.7% |
| Undetermined | 149 | 8.1% | $38.5 | 6.8% |
| Eligible with Ineligible Services | 12 | 0.7% | $7.4 | 1.3% |
| Liability Understated | 176 | 9.6% | $7.2 | 1.3% |
| Liability Overstated | 88 | 4.8% | $4.9 | 0.9% |
| Managed Care Error, Eligible for Managed Care but Improperly Enrolled | 6 | 0.3% | $0.3 | 0.1% |
| Managed Care Error, Ineligible for Managed Care | 1 | 0.1% | $0.0 | 0.0% |
| **Total** | **1,841** | **100.0%** | **$566.8** | **100.0%** |
| Note: Details do not always sum to the total due to rounding. | | | | |

Similar to Medicaid, in 2013 CMS began collecting eligibility category and cause of error information on CHIP eligibility cases (see the Medicaid section above for more information). This analysis is currently only available for the 34 Cycle 1 and Cycle 2 states measured in 2013 and 2014.

Unlike Medicaid, eligibility category is less relevant for CHIP. States have the option to use two different models for their Children's Health Insurance Program. The first is a Medicaid Expansion where CHIP is run using the same Medicaid benefits and operating structure. The second model is a stand-alone Children's Health Insurance Program where the state defines and operates the program independently from Medicaid. In the reviews of Children's Health Insurance Programs, improper payments were identified for cases from both Medicaid Expansion and stand-alone Children's Health Insurance Programs.

The primary causes of error for CHIP are below:

- Agency Miscalculated Countable Income represented 17% of total CHIP eligibility improper payments.
- CHIP Case not Properly Screened for Medicaid Eligibility represented 16% of the total CHIP eligibility improper payments.
- Client Ineligible Due to Third Party Liability also represented 14% of the total CHIP eligibility improper payments.

## ***Negative Cases***

PERM defines negative eligibility cases as those cases containing information on a recipient who applied for benefits and was denied or whose program benefits were terminated based on the state agency's eligibility determination. There are no claims data collected for negative cases, as there are no claims or payments associated with a termination or denial of eligibility. Table 6.4 shows the number of negative cases found in error and the number found correct.

**TABLE 6.4. ELIGIBILITY REVIEW FINDINGS FOR NEGATIVE CASES IN CHIP**

| Negative Case Action | Number of Sample Cases in Error | Percentage of Sample Cases |
|---|---|---|
| **CHIP** | | |
| Improper Termination | 257 | 2.5% |
| Improper Denial | 118 | 1.1% |
| Correct | 9,906 | 96.4% |
| **Total** | **10,281** | **100.0%** |
| Note: Due to rounding, the sum may not equal 100%. | | |

# VII. DETERMINING THE IMPROPER PAYMENT RATE

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

For each reporting year, CMS calculates a national improper payment rate and an improper payment rate for the 17 states that were under review:

1. **National improper payment rate** – The national improper payment rate is a rolling rate. This rate combines the findings from the three prior measurement cycles, using information from all 50 states and the District of Columbia, to produce the improper payment rate for the current fiscal year which is published in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings added in.
2. **Cycle-specific rate** – This rate combines the findings from the 17 states sampled in the most recent measurement cycle. The result may be used to compare cycle specific changes from when the states were last sampled.

National Medicaid and CHIP and component improper payment rates are weighted by state size, so that a state with a $10 billion program "counts" 10 times more toward the national rate than a state with a $1 billion program. The national program improper payment rates represent the combination of FFS, managed care, and eligibility[14] improper payment rates. A small correction factor ensures that eligibility improper payments do not get "double counted. [15]"

The PERM program considers both overpayments and underpayments to be improper payments. Table 7.1 summarizes the error findings and the projected over- and underpayments for the four types of reviews conducted: managed care data processing reviews, FFS data processing reviews, FFS medical reviews, and eligibility determinations.

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

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

**TABLE 7.1. SUMMARY OF PROJECTED OVERPAYMENTS AND UNDERPAYMENTS**

| Category | Overpayments | | Underpayments | |
|---|---|---|---|---|
| | Number of Sample Payment Errors | Projected Dollars in Errors ($Millions) | Number of Sample Payment Errors | Projected Dollars in Errors ($Millions) |
| **Medicaid** | | | | |
| FFS Medical Review | 468 | $5,565.8 | 8 | $43.1 |
| FFS Data Processing | 585 | $10,054.6 | 54 | $776.6 |
| Managed Care | 32 | $261.1 | 62 | $4.1 |
| Eligibility | 841 | $13,195.4 | 44 | $403.8 |
| **Total** | **1,926** | **$29,077.0** | **168** | **$1,227.6** |
| **CHIP** | | | | |
| FFS Medical Review | 697 | $158.2 | 8 | $1.1 |
| FFS Data Processing | 892 | $163.5 | 98 | $7.7 |
| Managed Care | 16 | $13.7 | 105 | $0.0 |
| Eligibility | 1,439 | $562.0 | 88 | $4.9 |
| **Total** | **3,044** | **$897.4** | **299** | **$13.7** |
| Note: Details do not always sum to the total due to rounding. | | | | |

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

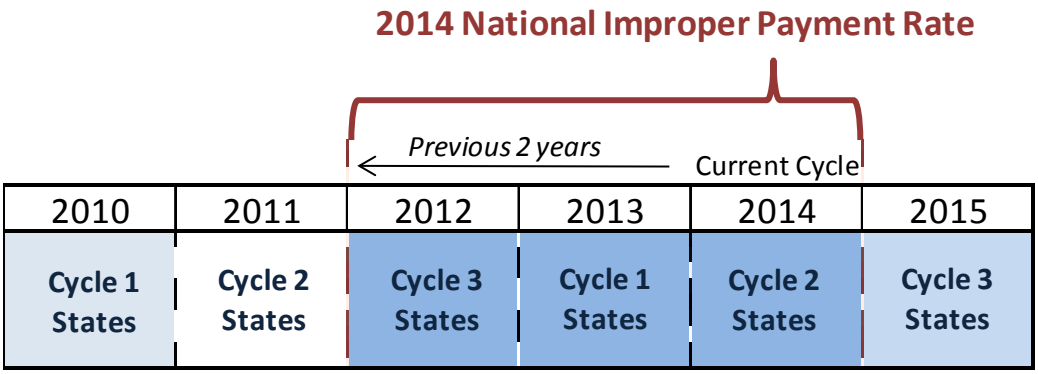
CMS attributes the variation in state-specific improper payment rates to multiple factors related to differences in how the states implement and administer their programs, as well as the enrolled population size. For example, states with proportionately larger managed care programs are likely to have lower overall improper payment rates. These states are processing more of the capitated monthly payments to plans, which are based on fewer variables than payments made to providers for specific services under FFS. Not only does this cause differences in improper payment rates among states in a cycle, but it could cause differences in improper payment rates between cycle measurements for the same state if in future years the state chooses to adopt managed care programs. The PERM findings should be considered in the context of these differences and operational realities.

## 2014 National Rolling Improper Payment Rate

The national rolling improper payment rate includes findings from the most recent three measurements to reflect findings for all 50 states and the District of Columbia. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are added. The national rolling improper payment rate is

then calculated across all states by component. Then, the FFS, managed care, and eligibility national rolling improper payment rates are combined to create an overall improper payment rate. Figure 4 below shows the measurements that are included in the national rolling improper payment rate.

**FIGURE 4. PERM NATIONAL ROLLING IMPROPER PAYMENT RATE**




The national rolling rate reflects any data changes that occurred after cycle cutoff dates for the two oldest measurements. Data changes could occur after the cycle cutoff date for a limited number of reasons including continued claim processing[16] or corrections to data to resolve previously undiscovered data inaccuracies. Due to the timing of improper payment rate reporting, the most recent cycle in the rolling improper payment rate does not include any changes made to the data based on continued processing, since they occur after the improper payment rate is reported.

Details on the 2014 Medicaid and CHIP official national rolling improper payment rates are provided in the following sections.

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

## *2014 National Medicaid Improper Payment Rate*

Table 7.2 below summarizes the 2014 rolling national Medicaid improper payment rate findings.

**TABLE 7.2. 2014 NATIONAL MEDICAID IMPROPER PAYMENT RATES SUMMARY**

| | 2014 Medicaid Rolling Improper Payment Rate |
|---|---|
| **Improper Payment Rate** | 6.7% |
| **Total Projected Improper Payments ($Billions)** | $29.3 |
| **Federal Share Projected Improper Payments ($Billions)** | $17.5 |

The **2014 national Medicaid rolling improper payment rate**, which is based on measurements that were conducted in 2012, 2013, and 2014, is **6.7%**. This represents an estimated $17.5 billion in improper federal expenditures and $29.3 billion in estimated improper payments for Medicaid as a whole (state and federal) annually. These projected dollars in error are based on the sum of the absolute value of the underpayments and overpayments identified through review of claims and eligibility decisions.

To better understand the drivers of the overall national improper payment rates, the improper payment rates for each component are calculated and reviewed. As can be seen in Table 7.3, FFS and eligibility were the major contributors to the Medicaid improper payment rates. Conversely, managed care payments account for a limited portion of all improper payments.

**TABLE 7.3. 2014 MEDICAID IMPROPER PAYMENT RATES BY COMPONENT**

| Component | 2014 Medicaid Rolling Improper Payment Rate |
|---|---|
| FFS | 5.1% |
| Managed Care | 0.2% |
| Eligibility | 3.1% |
| **National** | **6.7%** |
| *The national improper payment rates are comprised of a weighted average of FFS and managed care, the addition of eligibility, and the removal of a statistical overlap between the weighted average of FFS and managed care with the eligibility review processes. | |

The 2014 Medicaid improper payment rate is higher than the CMS target of 5.6%. Additionally, the rate increased from 5.8% in 2013, meaning that the improper payment rate for the 17 states measured in 2014 was higher than their 2011 improper payment rate. The increase in the national

rolling improper payment rate is due to the increase in data processing errors in the 2014 cycle. The increase was due to state difficulties getting systems into compliance with new requirements. In particular, all referring or ordering providers must now be enrolled in Medicaid, states are required to screen providers under a risk-based screening process prior to enrollment, and the attending provider NPI must be included on all electronically filed institutional claims. While these requirements will strengthen the integrity of the program, they require systems changes that many states had not fully implemented during the period of measurement.

The 2014 Medicaid national rolling improper payment rate would be 5.4% if these systems errors did not occur, meaning that improvement was made in all other aspects of review. As shown in Table 7.4, the increase in data processing error is statistically significant from 2013 to 2014, which means that the increase is not completely attributable to chance. Likewise, the decrease in medical review error is also significant. The overall FFS results, which combine data processing and medical review error, significantly increased from 2013 to 2014.

It is important to note that the difference between the 2013 national rolling improper payment rate and the 2014 national rolling improper payment rate is the replacement of the 2011 cycle 2 states' data with the more recently sampled 2014 cycle 2 states' data. Therefore, any changes in the rolling improper payment rate are attributable to the 2014 cycle states.

**TABLE 7.4. 2013 - 2014 MEDICAID FFS DATA PROCESSING AND MEDICAL REVIEW ROLLING IMPROPER PAYMENT RATES**

| | 2014 National Rolling | | | 2013 National Rolling | | |
|---|---|---|---|---|---|---|
| | Improper Payment Rate | Standard Error | 90% Confidence Interval | Improper Payment Rate | Standard Error | 90% Confidence Interval |
| **Medicaid** | | | | | | |
| FFS | 5.06% | 0.53% | 4.2% - 5.9% | 3.58% | 0.26% | 3.2% - 4.9% |
| FFS Data Processing | 3.44% | 0.50% | 2.6% - 4.3% | 1.14% | 0.20% | 0.8% - 1.5% |
| FFS Medical Review | 1.78% | 0.19% | 1.5% - 2.1% | 2.52% | 0.16% | 2.3% - 2.8% |

The 2014 national Medicaid improper payment rates meet the IPERA precision requirement of +/- 2.5 percentage points, suggesting that the results would be highly similar if the study were to be repeated.

Using the component specific improper payment rates, CMS calculates the projected improper payments and the dollars associated with the federal share, as shown in Table 7.5. To understand the reasonability of this estimate, the 90 percent confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90 percent of the time if the study were repeated many times.

**TABLE 7.5. 2014 MEDICAID IMPROPER PAYMENT RATE APPLIED TO TOTAL EXPENDITURES AND THE FEDERAL SHARE (DOLLARS IN BILLIONS)**

| Component | 2014 Expenditures ($Billions) | Projected Improper Payments ($Billions) | Lower 90% Confidence Limit ($Billions) | Upper 90% Confidence Limit ($Billions) |
|---|---|---|---|---|
| **Medicaid** | | | | |
| FFS Total | $314.5 | $15.9 | $13.2 | $18.6 |
| Federal Share | $187.4 | $9.5 | $7.9 | $11.1 |
| Managed Care Total | $123.5 | $0.3 | $0.1 | $0.4 |
| Federal Share | $74.2 | $0.2 | $0.1 | $0.3 |
| Eligibility Total | $438.0 | $13.6 | $10.1 | $17.1 |
| Federal Share | $261.6 | $8.1 | $6.1 | $10.2 |
| **National Total*** | **$438.0** | **$29.3** | **$25.0** | **$33.5** |
| **Federal Share*** | **$261.6** | **$17.5** | **$15.0** | **$20.0** |

*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.

## *2014 National CHIP Improper Payment Rate*

Table 7.6 below summarizes the 2014 rolling national CHIP improper payment rate findings.

**TABLE 7.6. 2014 NATIONAL CHIP IMPROPER PAYMENT RATES SUMMARY**

| | 2014 CHIP Rolling Improper Payment Rate |
|---|---|
| **Improper Payment Rate** | 6.5% |
| **Total Projected Improper Payments ($Billions)** | $0.9 |
| **Federal Share Projected Improper Payments ($Billions)** | $0.6 |

The **2014 national CHIP rolling improper payment rate**, which is based on measurements that were conducted in 2012, 2013, and 2014, is **6.5%**. This represents an estimated $0.6 billion in improper federal expenditures and $0.9 billion in estimated improper payments for CHIP as a whole (state and federal) annually.

To better understand the drivers of the overall national improper payment rates, the improper payment rates for each component are calculated and reviewed. As can be seen in Table 7.7, FFS

and eligibility were the major contributors to the CHIP improper payment rates. Conversely, managed care payments account for a limited portion of all improper payments.

**TABLE 7.7. 2014 CHIP IMPROPER PAYMENT RATES BY COMPONENT**

| Component | 2014 CHIP Rolling Improper Payment Rate |
|---|---|
| FFS | 6.2% |
| Managed Care | 0.2% |
| Eligibility | 4.2% |
| **National** | **6.5%** |
| *The national improper payment rates are comprised of a weighted average of FFS and managed care, the addition of eligibility, and the removal of a statistical overlap between the weighted average of FFS and managed care with the eligibility review processes. | |

The 2014 CHIP improper payment rate reflects the first measurement of all 50 states and DC and is the first baseline improper payment rate for CHIP. The 2014 CHIP improper payment rate is lower than the 2013 rate of 7.1%. However, this does not necessarily represent a reduction in improper payments. Rather, CMS has incorporated the final cycle of states into the estimate. Once states have been measured for a second time beginning in 2015, we can attribute changes in the rolling rate to improvements or regressions from the last time a cycle of states was measured.

The 2014 national CHIP improper payment rates meet the IPERA precision requirement of +/- 2.5 percentage points, suggesting that the results would be highly similar if the study were to be repeated.

Using the component specific improper payment rates, CMS calculates the projected improper payments and the dollars associated with the federal share, as shown in Table 7.8. To understand the reasonability of this estimate, the 90 percent confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90 percent of the time if the study were repeated many times.

**TABLE 7.8. 2014 CHIP IMPROPER PAYMENT RATE APPLIED TO TOTAL EXPENDITURES AND THE FEDERAL SHARE (DOLLARS IN BILLIONS)**

| Component | 2014 Expenditures ($billions) | Projected Improper Payments ($billions) | Lower 90% Confidence Limit ($billions) | Upper 90% Confidence Limit ($billions) |
|---|---|---|---|---|
| **CHIP** | | | | |
| FFS Total | $5.0 | $0.3 | $0.3 | $0.3 |
| Federal Share | $3.6 | $0.2 | $0.2 | $0.2 |
| Managed Care Total | $8.6 | $0.0 | $0.0 | $0.0 |
| Federal Share | $5.9 | $0.0 | $0.0 | $0.0 |
| Eligibility Total | $13.6 | $0.6 | $0.5 | $0.6 |
| Federal Share | $9.5 | $0.4 | $0.3 | $0.4 |
| **National Total*** | **$13.6** | **$0.9** | **$0.8** | **$1.0** |
| **Federal Share*** | **$9.5** | **$0.6** | **$0.6** | **$0.7** |

*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.

## 2014 Cycle-Specific Improper Payment Rate

A cycle rate is an improper payment rate based on the 17 states measured in a cycle. The cycle improper payment rate does not reflect findings from the entire nation as the rolling rate does, but provides a snapshot of the results specific to the states participating in a given cycle. Table 7.9 lists the cycle rates from the three most recent PERM cycles which are the measurements included in the 2014 rolling rate.

**TABLE 7.9. 2012 – 2014 MEDICAID AND CHIP IMPROPER PAYMENT CYCLE RATES[17]**

| | 2012 Cycle 3 | 2013 Cycle 1 | 2014 Cycle 2 |
|---|---|---|---|
| **MEDICAID** | | | |
| **Improper Payment Rate** | 6.2% | 5.7% | 8.2% |
| **CHIP** | | | |
| **Improper Payment Rate** | 8.2% | 7.3% | 4.8% |

As seen in Table 6.8, the 2014 Medicaid Cycle 2 improper payment rate is 8.2%. The 2014 CHIP Cycle 2 improper payment rate is 4.8%. The Cycle 2 states reviewed in 2014 were the same states

[17] Cycle 3 and Cycle 1 rates include state-level improper payment rate recalculations.

reviewed in 2011 and in 2008. The 2014 Medicaid Cycle 2 improper payment rate increased from the 2011 Cycle 2 improper payment rate of 6.0% for these states. This suggests that, as a whole, this cycle of states was not able to reduce its overall improper payments since the last PERM measurement. The increase in the Cycle 2 improper payment rate caused the rolling improper payment rate to increase from 5.8% in 2013 to 6.7% in 2014.

Table 7.10 shows the Medicaid cycle 2 rates by component in 2008 and 2011 compared to the current cycle rates in 2014.

**TABLE 7.10. 2008 - 2014 MEDICAID CYCLE RATES BY COMPONENT[18]**

| Component | 2008 Cycle 2 Improper Payment Rate | 2011 Cycle 2 Improper Payment Rate | 2014 Cycle 2 Improper Payment Rate |
|---|---|---|---|
| FFS | 8.4% | 3.9% | 8.8% |
| Managed Care | 2.9% | 0.5% | 0.1% |
| Eligibility | 2.4% | 2.9% | 2.3% |
| **Cycle** | **9.8%** | **6.0%** | **8.2%** |

Table 7.11 shows the CHIP cycle 2 rates by component in 2014 since there were no CHIP rates for this cycle of states prior to 2011[19].

**TABLE 7.11. 2014 CHIP CYCLE RATES BY COMPONENT**

| Component | 2014 Cycle 2 Improper Payment Rate |
|---|---|
| FFS | 6.2% |
| Managed Care | 0.0% |
| Eligibility | 2.6% |
| **Cycle** | **4.8%** |

In addition to the national improper payment rates, each state receives the overall improper payment rate and the rates for each component that are specific to the state for the cycle. The state-specific rate provides the state's performance in comparison to the national rate and its performance in comparison to previous PERM cycles.

[18] Both 2008 and 2011 rates include state-level improper payment rate recalculations. The 17 state cycle rates were previously not reported.

[19] CHIP was measured for Cycle 2 states in 2008. However, the the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states that participated in the 2008 PERM CHIP measurement the option of accepting the improper payment rate from that cycle or not accepting that rate and treating the next cycle (2014) as the first fiscal year for which the PERM requirements applied to the state for CHIP. The vast majority of states elected to reject their 2008 CHIP improper payment rate and, therefore, there are no Cycle 2 CHIP improper payment rates prior to 2014.

## ***Reconciling Improper Payments Identified by the PERM Program***

The last step in the PERM process is correcting the improper payments identified through recovery of overpayments and corrective action implementation. Recoveries of overpayments are governed by longstanding statutory and regulatory requirements, for Medicaid under Section 1903(d)(2) of the Social Security Act, 42 CFR Part 433 Subpart F and for CHIP under section 2105(c)(6)(B) and 2105(e) of the Social Security Act, 42 CFR Part 457 Subpart B and F. CMS expects to recover the federal share of Medicaid and CHIP overpayments identified in the FFS and managed care samples from the states on a claim-by-claim basis.

# VIII. REDUCING IMPROPER PAYMENTS

Reducing improper payments is a high priority for CMS, and states are critical partners in the corrective action phase of the PERM cycle. States' systems, claims payment methodologies, eligibility determination processes, provider billing errors, and provider compliance with record requests all contribute to the national improper payment rates in various ways. PERM identifies and classifies different types of errors, but states must conduct root cause analyses to identify why the errors occur to then implement effective corrective actions. CMS is also working on multiple fronts to reduce improper payments in an effort to meet improper payment rate targets, as shown in Table 8.1. CMS continuously reviews the causes of errors and implements national and state-focused activities to decrease Medicaid and CHIP improper payments.

**TABLE 8.1. IMPROPER PAYMENT RATE TARGETS**

| | 2015 | 2016 | 2017 |
|---|---|---|---|
| **MEDICAID** | | | |
| **Improper Payment Rate** | 6.7% | 6.4% | 6.2% |
| **CHIP** | | | |
| **Improper Payment Rate** | 6.5% | 6.4% | 6.2% |

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

## PERM Corrective Action Plan Process

Through the improper payment rate measurement, CMS identifies and classifies types of errors and shares this information with each state. States then analyze the findings to determine the root causes for improper payments to identify why the errors occur, which is a necessary precursor to developing and implementing effective corrective actions. CMS works closely with states following each measurement cycle to develop state-specific **corrective action plans (CAPs)**. States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs.

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

- Data analysis – analyses of the findings to identify the reasons for errors and where errors are occurring with respect to the FFS, managed care, and eligibility components;
- Program analysis – analyses of the findings to determine the root causes of errors in program operations that are conducive to long-lasting system enhancements and improvements from a payment error perspective;
- Corrective action planning – steps taken to determine cost-effective actions that can be implemented for achieving long-lasting error reduction in concert with national and state policy targets and goals;
- Implementation and monitoring – plans to operationalize the corrective actions, including milestones and timeframes for achieving quantitative improper payment rate reductions, and monitoring to determine whether the implemented CAP is in the process of yielding intended results and meeting identified goals for reducing errors; and
- Evaluation – assessment of whether the corrective actions are in place and are effective at reducing or eliminating the targeted root causes of the errors, including rapid cycle feedback or other relevant time-cycle components. In addition to current corrective action evaluations, states must submit updates on previous corrective action plans from the prior PERM cycle and evaluate effectiveness of previous corrective actions.

## State Corrective Actions

Note that for Medicaid, the 17 states reviewed in 2014 were the same set of 17 states reviewed in 2011 (Cycle 2 states). The improper payment rate for these states increased from 6.0% in 2011 to 8.2% in 2014, causing the 2014 Medicaid rolling improper payment rate to increase from 5.8% to 6.7%. The Cycle 2 states submitted CAPs following their 2011 PERM measurement and can evaluate effectiveness based on their 2014 results.

Although the overall error rate increased due to an increase in systems errors, the Cycle 2 states improved in the medical review and eligibility review aspects of PERM. The Cycle 2 states that experienced the biggest decrease in their eligibility improper payment rate implemented corrective actions such as:

- Implementing an automated case review system that has a web-based data collection, analysis and reporting environment which can be modified to target error prone elements;
- Utilizing an online payroll information system that will search for employer information without having direct caseworker involvement thereby reducing the amount of undetermined cases;
- Created a new Quality Improvement process that will sample eligibility cases that were more error prone during the previous measurement which will allow the state to identify problem cases and resolve issues more effectively;
- Providing educational sessions that will focus on the cause of errors identified through random sampling of eligibility cases.

The cycle 2 states will submit CAPs based on the 2014 PERM reviews in February 2015 and will be reviewed again in 2017.

## ***Medical Review Corrective Actions***

Nationally, states focus their efforts where CMS and the state can identify clear patterns. Because a substantial portion of FFS improper payments was due to missing or insufficient documentation, the majority of states focused on provider education and communication methods to improve responsiveness and timeliness of submission of requested documentation. States that have found that particular provider types repeatedly fail to comply with documentation requirements may find that a targeted corrective action for these providers is cost-effective and likely to reduce future improper payments.

Implemented education and communication methods include:

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

CMS assisted states in their efforts by providing advanced information of the impending impact of documentation errors on their improper payment rates. CMS believes these methods proved successful as documentation errors declined with each wave of active intervention.

## ***Data Processing Corrective Actions***

States often made system updates as data processing errors were identified during a PERM cycle to immediately address issues. To address the recent increase in systems issues state are using the following strategies:

- Implementing systems edits to enforce new requirements and to enforce additional field requirements for claim submission within the MMIS systems;

- Migrating to a new, more sophisticated MMIS system that is anticipated to prevent these types of errors in the future; and

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

States are updating and upgrading systems to be in compliance with new requirements.

### ***Eligibility Corrective Actions***

The eligibility component continues to contribute to the Medicaid and CHIP national improper payment rates. CMS is working with states to take action to address these vulnerabilities.

To reduce these errors, states have implemented strategies including:

- Improving leveraging technology and available databases to obtain eligibility verification information without client contact;
- Providing additional caseworker training, particularly in areas determined through PERM review to be error-prone (e.g., earned income, duplicate benefits);
- Offering caseworkers additional eligibility policy resources through a consolidated manual and web-based training; and
- Utilizing administrative renewals in an effort to streamline processes and obtain valid documentation without contacting the recipient.

Moreover, the investments being made by the federal government and states to streamline, standardize, and simplify eligibility processes, and to modernize technology solutions (including real-time verifications) in support of those activities, have the potential to greatly reduce enrollment errors in Medicaid and CHIP.

## CMS Program Improvements

### ***Provider Outreach***

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

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

Many of these corrective actions were developed and will continue to be developed through the PERM provider education workgroup. Through this workgroup, CMS works with state representatives to develop collaborative education and outreach plans targeted at Medicaid and CHIP providers, especially those providers that did not meet documentation requirements in previous PERM cycles.

## ***State Outreach***

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

- CMS conducts "mini-PERM audits" with states. Mini-PERMs are voluntary state-specific improper payment reviews, intended to assist states in identifying and eliminating improper payments during fiscal years that states are not measured under PERM. These reviews assist states in developing targeted CAPs to decrease Medicaid and CHIP improper payments.
- CMS created a quarterly PERM Newsletter that provides important PERM related activities to state PERM contacts.
- CMS worked with the National Association of Medicaid Directors (NAMD) to establish an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. That workgroup has met regularly and has made substantial progress in expanding state access to Medicare and CMS data for program integrity purposes.
- CMS redesigned the comprehensive state program integrity reviews and conducted focused program integrity reviews in select states that included an assessment of state compliance with the new provider enrollment and screening requirements.
- CMS created a process to allow states to share information on terminated providers and to view information on Medicare providers and suppliers with revoked billing privileges.
- CMS issued state-specific improper payment rate targets. State-level goals for reducing improper payments provide a foundation for meeting national improper payment targets. Collaboration between CMS and the states is vital to achieve national and state-specific targets.
- CMS issued updated CAP development guidance for states and improved protocols for CMS' review of state CAPs. These improvements ensure that state CAPs fully address errors and reduce improper payments.
- CMS continuously to follows up with states on the status of implemented corrective actions.
- CMS continues to offer training, technical assistance, and support to state Medicaid program officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and

2014, the MII provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through over 5,100 enrollments in 114 courses and 8 workgroups at no cost to the states.

- CMS continues the state systems workgroup to address individual state systems problems that may cause payment errors and/or make it difficult for states to submit accurate claims data for PERM review.
- CMS conducts webinars with each state after CAP submissions have been made for each cycle. Post-CAP meetings are held to recap the previous cycle, discuss improper payment trends, share strategies for future success, and discuss the state's submitted CAP.
- CMS convenes quarterly national CAP best practice calls to facilitate idea sharing and lessons learned among the states. States present their corrective action success stories in decreasing improper payments so other states can implement similar initiatives.

## ***Regulations***

CMS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" on September 16, 2011, implementing the Affordable Care Act requirement for states to establish Medicaid Recovery Audit Contractors (RAC) programs.[20] Medicaid RACs will review Medicaid provider claims to identify and recover overpayments and identify underpayments made for services provided under Medicaid State Plans and Medicaid waivers. CMS believes these regulations will contribute to decreasing improper payments. As of September 30, 2014, 47 States and the District of Columbia have implemented Medicaid Recovery Auditing Contractor (RAC) programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs.

Section 6401 of the Affordable Care Act added new Section 1866(j)(7) to the Social Security Act, which provides CMS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, CMS launched the first temporary (six month) enrollment moratorium under the Affordable Care Act for Miami-area and Chicago-area home health agencies (HHAs) and ground ambulance suppliers in the Houston-area. On January 30, 2014, CMS extended the original moratoria for these locations and expanded the enrollment moratoria to include HHAs in the Ft. Lauderdale; Detroit; and Dallas areas. CMS also expanded the moratoria for ground ambulance suppliers into the Philadelphia-area. All of these moratoria actions were extended an additional six months with the latest notice effective July 30, 2014. The focus of these efforts is to prevent and deter fraud, waste, and abuse in problematic services and areas across the country while ensuring beneficiary access to care.

[20] 76 Fed. Reg. 57807 (Sept. 16, 2011).

## ***Systems Enhancements***

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

CMS is also developing the Transformed Medicaid Statistical Information System (T-MSIS). States will move to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format in 2015. T-MSIS will facilitate state submission of timely claims data to CMS, expand the MSIS data set, and allow CMS to review the completeness and quality of state MSIS submittals in real-time. CMS will use this data for the Medicaid improper payment measurement and to satisfy other CMS requirements. Through the use of T-MSIS, CMS will not only acquire higher quality data, but will also reduce state data requests.

CMS also continues the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and reduce improper coding which may result in improper payments of Medicaid claims.

### ***Agency-wide Collaboration Corrective Action - Program Integrity Board***

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

Underneath the Board, a PI Workgroup will consider payment trends, vulnerabilities and strategic issues to make recommendations for new corrective actions for the PI Board's consideration. The PI Workgroup will also implement the decisions and priorities articulated from the Board across the agency. The PI Workgroup will establish multiple Integrated Project Teams to focus on one particular vulnerability area and research and develop possible solutions. The Integrated Project Teams focus on operational aspects of program integrity vulnerabilities.

The PI Workgroup and Integrated Project Teams will utilize data provided by an Improper Payments Corrective Action Team to target drivers and root causes of improper payments. The Improper Payments Corrective Action Team analyses and communicates data gathered from improper payment measurements such as the PERM program.

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

## ***PERM Process Improvements***

CMS has also implemented a number of PERM process improvements in order to minimize state burden, increase data universe accuracy, and support CMS/state cooperation in an effort to reduce improper payments.

- CMS continues to offer PERM+ as an optional method for states to submit claims data. It makes claims data submission easier for states and condenses the PERM audit timeline. As implemented, this approach positions CMS to integrate PERM data collection with other emerging CMS program integrity initiatives, thus easing the administrative burden.
- CMS continues to utilize an aggregate payment framework that allows aggregate payments to be submitted and sampled for PERM where appropriate. Prior to the aggregate payment methodology implementation, the PERM sampling and review methodology required states to submit individual service-level claims to support a PERM improper payment rate calculation based on reviews of sampled individual service-level FFS and managed care payments made in the federal fiscal year under review. Many states struggled to provide such documentation since they do not make or store all payments at the recipient level, and instead make some aggregate payments.
- The Affordable Care Act created significant changes to Medicaid and CHIP eligibility applicable to all states. The interaction of the Marketplaces, Medicaid, and CHIP, and the cross-program interdependencies and coordination built to create an efficient system of coverage, will need special consideration in the planning of future program measurements and accountability. Accordingly, the current methodologies applied to measurement of eligibility accuracy under PERM need to be updated to reflect the changes states are making in their eligibility processes and systems and incorporate new regulations concerning the changes. Therefore, HHS is implementing an interim methodology to conduct PERM eligibility reviews for determinations made in FY 2014 to FY 2016, which will be reported on in 2015 to 2017. During this three-year period, all states will participate in Medicaid and CHIP Eligibility Review Pilots to provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots will use targeted measurements to:
    - Provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility;
    - Identify strengths and weaknesses in operations and systems leading to errors; and
    - Test the effectiveness of corrections and improvements in reducing or eliminating those errors.

# APPENDIX A: ERROR CODE DEFINITIONS

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

- **Duplicate item** - An exact duplicate of the sampling unit was paid.
- **Non-covered service** - State policies indicate that the service is not payable by Medicaid under the State Plan or for the coverage category under which the person is eligible.
- **FFS claim for a managed care service** - The recipient is enrolled in a managed care plan and the managed care plan should have covered the service rather than paid under FFS.
- **Third-party liability** - A third-party insurer is liable for all or part of the payment.
- **Pricing error** - Payment for the service does not correspond with the pricing schedule for that service.
- **Logic edit** - A system edit was not in place based on policy or a system edit was in place but was not working correctly and the sampling unit was paid (e.g., incompatibility between gender and procedure, or ineligible recipient or provider).
- **Data entry error** - Clerical error in the data entry of the sampling unit.
- **Rate cell error** - The recipient was enrolled in managed care and payment was made, but for the wrong rate cell.
- **Managed care payment error** - The recipient was enrolled in managed care, but was assigned the wrong payment amount.
- **Administrative/other** - A payment error was discovered during a data processing review but the error did not fall into one of the above error categories. The specific nature of the error is recorded.

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

- **No documentation** - The provider did not respond to the request for records.
- **Insufficient documentation** - There is not enough documentation to support the service.

- **Procedure coding error** - The provider performed a procedure but billed using an incorrect procedure code.

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

- **Unbundling** - The provider billed for the separate components of a procedure code when only one inclusive procedure code should have been billed.

- **Number of unit(s) error** - The provider billed for an incorrect number of units for a particular service provided.

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

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

- **Administrative/other** - A payment error was discovered during a medical review but did not fit into one of the above error categories. The specific nature of the error is recorded.

Upon reviewing a case to verify eligibility, states report their eligibility and payment findings to CMS. **ACTIVE CASES** can be found to have the following results:

- **Eligible** - An individual recipient meets the state's categorical and financial criteria for receipt of benefits under the program.

- **Eligible with ineligible services** - An individual recipient meets the state's categorical and financial criteria for receipt of benefits under the Medicaid program but received services that were not covered under his/her benefit package.

- **Not eligible** - An individual recipient is receiving benefits under the program but does not meet the state's categorical and financial criteria for the month eligibility is being verified.

- **Undetermined** - A recipient case subject to a Medicaid eligibility determination under PERM about which a definitive determination could not be made.

- **Liability overstated** - The recipient paid too much toward his/her liability amount or cost of institutional care and the state paid too little.

- **Liability understated** - The recipient paid too little towards his/her liability amount or cost of institutional care and the state paid too much.

- **Managed care error, ineligible for managed care** - Upon verification of residency and program eligibility, the recipient is enrolled in managed care but is not eligible for managed care.

- **Managed care error, eligible for managed care but improperly enrolled** - Recipient is eligible for both the program and for managed care, but not enrolled in the correct managed care plan as of the month eligibility is being verified.

# APPENDIX B: GLOSSARY OF TERMS

**Active case:** A case containing information on a recipient who is enrolled in the Medicaid program or CHIP in the month that eligibility is reviewed.

**Agency:** Agency means, for purposes of the PERM eligibility reviews under this part, the entity that performs the Medicaid and CHIP eligibility reviews under PERM and excludes the state Medicaid or CHIP agency as defined in the regulation.

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

**Case:** An individual recipient or family enrolled in Medicaid or CHIP or individual or family who has been denied enrollment or has been terminated from Medicaid or CHIP. The case as a sampling unit only applies to the eligibility component.

**Case improper payment rate:** An improper payment rate that reflects the number of cases in error in the eligibility sample for the active cases or the number of cases in error in the eligibility sample for the negative cases expressed as a percentage of the total number of cases examined in the sample.

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

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

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

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

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

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

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

**Eligibility error:** An eligibility error occurs when a person is not eligible for the program or for a specific service and a payment for the sampled service or a capitation payment covering the date of service has been made.

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

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

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

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

**Medicaid:** A joint federal and state program, authorized under Title XIX of the Social Security Act that provides medical care to people with low incomes, limited resources, and certain other categorically eligible groups.

**Medicaid Eligibility Quality Control (MEQC):** A federal program requiring states to annually assess Medicaid beneficiaries' eligibility, according to statistically reliable samples of cases selected from the state eligibility file. States may choose 'traditional' MEQC programs, where the sample draws from the entire Medicaid population, or they may implement 'pilot' MEQC reviews that focus on a particular Medicaid program and population sub-set.

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

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

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

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

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

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

**Rolling rate:** The official Medicaid and CHIP improper payment rates include findings from the most recent three measurements to reflect findings from all 50 states and the District of Columbia. Each time a group of 17 states is measured under PERM, the previous findings for that group of states are dropped from the calculation and the newest findings are added in.

**Technical error:** Errors in eligibility which would not result in a difference between the amount that was paid and the amount that should have been paid (i.e., an improper payment).

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

# APPENDIX C: ACRONYMS

- Agency Financial Report (AFR)
- Centers for Medicare & Medicaid Services (CMS)
- Children's Health Insurance Program (CHIP)
- Corrective action plan (CAP)
- Fiscal Year (FY)
- Fee-for-service (FFS)
- Improper Payments Elimination and Recovery Act of 2010 (IPERA)
- Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)
- Improper Payments Information Act of 2002 (IPIA)
- Medicaid and CHIP State Information Sharing System (MCIS)
- Medicaid Eligibility Quality Control (MEQC)
- Medicaid Management Information Systems (MMIS)
- Payment Error Rate Measurement (PERM)
- State Plan Amendment (SPA)
- Transformed Medicaid Statistical Information System (T-MSIS)
- United States Department of Health and Human Services (HHS)