

Appendices

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

Appendix 1: Medicaid Trending for Cycle-Specific and National Rolling Improper Payment Rates

Table A1. Inception to Date Cycle-Specific Medicaid Component Improper Payment Rates

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

*The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled.

** For the current 2015 measurement, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed for the 2015 rate.

Table A2. National Rolling Medicaid Component Improper Payment Rates

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

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

**Note: Rolling eligibility component statistics for 2015 reflect the latest eligibility calculations from 2014.

Appendix 2: Medicaid Supplemental Information

CMS reported a rolling improper payment rate for Medicaid in 2015 based on the 51 states reviewed from 2012-2014. Unless otherwise noted, all tables and figures in Appendix 2 are based on the rolling rate. There was no eligibility component review in 2015 and the rolling eligibility rate from 2014 is included in the overall calculation for consistency in the overall results.

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Medicaid Overpayments and Underpayments

Table S1. Summary of Medicaid Projected Improper Payments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	2,166	20,414	\$5,154,079.8	\$474,110,676.6	\$35,418.3	\$334,350.5	10.6%	9.4% - 11.8%
FFS Medical Review	517	20,414	\$367,549.9	\$474,110,676.6	\$7,389.4	\$334,350.5	2.2%	1.7% - 2.7%
FFS Data Processing	1,713	20,414	\$4,843,923.1	\$474,110,676.6	\$29,451.6	\$334,350.5	8.8%	7.7% - 10.0%
Managed Care	55	9,714	\$31,205.0	\$8,979,325.4	\$223.6	\$182,853.4	0.1%	0.0% - 0.2%
<i>Eligibility</i>	<i>1,054</i>	<i>25,914</i>	<i>\$419,948.2</i>	<i>\$13,922,896.8</i>	<i>\$16,069.4</i>	<i>\$517,203.9</i>	<i>3.1%</i>	<i>2.2% - 4.0%</i>
Total	3,275	56,042	\$5,605,233.0	\$497,012,898.8	\$50,603.9	\$517,203.9	9.8%	8.6% - 10.9%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

Table S2. Summary of Projected Medicaid Overpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	2,117	20,414	\$5,140,319.2	\$474,110,676.6	\$34,933.9	\$334,350.5	10.4%	9.3% - 11.6%
FFS Medical Review	512	20,414	\$360,680.8	\$474,110,676.6	\$7,364.0	\$334,350.5	2.2%	1.7% - 2.7%
FFS Data Processing	1,668	20,414	\$4,837,027.8	\$474,110,676.6	\$28,992.3	\$334,350.5	8.7%	7.5% - 9.8%
Managed Care	27	9,714	\$30,401.8	\$8,979,325.4	\$222.3	\$182,853.4	0.1%	0.0% - 0.2%
<i>Eligibility</i>	<i>1,009</i>	<i>25,914</i>	<i>\$414,366.4</i>	<i>\$13,922,896.8</i>	<i>\$15,647.6</i>	<i>\$517,203.9</i>	<i>3.0%</i>	<i>2.1% - 4.0%</i>
Total	3,153	56,042	\$5,585,087.5	\$497,012,898.8	\$49,740.2	\$517,203.9	9.6%	8.5% - 10.8%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

Table S3. Summary of Projected Medicaid Underpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	50	20,414	\$13,764.5	\$474,110,676.6	\$484.5	\$334,350.5	0.1%	(0.1%) - 0.4%
FFS Medical Review	5	20,414	\$6,869.2	\$474,110,676.6	\$25.3	\$334,350.5	0.0%	(0.0%) - 0.0%
FFS Data Processing	45	20,414	\$6,895.3	\$474,110,676.6	\$459.2	\$334,350.5	0.1%	(0.1%) - 0.4%
Managed Care	28	9,714	\$803.2	\$8,979,325.4	\$1.3	\$182,853.4	0.0%	0.0% - 0.0%
<i>Eligibility</i>	<i>45</i>	<i>25,914</i>	<i>\$5,581.7</i>	<i>\$13,922,896.8</i>	<i>\$421.8</i>	<i>\$517,203.9</i>	<i>0.1%</i>	<i>0.0% - 0.2%</i>
Total	123	56,042	\$20,149.4	\$497,012,898.8	\$907.3	\$517,203.9	0.2%	0.0% - 0.3%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

Medicaid FFS Component Improper Payment Rate

Table S4. Medicaid FFS Medical Review and Data Processing Improper Payment Rates by State

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
National	517	\$367,549.9	2.2%	1,713	\$4,843,923.1	8.8%	\$474,110,676.6	10.6%
ST1	8	\$6,044.0	1.4%	125	\$378,911.0	45.5%	\$951,586.6	46.2%
ST2	0	\$0.0	0.0%	93	\$288,409.3	30.7%	\$1,059,969.5	30.7%
ST3	65	\$35,039.2	7.8%	236	\$967,732.2	23.7%	\$4,346,355.2	29.8%
ST4	23	\$9,142.4	2.4%	136	\$579,180.2	16.9%	\$3,512,204.6	18.6%
ST5	2	\$60.6	0.1%	17	\$14,548.7	17.9%	\$491,820.7	18.0%
ST6	14	\$8,543.8	2.5%	81	\$137,875.1	15.6%	\$3,791,727.7	18.0%
ST7	13	\$936.0	2.6%	29	\$99,407.4	15.2%	\$469,941.7	17.8%
ST8	33	\$7,164.3	9.9%	51	\$23,303.5	7.4%	\$1,278,841.2	16.8%
ST9	17	\$9,878.5	16.5%	0	\$0.0	0.0%	\$341,268.3	16.5%
ST10	8	\$634.8	0.9%	24	\$137,135.4	15.4%	\$788,520.6	16.3%
ST11	16	\$18,882.6	0.9%	151	\$654,280.9	15.4%	\$5,010,203.2	16.0%

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
ST12	10	\$2,941.7	6.7%	22	\$12,909.4	8.6%	\$155,472.9	15.3%
ST13	5	\$4,345.9	1.8%	60	\$29,693.1	12.7%	\$245,411.4	14.3%
ST14	26	\$57,070.6	8.3%	21	\$32,243.6	8.3%	\$885,260.6	13.8%
ST15	9	\$3,408.9	2.3%	25	\$156,324.0	10.6%	\$1,057,266.8	12.9%
ST16	7	\$6,562.0	3.0%	36	\$176,027.0	10.1%	\$723,419.1	12.8%
ST17	4	\$7,006.8	0.5%	54	\$86,606.0	12.2%	\$566,547.6	12.7%
ST18	2	\$23.9	0.1%	18	\$30,421.4	11.7%	\$198,955.9	11.8%
ST19	7	\$2,046.9	11.0%	30	\$947.2	0.8%	\$172,272.3	11.8%
ST20	6	\$2,927.2	0.4%	39	\$78,853.4	11.2%	\$432,207,201.3	11.3%
ST21	9	\$923.1	1.5%	38	\$14,661.0	10.6%	\$391,570.6	11.1%
ST22	15	\$292.5	1.4%	17	\$36,154.4	9.7%	\$207,175.8	11.1%
ST23	6	\$11,534.6	1.7%	35	\$130,813.8	9.8%	\$1,404,177.9	10.7%
ST24	15	\$33,518.7	3.9%	31	\$63,886.4	7.2%	\$885,573.3	10.6%
ST25	10	\$679.9	1.8%	50	\$142,225.7	8.7%	\$905,762.2	10.5%
ST26	16	\$6,564.1	5.4%	25	\$22,523.0	4.8%	\$259,270.9	10.2%
ST27	4	\$7,835.8	1.2%	32	\$285,387.5	8.6%	\$1,158,002.9	9.9%
ST28	17	\$8,075.1	8.2%	9	\$856.3	1.0%	\$215,433.1	9.2%
ST29	4	\$14,986.9	3.8%	22	\$97,066.0	6.1%	\$1,009,438.6	8.8%
ST30	11	\$4,418.5	5.4%	6	\$6,692.3	4.9%	\$305,068.2	7.7%
ST31	10	\$448.1	1.8%	8	\$694.3	5.1%	\$66,243.4	6.9%
ST32	2	\$18.8	0.0%	16	\$18,666.2	6.3%	\$218,090.1	6.3%
ST33	3	\$66.4	0.2%	23	\$74,978.0	5.6%	\$895,989.0	5.8%
ST34	1	\$252.6	1.5%	12	\$8,965.0	4.3%	\$238,659.5	5.8%
ST35	6	\$1,067.7	0.8%	15	\$5,567.8	4.8%	\$276,904.8	5.6%
ST36	13	\$1,909.9	2.2%	31	\$37,278.0	2.6%	\$1,274,463.9	4.5%
ST37	17	\$21,787.3	4.0%	4	\$87.5	0.3%	\$434,396.9	4.4%
ST38	6	\$5,326.2	4.0%	3	\$150.0	0.0%	\$1,065,956.2	4.0%
ST39	4	\$12,151.0	1.9%	28	\$7,700.8	2.1%	\$239,443.6	4.0%
ST40	9	\$9,798.0	2.1%	2	\$213.3	1.4%	\$200,416.9	3.4%

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
ST41	1	\$54.3	0.3%	19	\$3,240.4	2.4%	\$192,491.3	2.7%
ST42	4	\$7,316.1	2.3%	0	\$0.0	0.0%	\$337,425.3	2.3%
ST43	4	\$523.5	2.0%	1	\$57.8	0.3%	\$280,557.3	2.2%
ST44	11	\$2,833.2	1.7%	13	\$415.3	0.3%	\$343,381.7	2.0%
ST45	26	\$18,824.4	1.5%	11	\$525.3	0.4%	\$918,309.5	1.8%
ST46	7	\$7,457.7	1.4%	0	\$0.0	0.0%	\$475,998.2	1.4%
ST47	3	\$101.8	1.1%	3	\$39.9	0.1%	\$350,341.8	1.2%
ST48	1	\$42.5	0.5%	2	\$6.5	0.1%	\$323,484.9	0.6%
ST49	5	\$5,769.7	0.4%	3	\$41.3	0.0%	\$512,035.5	0.4%
ST50	1	\$294.0	0.3%	0	\$0.0	0.0%	\$194,993.1	0.3%
ST51	1	\$17.6	0.0%	6	\$221.0	0.2%	\$275,373.1	0.2%

Medicaid FFS Payment Errors by Type of Error

Table S5. Summary of Medicaid FFS Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,522	\$4,733,544.5	\$4,735,366.0	\$27,240.4	\$23,330.8	\$31,150.0
Insufficient Documentation	225	\$180,651.6	\$180,651.6	\$3,498.2	\$2,548.7	\$4,447.7
No Documentation	161	\$87,544.0	\$87,544.0	\$1,250.7	\$818.2	\$1,683.2
Policy Violation	62	\$60,750.1	\$64,136.8	\$1,111.6	\$580.1	\$1,643.1
Number of Unit(s) Error	25	\$3,210.6	\$4,233.7	\$559.3	-\$254.3	\$1,372.9
Administrative/Other	24	\$8,160.1	\$8,160.1	\$426.1	\$43.4	\$808.7
Data Entry Error	4	\$1,908.5	\$3,024.5	\$390.6	-\$374.2	\$1,155.5
Third-party Liability	12	\$9,714.0	\$10,798.6	\$271.2	-\$9.7	\$552.0
Procedure Coding Error	11	\$1,420.0	\$1,599.5	\$250.6	-\$67.4	\$568.7
Diagnosis Coding Error	9	\$29,323.1	\$54,876.6	\$132.2	-\$2.7	\$267.0

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error	87	\$21,239.6	\$226,681.1	\$122.2	-\$29.9	\$274.2
Duplicate Item	5	\$9,907.1	\$9,907.1	\$72.5	-\$35.3	\$180.2
Logic Edit	4	\$185.4	\$160.7	\$54.6	-\$28.0	\$137.3
FFS Claim for Managed Care Service	9	\$5,287.5	\$5,287.5	\$32.8	-\$1.0	\$66.6
Unbundling	3	\$7.7	\$7.7	\$3.0	-\$1.1	\$7.2
Medically Unnecessary	3	\$1,226.0	\$1,322.3	\$2.4	-\$0.8	\$5.5
Total	2,166	\$5,154,079.8	\$474,110,676.6	\$35,418.3	\$31,171.1	\$39,665.4

Note: Details do not always sum to the total due to rounding.

Medicaid FFS Medical Review Payment Errors

Table S6. Summary of Medicaid FFS Medical Review Overall Errors

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Insufficient Documentation	225	\$180,651.6	\$180,651.6	\$3,498.2	\$2,548.7	\$4,447.7
No Documentation	161	\$87,541.8	\$87,544.0	\$1,250.7	\$818.2	\$1,683.2
Policy Violation	62	\$60,750.1	\$64,136.8	\$1,111.6	\$580.1	\$1,643.1
Administrative/Other	18	\$3,419.0	\$3,419.0	\$581.4	\$68.4	\$1,094.3
Number of Unit(s) Error	25	\$3,210.6	\$4,233.7	\$559.3	-\$254.3	\$1,372.9
Procedure Coding Error	11	\$1,420.0	\$1,599.5	\$250.6	-\$67.4	\$568.7
Diagnosis Coding Error	9	\$29,323.1	\$54,876.6	\$132.2	-\$2.7	\$267.0
Unbundling	3	\$7.7	\$7.7	\$3.0	-\$1.1	\$7.2
Medically Unnecessary	3	\$1,226.0	\$1,322.3	\$2.4	-\$0.8	\$5.5
Total	517	\$367,549.9	\$474,110,676.6	\$7,389.4	\$5,840.6	\$8,938.1

Note: Details do not always sum to the total due to rounding.

Table S7. Summary of Medicaid FFS Medical Review Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Insufficient Documentation	225	\$180,651.6	\$180,651.6	\$3,498.2	\$2,548.7	\$4,447.7
No Documentation	161	\$87,541.8	\$87,544.0	\$1,250.7	\$818.2	\$1,683.2
Policy Violation	62	\$60,750.1	\$64,136.8	\$1,111.6	\$580.1	\$1,643.1
Administrative/Other	18	\$3,419.0	\$3,419.0	\$581.4	\$68.4	\$1,094.3
Number of Unit(s) Error	25	\$3,210.6	\$4,233.7	\$559.3	-\$254.3	\$1,372.9
Procedure Coding Error	9	\$1,376.6	\$1,599.5	\$246.5	-\$71.5	\$564.5
Diagnosis Coding Error	6	\$22,497.3	\$54,876.6	\$111.0	-\$20.5	\$242.4
Unbundling	3	\$7.7	\$7.7	\$3.0	-\$1.1	\$7.2
Medically Unnecessary	3	\$1,226.0	\$1,322.3	\$2.4	-\$0.8	\$5.5
Total	512	\$360,680.8	\$474,110,676.6	\$7,364.0	\$5,815.6	\$8,912.5
Note: Details do not always sum to the total due to rounding.						

Table S8. Summary of Medicaid FFS Medical Review Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Diagnosis Coding Error	3	\$6,825.8	\$54,876.6	\$21.2	-\$8.7	\$51.1
Procedure Coding Error	2	\$43.4	\$1,599.5	\$4.1	-\$1.6	\$9.9
Administrative/Other	0	\$0.0	\$3,419.0	\$0.0	\$0.0	\$0.0
Insufficient Documentation	0	\$0.0	\$180,651.6	\$0.0	\$0.0	\$0.0
Medically Unnecessary	0	\$0.0	\$1,322.3	\$0.0	\$0.0	\$0.0
No Documentation	0	\$0.0	\$87,544.0	\$0.0	\$0.0	\$0.0
Number of Unit(s) Error	0	\$0.0	\$4,233.7	\$0.0	\$0.0	\$0.0
Policy Violation	0	\$0.0	\$64,136.8	\$0.0	\$0.0	\$0.0
Unbundling	0	\$0.0	\$7.7	\$0.0	\$0.0	\$0.0
Total	5	\$6,869.2	\$474,110,676.6	\$25.3	-\$5.1	\$55.7
Note: Details do not always sum to the total due to rounding.						

Medical Review Payment Errors: Insufficient Documentation

Table S9. Specific Causes of "Insufficient Documentation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Required progress notes applicable to DOS sampled not provided	42	\$53,436.3	\$621.1	\$303.4	\$938.8
Medical records do not contain daily documentation of specific tasks performed on sampled DOS	34	\$12,996.2	\$597.0	\$33.2	\$1,160.8
Medical records do not contain the service plan	28	\$15,082.7	\$547.8	\$216.5	\$879.0
Provider did not supply sufficient documentation to support the claim	36	\$36,122.6	\$541.4	\$199.1	\$883.6
Medical records do not contain the provider's order	28	\$38,055.0	\$526.6	\$147.2	\$906.1
Individual plan was provided but not applicable to the sampled DOS	27	\$17,472.9	\$305.6	\$80.7	\$530.6
Provider did not supply a valid prescription	3	\$134.2	\$98.0	-\$74.6	\$270.7
Documentation of patient counseling not provided	11	\$263.9	\$95.3	-\$27.8	\$218.4
Face to face assessment documentation not provided	2	\$971.2	\$47.1	-\$33.0	\$127.3
Evidence recipient present on DOS missing from submitted documentation	2	\$94.5	\$46.7	-\$44.4	\$137.8
Pharmacy signature log not provided	5	\$3,367.7	\$38.8	-\$4.4	\$82.1
Required attendance log/census not provided	4	\$1,627.1	\$16.4	-\$1.9	\$34.7
Required signed timesheet not provided	3	\$1,027.4	\$16.2	-\$7.1	\$39.6
Total	225	\$180,651.6	\$3,498.2	\$2,548.7	\$4,447.7
Note: Details do not always sum to the total due to rounding.					

Medical Review Payment Errors: No Documentation

Table S10. Specific Causes of "No Documentation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	91	\$61,846.7	\$757.3	\$388.8	\$1,125.9
Provider states recipient not seen on sampled DOS	19	\$15,443.2	\$140.2	\$37.1	\$243.4
Provider under fraud investigation	26	\$4,398.7	\$131.0	\$13.5	\$248.5
State could not locate provider	6	\$647.1	\$64.7	-\$21.5	\$150.9
Provider cannot locate record	3	\$236.2	\$62.3	-\$56.9	\$181.5
Provider did not have patient on file or in their system	8	\$3,415.5	\$45.2	\$3.9	\$86.4
Provider out of business/retired and record is not available	4	\$272.5	\$37.4	-\$19.2	\$94.0
Other	3	\$1,128.2	\$8.5	-\$6.6	\$23.6
Provider states billed for wrong recipient	1	\$153.8	\$4.0	N/A	N/A
Total	161	\$87,541.8	\$1,250.7	\$818.2	\$1,683.2
Note: Details do not always sum to the total due to rounding.					

Medical Review Payment Errors: Policy Violation

Table S11. Specific Causes of "Policy Violation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation does not meet the state policy requirements for the service performed	27	\$10,644.1	\$593.1	\$174.9	\$1,011.4
Required provider signature and/or credentials not provided	10	\$15,690.8	\$341.6	\$36.8	\$646.3
Required record of recipient acceptance or refusal of medication counseling not provided	17	\$11,759.2	\$148.2	\$30.8	\$265.7
Other	6	\$18,516.2	\$25.0	-\$4.5	\$54.5
Required physician certification/recertification for services not provided	1	\$4,128.7	\$3.5	N/A	N/A
Required supervision documentation not provided	1	\$11.0	\$0.2	N/A	N/A
Total	62	\$60,750.1	\$1,111.6	\$580.1	\$1,643.1
Note: Details do not always sum to the total due to rounding.					

Medicaid FFS Medical Review Errors by Service Type

Table S12. Medicaid FFS Medical Review Error by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Nursing Facility, Intermediate Care Facilities	48	1,999	\$128,402.8	\$7,888,261.1	\$1,330.5	\$76,209.4	1.7%	1.0% - 2.5%
Habilitation and Waiver Programs, School Services	100	2,411	\$65,951.1	\$2,635,871.1	\$1,291.5	\$45,037.2	2.9%	1.7% - 4.0%
Prescribed Drugs	67	1,918	\$18,068.5	\$1,159,677.9	\$1,240.0	\$27,074.5	4.6%	2.4% - 6.8%
Personal Support Services	57	1,020	\$10,535.1	\$237,158.5	\$1,004.8	\$30,067.8	3.3%	0.5% - 6.2%
Inpatient and Outpatient Hospital	32	2,583	\$67,357.2	\$19,981,065.8	\$623.9	\$49,016.9	1.3%	0.9% - 1.7%
Outpatient Hospital Services and Clinics	27	1,060	\$8,639.5	\$204,435.5	\$415.5	\$11,668.8	3.6%	2.1% - 5.0%
Physicians and Other Licensed Practitioner Services	34	848	\$5,797.3	\$113,438.5	\$364.2	\$11,083.2	3.3%	0.5% - 6.0%
ICF for the Mentally Retarded and Group Homes	10	316	\$25,860.8	\$2,709,508.0	\$352.3	\$9,587.0	3.7%	2.2% - 5.1%
Psychiatric, Mental Health, and Behavioral Health Services	38	1,099	\$26,650.5	\$2,202,296.9	\$240.3	\$17,172.1	1.4%	0.5% - 2.3%
Transportation and Accommodations	22	319	\$1,407.6	\$40,255.0	\$171.6	\$2,941.8	5.8%	(1.2%) - 12.9%
Home Health Services	28	382	\$4,726.8	\$116,085.3	\$120.6	\$5,380.8	2.2%	1.1% - 3.3%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	9	325	\$786.3	\$76,686.0	\$73.7	\$3,516.3	2.1%	0.1% - 4.1%
Dental and Other Oral Surgery Services	16	589	\$2,333.7	\$53,342.8	\$66.6	\$6,045.5	1.1%	0.5% - 1.7%
Laboratory, X-ray and Imaging Services	22	509	\$706.8	\$33,670.1	\$49.3	\$2,024.1	2.4%	1.4% - 3.5%
Vision: Ophthalmology, Optometry and Optical Services	4	108	\$116.3	\$5,498.5	\$34.4	\$664.5	5.2%	4.3% - 6.0%
Therapies, Hearing and Rehabilitation Services	3	112	\$209.6	\$10,143.3	\$10.3	\$1,291.3	0.8%	0.1% - 1.5%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Capitated Care/Fixed Payments	0	2,368	\$0.0	\$436,017,258.8	\$0.0	\$26,140.8	0.0%	0.0% - 0.0%
Crossover Claims	0	840	\$0.0	\$468,820.1	\$0.0	\$7,857.7	0.0%	0.0% - 0.0%
Denied Claims	0	1,563	\$0.0	\$0.0	\$0.0	\$0.0	N/A	N/A
Hospice Services	0	45	\$0.0	\$157,203.5	\$0.0	\$1,570.9	0.0%	0.0% - 0.0%
Total	517	20,414	\$367,549.9	\$474,110,676.6	\$7,389.4	\$334,350.5	2.2%	1.7% - 2.7%
Note: Details do not always sum to the total due to rounding.								

Medicaid FFS Data Processing Payment Errors

Table S13. Summary of Medicaid FFS Data Processing Overall Improper Payments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,579	\$4,790,089.4	\$4,791,910.9	\$28,487.4	\$24,465.4	\$32,509.5
Data Entry Error	4	\$1,908.5	\$3,024.5	\$390.6	-\$374.2	\$1,155.5
Third-party Liability	12	\$9,714.0	\$10,798.6	\$271.2	-\$9.7	\$552.0
Pricing Error	91	\$21,614.7	\$238,237.5	\$123.1	-\$29.0	\$275.1
Duplicate Item	5	\$9,907.1	\$9,907.1	\$72.5	-\$35.3	\$180.2
Logic Edit	5	\$331.2	\$306.5	\$54.8	-\$27.8	\$137.4
FFS Claim for Managed Care Service	9	\$5,287.5	\$5,287.5	\$32.8	-\$1.0	\$66.6
Administrative/Other	8	\$5,070.7	\$5,070.7	\$19.2	\$0.7	\$37.8
Total	1,713	\$4,843,923.1	\$474,110,676.6	\$29,451.6	\$25,349.0	\$33,554.1
Note: Details do not always sum to the total due to rounding.						

Table S14. Summary of Medicaid FFS Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,579	\$4,790,089.4	\$4,791,910.9	\$28,487.4	\$24,465.4	\$32,509.5
Third-party Liability	11	\$9,668.5	\$10,798.6	\$269.0	-\$11.8	\$549.9
Pricing Error	50	\$15,698.4	\$238,237.5	\$97.2	-\$52.8	\$247.2
Duplicate Item	5	\$9,907.1	\$9,907.1	\$72.5	-\$35.3	\$180.2
FFS Claim for Managed Care Service	9	\$5,287.5	\$5,287.5	\$32.8	-\$1.0	\$66.6
Administrative/Other	8	\$5,070.7	\$5,070.7	\$19.2	\$0.7	\$37.8
Logic Edit	4	\$306.2	\$306.5	\$13.8	-\$5.3	\$32.9
Data Entry Error	2	\$1,000.0	\$3,024.5	\$0.4	-\$0.4	\$1.1
Total	1,668	\$4,837,027.8	\$474,110,676.6	\$28,992.3	\$24,962.5	\$33,022.1
Note: Details do not always sum to the total due to rounding.						

Table S15. Summary of Medicaid FFS Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Data Entry Error	2	\$908.5	\$3,024.5	\$390.2	-\$374.6	\$1,155.1
Logic Edit	1	\$25.0	\$306.5	\$41.0	N/A	N/A
Pricing Error	41	\$5,916.3	\$238,237.5	\$25.8	\$0.8	\$50.9
Third-party Liability	1	\$45.5	\$10,798.6	\$2.1	N/A	N/A
Administrative/Other	0	\$0.0	\$5,070.7	\$0.0	\$0.0	\$0.0
Duplicate Item	0	\$0.0	\$9,907.1	\$0.0	\$0.0	\$0.0
FFS Claim for Managed Care Service	0	\$0.0	\$5,287.5	\$0.0	\$0.0	\$0.0
Non-covered Service	0	\$0.0	\$4,791,910.9	\$0.0	\$0.0	\$0.0
Total	45	\$6,895.3	\$474,110,676.6	\$459.2	-\$310.3	\$1,228.7
Note: Details do not always sum to the total due to rounding.						

Data Processing Payment Errors: Non-covered Service

Table S16. Specific Causes of "Non-covered Service" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Attending or rendering provider required but not listed on institutional claim	619	\$3,043,468.7	\$16,295.4	\$14,280.7	\$18,310.0
New provider was not enrolled using ACA risk-based criteria	316	\$630,095.8	\$2,652.4	\$1,849.5	\$3,455.3
Referring/ordering provider required but not listed on the claim	247	\$163,922.4	\$2,454.2	\$1,348.5	\$3,560.0
Provider not enrolled in Medicaid/CHIP	117	\$715,399.7	\$2,286.9	\$1,047.2	\$3,526.5
Referring/ordering provider not enrolled	125	\$65,149.9	\$2,015.2	\$782.2	\$3,248.2
Prior authorization was required or not current for DOS	12	\$3,348.2	\$1,723.6	-\$943.2	\$4,390.5
Other	100	\$113,109.8	\$661.1	\$430.1	\$892.0
Recipient was ineligible for the applicable program on DOS	35	\$31,498.8	\$295.0	-\$15.7	\$605.7
Required provider license was not current for DOS	5	\$23,992.8	\$70.6	-\$23.0	\$164.2
HCBS was not approved by Service Plan	1	\$85.3	\$30.2	N/A	N/A
Non-covered based on recipient Benefit Plan	1	\$2.9	\$1.5	N/A	N/A
CLIA certification was not current for DOS	1	\$15.1	\$1.4	N/A	N/A
Total	1,579	\$4,790,089.4	\$28,487.4	\$24,465.4	\$32,509.5
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Data Entry Error

Table S17. Specific Causes of "Data Entry Error" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other	1	\$902.4	\$390.2	N/A	N/A
Incorrect data entry made from paper claim	2	\$1,006.2	\$0.4	-\$0.4	\$1.1
Rate incorrectly entered into rate file in system	1	\$0.0	\$0.0	N/A	N/A
Total	4	\$1,908.5	\$390.6	-\$374.2	\$1,155.5
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Third-party Liability

Table S18. Specific Causes of "Third-party Liability" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Payment should have been denied pending payment by TPL	11	\$9,707.6	\$271.2	-\$9.7	\$552.0
Claim processed as a Medicare crossover, but recipient was ineligible for Medicare	1	\$6.4	\$0.0	N/A	N/A
Total	12	\$9,714.0	\$271.2	-\$9.7	\$552.0
Note: Details do not always sum to the total due to rounding.					

Medicaid FFS Data Processing Errors by Service Type

Table S19. Medicaid FFS Data Processing Error by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Nursing Facility, Intermediate Care Facilities	376	1,999	\$1,463,048.9	\$7,888,261.1	\$8,760.3	\$76,209.4	11.5%	9.5% - 13.5%
Prescribed Drugs	268	1,918	\$248,598.2	\$1,159,677.9	\$4,011.8	\$27,074.5	14.8%	9.3% - 20.3%
ICF for the Mentally Retarded and Group Homes	156	316	\$1,473,567.2	\$2,709,508.0	\$3,940.9	\$9,587.0	41.1%	36.1% - 46.2%
Personal Support Services	43	1,020	\$15,226.6	\$237,158.5	\$3,047.7	\$30,067.8	10.1%	1.7% - 18.5%
Habilitation and Waiver Programs, School Services	77	2,411	\$163,987.0	\$2,635,871.1	\$1,960.9	\$45,037.2	4.4%	2.1% - 6.6%
Psychiatric, Mental Health, and Behavioral Health Services	107	1,099	\$441,919.0	\$2,202,296.9	\$1,615.7	\$17,172.1	9.4%	5.4% - 13.4%
Inpatient and Outpatient Hospital	158	2,583	\$817,683.5	\$19,981,065.8	\$1,417.1	\$49,016.9	2.9%	2.2% - 3.6%
Outpatient Hospital Services and Clinics	50	1,060	\$34,358.7	\$204,435.5	\$1,269.1	\$11,668.8	10.9%	5.4% - 16.4%
Home Health Services	61	382	\$15,532.8	\$116,085.3	\$616.2	\$5,380.8	11.5%	6.6% - 16.3%
Hospice Services	7	45	\$31,725.9	\$157,203.5	\$512.3	\$1,570.9	32.6%	14.3% - 50.9%
Denied Claims	4	1,563	\$979.0	\$0.0	\$433.4	\$0.0	N/A	N/A
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	55	325	\$24,027.9	\$76,686.0	\$407.5	\$3,516.3	11.6%	8.9% - 14.2%
Crossover Claims	62	840	\$68,256.4	\$468,820.1	\$351.7	\$7,857.7	4.5%	2.1% - 6.9%
Dental and Other Oral Surgery Services	87	589	\$12,275.2	\$53,342.8	\$329.4	\$6,045.5	5.4%	3.7% - 7.2%
Laboratory, X-ray and Imaging Services	93	509	\$5,486.5	\$33,670.1	\$318.3	\$2,024.1	15.7%	11.4% - 20.0%
Physicians and Other Licensed Practitioner Services	43	848	\$5,371.5	\$113,438.5	\$205.9	\$11,083.2	1.9%	0.9% - 2.9%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Therapies, Hearing and Rehabilitation Services	10	112	\$793.1	\$10,143.3	\$161.5	\$1,291.3	12.5%	5.9% - 19.1%
Capitated Care/Fixed Payments	38	2,368	\$19,847.1	\$436,017,258.8	\$73.3	\$26,140.8	0.3%	0.1% - 0.4%
Transportation and Accommodations	14	319	\$1,180.0	\$40,255.0	\$12.4	\$2,941.8	0.4%	0.2% - 0.6%
Vision: Ophthalmology, Optometry and Optical Services	4	108	\$58.6	\$5,498.5	\$6.3	\$664.5	0.9%	0.6% - 1.3%
Total	1,713	20,414	\$4,843,923.1	\$474,110,676.6	\$29,451.6	\$334,350.5	8.8%	7.7% - 10.0%
Note: Details do not always sum to the total due to rounding.								

Medicaid Managed Care Component Improper Payment Rate

Table S20. Medicaid Managed Care Data Processing Improper Payment Rates by State

State	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Improper Payment Rate	95% CI
National	55	\$31,205.0	\$8,979,325.4	0.1%	0.0% - 0.2%
ST1	2	\$445.1	\$204,870.2	1.1%	(0.4%) - 2.6%
ST2	2	\$7,114.7	\$174,924.7	1.0%	(0.4%) - 2.5%
ST3	2	\$1,187.5	\$182,404.1	0.9%	(0.3%) - 2.1%
ST4	41	\$2,846.2	\$225,462.4	0.8%	(0.0%) - 1.6%
ST5	1	\$263.6	\$292,633.1	0.5%	(0.5%) - 1.6%
ST6	1	\$5,579.0	\$346,634.8	0.5%	(0.5%) - 1.5%
ST7	1	\$937.3	\$212,318.0	0.4%	(0.4%) - 1.1%
ST8	1	\$6,500.4	\$302,004.3	0.4%	(0.3%) - 1.1%
ST9	1	\$2,960.5	\$260,946.0	0.3%	(0.3%) - 0.9%
ST10	1	\$3,218.4	\$325,966.7	0.2%	(0.2%) - 0.7%
ST11	1	\$101.1	\$231,106.5	0.0%	(0.0%) - 0.1%
ST12	1	\$51.2	\$448,543.3	0.0%	(0.0%) - 0.0%
ST13	0	\$0.0	\$270,025.9	0.0%	0.0% - 0.0%
ST14	0	\$0.0	\$211,846.8	0.0%	0.0% - 0.0%
ST15	0	\$0.0	\$188,268.6	0.0%	0.0% - 0.0%
ST16	0	\$0.0	\$77,995.4	0.0%	0.0% - 0.0%
ST17	0	\$0.0	\$308,745.2	0.0%	0.0% - 0.0%
ST18	0	\$0.0	\$277,547.6	0.0%	0.0% - 0.0%
ST19	0	\$0.0	\$4,306.2	0.0%	0.0% - 0.0%
ST20	0	\$0.0	\$56,137.1	0.0%	0.0% - 0.0%
ST21	0	\$0.0	\$42,530.1	0.0%	0.0% - 0.0%
ST22	0	\$0.0	\$173,478.4	0.0%	0.0% - 0.0%
ST23	0	\$0.0	\$160,030.7	0.0%	0.0% - 0.0%
ST24	0	\$0.0	\$511,274.9	0.0%	0.0% - 0.0%
ST25	0	\$0.0	\$254,982.3	0.0%	0.0% - 0.0%
ST26	0	\$0.0	\$181,065.3	0.0%	0.0% - 0.0%
ST27	0	\$0.0	\$123,272.7	0.0%	0.0% - 0.0%
ST28	0	\$0.0	\$178,188.7	0.0%	0.0% - 0.0%

State	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Improper Payment Rate	95% CI
ST29	0	\$0.0	\$292,069.1	0.0%	0.0% - 0.0%
ST30	0	\$0.0	\$105,812.3	0.0%	0.0% - 0.0%
ST31	0	\$0.0	\$343,200.7	0.0%	0.0% - 0.0%
ST32	0	\$0.0	\$350,638.3	0.0%	0.0% - 0.0%
ST33	0	\$0.0	\$368,665.5	0.0%	0.0% - 0.0%
ST34	0	\$0.0	\$193,604.8	0.0%	0.0% - 0.0%
ST35	0	\$0.0	\$212,644.6	0.0%	0.0% - 0.0%
ST36	0	\$0.0	\$182,412.2	0.0%	0.0% - 0.0%
ST37	0	\$0.0	\$226,576.6	0.0%	0.0% - 0.0%
ST38	0	\$0.0	\$160,487.7	0.0%	0.0% - 0.0%
ST39	0	\$0.0	\$128,513.3	0.0%	0.0% - 0.0%
ST40	0	\$0.0	\$187,190.5	0.0%	0.0% - 0.0%

Note: Details do not always sum to the total due to rounding.

Medicaid Managed Care Errors by Type of Error

Table S21. Summary of Medicaid Managed Care Data Processing Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	11	\$16,415.3	\$16,415.3	\$177.9	\$38.2	\$317.6
Duplicate Item	2	\$12,786.9	\$12,786.9	\$28.0	-\$10.8	\$66.9
Rate Cell Error	1	\$937.3	\$1,118.5	\$12.7	N/A	N/A
MC Payment Error	40	\$1,014.3	\$41,838.7	\$4.6	-\$1.4	\$10.6
Pricing Error	1	\$51.2	\$3,175.6	\$0.3	N/A	N/A
Total	55	\$31,205.0	\$8,979,325.4	\$223.6	\$76.3	\$370.9

Note: Details do not always sum to the total due to rounding.

Medicaid Managed Care Data Processing Payment Errors

Table S22. Summary of Medicaid Managed Care Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	11	\$16,415.3	\$16,415.3	\$177.9	\$38.2	\$317.6
Duplicate Item	2	\$12,786.9	\$12,786.9	\$28.0	-\$10.8	\$66.9
Rate Cell Error	1	\$937.3	\$1,118.5	\$12.7	N/A	N/A
MC Payment Error	12	\$211.1	\$41,838.7	\$3.3	-\$2.7	\$9.3
Pricing Error	1	\$51.2	\$3,175.6	\$0.3	N/A	N/A
Total	27	\$30,401.8	\$8,979,325.4	\$222.3	\$75.0	\$369.6

Note: Details do not always sum to the total due to rounding.

Table S23. Summary of Medicaid Managed Care Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
MC Payment Error	28	\$803.2	\$41,838.7	\$1.3	\$1.0	\$1.6
Duplicate Item	0	\$0.0	\$12,786.9	\$0.0	\$0.0	\$0.0
Non-covered Service	0	\$0.0	\$16,415.3	\$0.0	\$0.0	\$0.0
Pricing Error	0	\$0.0	\$3,175.6	\$0.0	N/A	N/A
Rate Cell Error	0	\$0.0	\$1,118.5	\$0.0	N/A	N/A
Total	28	\$803.2	\$8,979,325.4	\$1.3	\$1.0	\$1.6

Note: Details do not always sum to the total due to rounding.

Data Processing Payment Errors: Non-covered Service

Table S24. Specific Causes of "Non-covered Service" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Recipient was ineligible for the applicable program on DOS	11	\$16,415.3	\$177.9	\$38.2	\$317.6
Total	11	\$16,415.3	\$177.9	\$38.2	\$317.6
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Duplicate Item

Table S25. Specific Causes of "Duplicate Item" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Sampled claim is a duplicate of a previously paid claim	2	\$12,786.9	\$28.0	-\$10.8	\$66.9
Total	2	\$12,786.9	\$28.0	-\$10.8	\$66.9
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Rate Cell Error

Table S26. Specific Causes of "Rate Cell Error" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Incorrect rate cell used for Medicare recipient	1	\$937.3	\$12.7	N/A	N/A
Total	1	\$937.3	\$12.7	N/A	N/A
Note: Details do not always sum to the total due to rounding.					

Appendix 3: CHIP Trending for Cycle-Specific and National Rolling Improper Payment Rates

Table B1. Inception to Date Cycle-Specific CHIP Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility	Overall*
2012	6.9%	0.1%	5.7%	8.2%
2013	6.1%	0.5%	4.4%	6.8%
2014	6.2%	0.0%	2.6%	4.8%
2015	13.1%	0.6%	N/A	N/A

*The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2012-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled.

**For the current 2015 measurement, eligibility reviews are suspended. Therefore, eligibility component improper payment rates have been removed for the 2015 rate.

Table B2. National Rolling CHIP Component Improper Payment Rates

Year	FFS	Managed Care	Eligibility	Overall*
2013 Rolling Rates	5.7%	0.2%	5.1%	7.1%
2014 Rolling Rates	6.2%	0.2%	4.2%	6.5%
2015 Rolling Rates	7.3%	0.4%	4.2%	6.8%

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

**Note: Rolling eligibility component statistics for 2015 reflect the latest eligibility calculations from 2014.

Appendix 4: CHIP Supplemental Information

CMS reported a rolling improper payment rate for CHIP in 2015 based on the 51 states reviewed from 2012-2014. Unless otherwise noted, all tables and figures in Appendix 4 are based on the rolling rate. There was no eligibility component review in 2015 and the rolling eligibility rate from 2014 is included in the overall calculation for consistency in the overall results.

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CHIP Overpayments and Underpayments

Table T1. Summary of CHIP Projected Improper Payments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	2,501	21,706	\$2,762,543.2	\$31,149,173.0	\$327.9	\$4,473.0	7.3%	6.5% - 8.2%
FFS Medical Review	704	21,706	\$461,685.1	\$31,149,173.0	\$129.1	\$4,473.0	2.9%	2.3% - 3.5%
FFS Data Processing	1,874	21,706	\$2,321,410.8	\$31,149,173.0	\$207.5	\$4,473.0	4.6%	4.0% - 5.3%
Managed Care	98	9,896	\$5,314.6	\$1,969,293.8	\$33.3	\$8,919.2	0.4%	0.1% - 0.6%
<i>Eligibility</i>	<i>1,841</i>	<i>25,358</i>	<i>\$240,621.1</i>	<i>\$5,617,602.3</i>	<i>\$565.0</i>	<i>\$13,392.2</i>	<i>4.2%</i>	<i>3.7% - 4.8%</i>
Total	4,440	56,960	\$3,008,478.9	\$38,736,069.1	\$910.9	\$13,392.2	6.8%	6.2% - 7.4%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

Table T2. Summary of Projected CHIP Overpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	2,400	21,706	\$2,755,183.2	\$31,149,173.0	\$325.1	\$4,473.0	7.3%	6.4% - 8.1%
FFS Medical Review	699	21,706	\$458,055.4	\$31,149,173.0	\$128.6	\$4,473.0	2.9%	2.3% - 3.5%
FFS Data Processing	1,776	21,706	\$2,317,680.5	\$31,149,173.0	\$205.2	\$4,473.0	4.6%	4.0% - 5.2%
Managed Care	26	9,896	\$5,300.0	\$1,969,293.8	\$33.3	\$8,919.2	0.4%	0.1% - 0.6%
<i>Eligibility</i>	<i>1,753</i>	<i>25,358</i>	<i>\$238,406.1</i>	<i>\$5,617,602.3</i>	<i>\$559.0</i>	<i>\$13,392.2</i>	<i>4.2%</i>	<i>3.6% - 4.7%</i>
Total	4,179	56,960	\$2,998,889.3	\$38,736,069.1	\$902.4	\$13,392.2	6.7%	6.1% - 7.4%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

Table T3. Summary of Projected CHIP Underpayments

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
FFS	103	21,706	\$7,359.9	\$31,149,173.0	\$2.8	\$4,473.0	0.1%	(0.0%) - 0.1%
FFS Medical Review	5	21,706	\$3,629.7	\$31,149,173.0	\$0.5	\$4,473.0	0.0%	(0.0%) - 0.0%
FFS Data Processing	98	21,706	\$3,730.2	\$31,149,173.0	\$2.3	\$4,473.0	0.1%	(0.0%) - 0.1%
Managed Care	72	9,896	\$14.6	\$1,969,293.8	\$0.0	\$8,919.2	0.0%	0.0% - 0.0%
<i>Eligibility</i>	88	25,358	\$2,215.0	\$5,617,602.3	\$5.9	\$13,392.2	0.0%	0.0% - 0.1%
Total	263	56,960	\$9,589.6	\$38,736,069.1	\$8.7	\$13,392.2	0.1%	0.0% - 0.1%

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the latest eligibility calculations from 2014.

CHIP FFS Component Improper Payment Rate

Table T4. CHIP FFS Medical Review and Data Processing Improper Payment Rates by State

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
National	704	\$461,685.1	2.9%	1,874	\$2,321,410.8	4.6%	\$31,149,173.0	7.3%
ST1	1	\$55.0	0.3%	438	\$49,352.8	59.7%	\$187,879.8	59.7%
ST2	0	\$0.0	0.0%	89	\$152,222.5	52.5%	\$630,405.8	52.5%
ST3	4	\$671.5	0.9%	38	\$68,218.4	36.7%	\$340,199.7	37.3%
ST4	8	\$5,768.7	1.7%	88	\$100,112.4	20.4%	\$594,648.8	22.0%
ST5	36	\$4,811.7	3.6%	93	\$335,636.7	17.5%	\$1,579,481.9	20.3%
ST6	41	\$2,945.1	13.1%	18	\$59,038.0	5.3%	\$382,040.2	16.9%
ST7	24	\$32,590.9	10.2%	59	\$104,083.3	6.6%	\$481,681.4	16.8%
ST8	27	\$12,369.7	11.8%	21	\$27,442.3	4.7%	\$543,254.1	15.7%
ST9	160	\$305,788.2	7.7%	178	\$550,358.9	8.1%	\$3,999,992.1	14.9%
ST10	9	\$3,866.3	2.8%	56	\$253,689.5	11.8%	\$974,013.1	14.2%
ST11	24	\$11,895.4	5.2%	19	\$11,535.4	6.4%	\$460,047.8	11.5%

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
ST12	49	\$4,883.4	10.0%	4	\$1,082.9	0.3%	\$275,669.6	10.3%
ST13	13	\$617.2	1.2%	110	\$45,812.7	9.4%	\$271,458.8	10.2%
ST14	5	\$1,257.1	1.7%	28	\$5,922.5	8.1%	\$769,291.1	9.6%
ST15	9	\$4,449.8	1.5%	26	\$84,701.9	7.7%	\$676,183.3	9.1%
ST16	17	\$2,860.0	1.3%	36	\$8,786.3	7.1%	\$1,072,591.1	8.4%
ST17	17	\$1,605.2	3.2%	25	\$5,926.2	4.5%	\$202,315.2	7.8%
ST18	11	\$956.0	3.9%	71	\$20,576.1	3.4%	\$176,824.9	6.8%
ST19	7	\$1,232.4	2.2%	15	\$85,163.4	4.3%	\$552,184.2	6.2%
ST20	1	\$1.0	0.0%	35	\$24,578.7	6.1%	\$463,412.6	6.2%
ST21	14	\$960.8	2.2%	26	\$18,095.0	4.0%	\$625,489.2	6.0%
ST22	16	\$230.8	0.5%	22	\$50,990.8	5.0%	\$995,600.1	5.5%
ST23	19	\$10,356.5	5.2%	17	\$7,739.4	0.1%	\$563,988.7	5.3%
ST24	19	\$3,948.2	5.1%	0	\$0.0	0.0%	\$307,475.3	5.1%
ST25	5	\$969.6	0.3%	38	\$36,526.9	4.5%	\$194,127.8	4.8%
ST26	18	\$2,811.1	2.5%	31	\$19,239.3	2.0%	\$182,546.6	4.5%
ST27	2	\$124.0	0.0%	10	\$12,738.3	4.3%	\$418,529.4	4.3%
ST28	22	\$3,361.9	4.2%	5	\$626.5	0.0%	\$241,316.1	4.2%
ST29	14	\$946.6	1.9%	35	\$11,411.4	1.5%	\$346,412.8	3.3%
ST30	2	\$192.1	0.1%	53	\$19,804.0	3.1%	\$4,620,553.7	3.1%
ST31	6	\$5,403.3	2.2%	23	\$13,781.7	0.8%	\$617,443.2	3.0%
ST32	2	\$74.3	0.3%	24	\$26,694.5	2.7%	\$477,932.0	3.0%
ST33	22	\$15,587.1	2.6%	15	\$191.9	0.1%	\$2,561,843.7	2.8%
ST34	16	\$7,501.8	2.4%	3	\$48.9	0.3%	\$133,015.1	2.7%
ST35	9	\$691.6	2.7%	0	\$0.0	0.0%	\$264,447.5	2.7%
ST36	11	\$791.7	1.0%	17	\$16,980.8	1.9%	\$289,014.9	2.6%
ST37	11	\$4,758.9	1.9%	6	\$431.8	0.7%	\$109,245.7	2.6%
ST38	1	\$158.1	0.2%	5	\$959.6	2.2%	\$474,575.5	2.2%
ST39	3	\$299.3	1.1%	12	\$2,461.4	0.9%	\$648,537.9	2.0%
ST40	5	\$1,014.9	1.3%	15	\$575.8	0.1%	\$174,969.4	1.4%

State	Medical Review			Data Processing			Sample Paid Amount	FFS Improper Payment Rate
	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate	Number of Sample Improper Payments	Sample Improper Payments	Improper Payment Rate		
ST41	3	\$127.7	0.3%	9	\$5,502.1	1.3%	\$286,374.7	1.3%
ST42	4	\$814.4	0.4%	8	\$74,394.9	0.6%	\$504,981.5	1.1%
ST43	4	\$447.9	0.0%	33	\$5,153.5	1.0%	\$317,030.5	1.0%
ST44	1	\$33.4	0.1%	5	\$206.2	0.4%	\$626,208.6	0.5%
ST45	9	\$1,407.0	0.2%	9	\$2,412.8	0.1%	\$157,297.6	0.3%
ST46	3	\$47.5	0.2%	6	\$202.8	0.1%	\$376,640.1	0.3%

CHIP FFS Payment Errors by Type of Error

Table T5. Summary of CHIP FFS Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,488	\$2,088,932.1	\$2,089,433.6	\$180.1	\$149.3	\$210.8
Insufficient Documentation	316	\$201,328.4	\$201,330.2	\$46.4	\$36.4	\$56.5
Policy Violation	118	\$39,426.6	\$39,440.4	\$43.7	\$19.0	\$68.5
No Documentation	181	\$175,102.0	\$175,108.2	\$23.1	\$17.1	\$29.1
Administrative/Other	45	\$20,608.1	\$20,741.1	\$10.4	\$3.7	\$17.1
Procedure Coding Error	20	\$2,414.2	\$3,757.1	\$3.9	\$1.4	\$6.5
FFS Claim for Managed Care Service	8	\$63,574.1	\$63,574.1	\$3.9	-\$3.0	\$10.7
Pricing Error	188	\$45,360.2	\$284,779.9	\$3.6	\$1.7	\$5.5
Third-party Liability	31	\$2,022.9	\$1,366.7	\$3.5	-\$0.3	\$7.4
Diagnosis Coding Error	9	\$31,119.3	\$42,274.6	\$3.1	-\$1.5	\$7.8
Number of Unit(s) Error	28	\$8,078.1	\$11,952.0	\$2.9	\$0.2	\$5.6
Duplicate Item	14	\$51,991.1	\$51,991.1	\$1.1	\$0.1	\$2.1
Logic Edit	16	\$447.2	\$476.8	\$1.0	\$0.0	\$1.9
Data Entry Error	37	\$32,039.2	\$32,325.1	\$0.9	-\$0.2	\$2.0

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Medically Unnecessary	1	\$95.0	\$95.0	\$0.1	N/A	N/A
Unbundling	1	\$4.8	\$4.8	\$0.0	N/A	N/A
Total	2,501	\$2,762,543.2	\$31,149,173.0	\$327.9	\$285.2	\$370.5

Note: Details do not always sum to the total due to rounding.

CHIP FFS Medical Review Payment Errors

Table T6. Summary of CHIP FFS Medical Review Overall Errors

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Insufficient Documentation	316	\$201,328.4	\$201,330.2	\$46.4	\$36.4	\$56.5
Policy Violation	118	\$39,426.6	\$39,440.4	\$43.7	\$19.0	\$68.5
No Documentation	181	\$175,102.0	\$175,108.2	\$23.1	\$17.1	\$29.1
Administrative/Other	30	\$4,116.6	\$4,259.1	\$5.7	\$1.6	\$9.8
Procedure Coding Error	20	\$2,414.2	\$3,757.1	\$3.9	\$1.4	\$6.5
Diagnosis Coding Error	9	\$31,119.3	\$42,274.6	\$3.1	-\$1.5	\$7.8
Number of Unit(s) Error	28	\$8,078.1	\$11,952.0	\$2.9	\$0.2	\$5.6
Medically Unnecessary	1	\$95.0	\$95.0	\$0.1	N/A	N/A
Unbundling	1	\$4.8	\$4.8	\$0.0	N/A	N/A
Total	704	\$461,685.1	\$31,149,173.0	\$129.1	\$100.9	\$157.3

Note: Details do not always sum to the total due to rounding.

Table T7. Summary of CHIP FFS Medical Review Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Insufficient Documentation	316	\$201,328.4	\$201,330.2	\$46.4	\$36.4	\$56.5
Policy Violation	118	\$39,426.6	\$39,440.4	\$43.7	\$19.0	\$68.5
No Documentation	181	\$175,102.0	\$175,108.2	\$23.1	\$17.1	\$29.1
Administrative/Other	30	\$4,116.6	\$4,259.1	\$5.7	\$1.6	\$9.8
Procedure Coding Error	18	\$2,343.1	\$3,757.1	\$3.5	\$1.0	\$5.9
Diagnosis Coding Error	6	\$27,560.7	\$42,274.6	\$3.1	-\$1.6	\$7.8
Number of Unit(s) Error	28	\$8,078.1	\$11,952.0	\$2.9	\$0.2	\$5.6
Medically Unnecessary	1	\$95.0	\$95.0	\$0.1	N/A	N/A
Unbundling	1	\$4.8	\$4.8	\$0.0	N/A	N/A
Total	699	\$458,055.4	\$31,149,173.0	\$128.6	\$100.4	\$156.8
Note: Details do not always sum to the total due to rounding.						

Table T8. Summary of CHIP FFS Medical Review Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Procedure Coding Error	2	\$71.1	\$3,757.1	\$0.5	-\$0.3	\$1.2
Diagnosis Coding Error	3	\$3,558.6	\$42,274.6	\$0.0	\$0.0	\$0.1
Administrative/Other	0	\$0.0	\$4,259.1	\$0.0	\$0.0	\$0.0
Insufficient Documentation	0	\$0.0	\$201,330.2	\$0.0	\$0.0	\$0.0
Medically Unnecessary	0	\$0.0	\$95.0	\$0.0	N/A	N/A
No Documentation	0	\$0.0	\$175,108.2	\$0.0	\$0.0	\$0.0
Number of Unit(s) Error	0	\$0.0	\$11,952.0	\$0.0	\$0.0	\$0.0
Policy Violation	0	\$0.0	\$39,440.4	\$0.0	\$0.0	\$0.0
Unbundling	0	\$0.0	\$4.8	\$0.0	N/A	N/A
Total	5	\$3,629.7	\$31,149,173.0	\$0.5	-\$0.3	\$1.2
Note: Details do not always sum to the total due to rounding.						

Medical Review Payment Errors: Insufficient Documentation

Table T9. Specific Causes of "Insufficient Documentation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation of patient counseling not provided	86	\$12,887.9	\$12.9	\$8.4	\$17.4
Medical records do not contain daily documentation of specific tasks performed on sampled DOS	34	\$13,887.4	\$9.7	\$2.9	\$16.6
Provider did not supply sufficient documentation to support the claim	67	\$129,817.9	\$7.5	\$4.6	\$10.4
Required progress notes applicable to DOS sampled not provided	37	\$4,392.5	\$5.8	\$2.8	\$8.9
Medical records do not contain the service plan	19	\$17,461.9	\$4.0	\$1.6	\$6.5
Medical records do not contain the provider's order	23	\$1,647.5	\$2.1	-\$0.1	\$4.3
Pharmacy signature log not provided	19	\$5,183.4	\$2.0	\$0.4	\$3.6
Individual plan was provided but not applicable to the sampled DOS	18	\$2,257.5	\$0.8	-\$0.1	\$1.7
Face to face assessment documentation not provided	4	\$525.5	\$0.5	-\$0.3	\$1.3
Provider did not supply a valid prescription	5	\$13,051.1	\$0.5	-\$0.1	\$1.2
Required signed timesheet not provided	3	\$101.3	\$0.4	-\$0.3	\$1.1
Other	1	\$114.7	\$0.0	N/A	N/A
Total	316	\$201,328.4	\$46.4	\$36.4	\$56.5
Note: Details do not always sum to the total due to rounding.					

Medical Review Payment Errors: Policy Violation

Table T10. Specific Causes of "Policy Violation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation does not meet the state policy requirements for the service performed	70	\$13,193.0	\$33.5	\$9.2	\$57.7
Required record of recipient acceptance or refusal of medication counseling not provided	32	\$23,145.8	\$6.3	\$2.1	\$10.4
Required provider signature and/or credentials not provided	12	\$643.6	\$2.7	\$0.6	\$4.7
Other	3	\$216.4	\$1.3	-\$0.7	\$3.3
Service performed is not a covered service	1	\$2,227.9	\$0.0	N/A	N/A
Total	118	\$39,426.6	\$43.7	\$19.0	\$68.5
Note: Details do not always sum to the total due to rounding.					

Medical Review Payment Errors: No Documentation

Table T11. Specific Causes of "No Documentation" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	105	\$58,466.6	\$14.0	\$9.7	\$18.4
Provider states recipient not seen on sampled DOS	23	\$3,632.4	\$3.5	\$0.9	\$6.1
Provider did not have patient on file or in their system	25	\$109,354.6	\$2.5	\$1.1	\$3.8
State could not locate provider	10	\$1,061.9	\$1.7	-\$0.8	\$4.2
Provider did not document the encounter	2	\$215.4	\$0.9	-\$0.6	\$2.3
Other	2	\$943.6	\$0.3	-\$0.2	\$0.7
Provider cannot locate record	9	\$1,111.7	\$0.2	\$0.0	\$0.5
Provider out of business/retired and record is not available	3	\$286.9	\$0.1	-\$0.1	\$0.2
Provider states billed for wrong recipient	1	\$4.0	\$0.0	N/A	N/A
Provider states record destroyed or lost	1	\$25.0	\$0.0	N/A	N/A
Total	181	\$175,102.0	\$23.1	\$17.1	\$29.1
Note: Details do not always sum to the total due to rounding.					

CHIP FFS Medical Review Errors by Service Type

Table T12. CHIP FFS Medical Review Error by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Prescribed Drugs	253	3,169	\$222,715.3	\$2,640,554.0	\$60.8	\$724.3	8.4%	5.1% - 11.6%
Psychiatric, Mental Health, and Behavioral Health Services	83	2,219	\$40,626.3	\$4,149,806.7	\$18.1	\$569.4	3.2%	2.2% - 4.2%
Outpatient Hospital Services and Clinics	56	1,774	\$14,723.6	\$257,217.0	\$10.7	\$415.8	2.6%	1.6% - 3.5%
Dental and Other Oral Surgery Services	50	2,852	\$2,863.0	\$397,807.3	\$8.6	\$733.6	1.2%	0.5% - 1.8%
Physicians and Other Licensed Practitioner Services	58	1,896	\$2,764.1	\$255,540.5	\$8.2	\$468.7	1.8%	1.1% - 2.5%
Inpatient and Outpatient Hospital	55	3,328	\$157,014.5	\$18,066,321.1	\$7.5	\$1,002.4	0.7%	0.2% - 1.2%
Habilitation and Waiver Programs, School Services	50	1,220	\$9,731.8	\$187,705.6	\$6.4	\$157.7	4.1%	1.8% - 6.3%
Personal Support Services	34	546	\$3,616.7	\$85,770.1	\$2.0	\$70.8	2.8%	0.9% - 4.7%
Therapies, Hearing and Rehabilitation Services	10	231	\$966.2	\$16,865.0	\$1.6	\$35.4	4.6%	1.6% - 7.7%
Home Health Services	13	361	\$1,784.9	\$63,271.8	\$1.2	\$17.4	7.1%	(0.2%) - 14.5%
Transportation and Accommodations	7	156	\$720.7	\$58,818.1	\$1.1	\$23.8	4.8%	1.5% - 8.0%
Laboratory, X-ray and Imaging Services	23	728	\$1,577.9	\$18,522.9	\$1.1	\$35.9	3.0%	1.4% - 4.6%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	8	189	\$1,915.4	\$29,287.1	\$0.9	\$28.2	3.1%	1.9% - 4.2%
Vision: Ophthalmology, Optometry and Optical Services	4	327	\$664.8	\$13,638.1	\$0.9	\$63.4	1.4%	1.1% - 1.6%
Capitated Care/Fixed Payments	0	835	\$0.0	\$4,807,482.4	\$0.0	\$115.2	0.0%	0.0% - 0.0%
Crossover Claims	0	261	\$0.0	\$23,639.8	\$0.0	\$0.3	0.0%	0.0% - 0.0%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Denied Claims	0	1,567	\$0.0	\$0.0	\$0.0	\$0.0	N/A	N/A
Hospice Services	0	4	\$0.0	\$1,053.0	\$0.0	\$0.5	0.0%	N/A
ICF for the Mentally Retarded and Group Homes	0	28	\$0.0	\$28,445.1	\$0.0	\$0.2	0.0%	0.0% - 0.0%
Managed Care	0	2	\$0.0	\$92.2	\$0.0	\$9.8	0.0%	N/A
Nursing Facility, Intermediate Care Facilities	0	13	\$0.0	\$47,335.2	\$0.0	\$0.2	0.0%	0.0% - 0.0%
Total	704	21,706	\$461,685.1	\$31,149,173.0	\$129.1	\$4,473.0	2.9%	2.3% - 3.5%
Note: Details do not always sum to the total due to rounding.								

CHIP FFS Data Processing Payment Errors

Table T13. Summary of CHIP FFS Data Processing Overall Improper Payments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,552	\$2,108,418.1	\$2,108,919.6	\$188.0	\$157.1	\$219.0
Administrative/Other	19	\$16,915.7	\$16,913.2	\$5.1	-\$0.2	\$10.3
FFS Claim for Managed Care Service	8	\$63,574.1	\$63,574.1	\$3.9	-\$3.0	\$10.7
Pricing Error	193	\$45,455.5	\$287,959.2	\$3.7	\$1.8	\$5.6
Third-party Liability	31	\$2,022.9	\$1,366.7	\$3.5	-\$0.3	\$7.4
Logic Edit	17	\$471.3	\$500.9	\$1.2	\$0.2	\$2.2
Duplicate Item	15	\$52,258.9	\$52,258.9	\$1.1	\$0.1	\$2.1
Data Entry Error	39	\$32,294.4	\$32,677.5	\$1.0	-\$0.1	\$2.0
Total	1,874	\$2,321,410.8	\$31,149,173.0	\$207.5	\$175.0	\$240.0

Note: Details do not always sum to the total due to rounding.

Table T14. Summary of CHIP FFS Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	1,551	\$2,108,407.2	\$2,108,919.6	\$188.0	\$157.1	\$219.0
Administrative/Other	18	\$16,913.2	\$16,913.2	\$5.1	-\$0.2	\$10.3
FFS Claim for Managed Care Service	8	\$63,574.1	\$63,574.1	\$3.9	-\$3.0	\$10.7
Pricing Error	106	\$42,452.3	\$287,959.2	\$3.1	\$1.3	\$4.9
Third-party Liability	25	\$1,366.7	\$1,366.7	\$1.9	-\$0.1	\$3.9
Logic Edit	14	\$413.8	\$500.9	\$1.2	\$0.1	\$2.2
Duplicate Item	15	\$52,258.9	\$52,258.9	\$1.1	\$0.1	\$2.1
Data Entry Error	39	\$32,294.4	\$32,677.5	\$1.0	-\$0.1	\$2.0
Total	1,776	\$2,317,680.5	\$31,149,173.0	\$205.2	\$172.9	\$237.5

Note: Details do not always sum to the total due to rounding.

Table T15. Summary of CHIP FFS Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Third-party Liability	6	\$656.2	\$1,366.7	\$1.7	-\$1.6	\$4.9
Pricing Error	87	\$3,003.2	\$287,959.2	\$0.6	\$0.1	\$1.1
Administrative/Other	1	\$2.4	\$16,913.2	\$0.0	N/A	N/A
Non-covered Service	1	\$10.9	\$2,108,919.6	\$0.0	N/A	N/A
Logic Edit	3	\$57.6	\$500.9	\$0.0	\$0.0	\$0.0
Data Entry Error	0	\$0.0	\$32,677.5	\$0.0	\$0.0	\$0.0
Duplicate Item	0	\$0.0	\$52,258.9	\$0.0	\$0.0	\$0.0
FFS Claim for Managed Care Service	0	\$0.0	\$63,574.1	\$0.0	\$0.0	\$0.0
Total	98	\$3,730.2	\$31,149,173.0	\$2.3	-\$1.0	\$5.6
Note: Details do not always sum to the total due to rounding.						

Data Processing Payment Errors: Non-covered Service

Table T16. Specific Causes of "Non-covered Service" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
New provider was not enrolled using ACA risk-based criteria	367	\$425,692.7	\$67.0	\$51.3	\$82.7
Referring/ordering provider not enrolled	115	\$319,199.0	\$31.5	\$18.8	\$44.2
Referring/ordering provider required but not listed on the claim	262	\$142,105.4	\$24.4	\$12.5	\$36.2
Provider not enrolled in Medicaid/CHIP	110	\$470,760.1	\$22.8	\$12.6	\$33.1
Attending or rendering provider required but not listed on institutional claim	98	\$278,360.9	\$21.8	\$4.5	\$39.0
Other	464	\$92,907.7	\$13.5	\$10.5	\$16.4
Recipient was ineligible for the applicable program on DOS	118	\$378,497.6	\$6.0	\$2.8	\$9.2
Non-covered based on service location	6	\$138.8	\$0.5	-\$0.2	\$1.2
Required provider license was not current for DOS	7	\$602.2	\$0.3	\$0.0	\$0.7
HCBS was not approved by Service Plan	2	\$94.1	\$0.2	-\$0.1	\$0.5
Prior authorization was required or not current for DOS	2	\$48.8	\$0.1	-\$0.1	\$0.3
Covered service was incorrectly denied	1	\$10.9	\$0.0	N/A	N/A
Total	1,552	\$2,108,418.1	\$188.0	\$157.1	\$219.0
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Administrative/Other

Table T17. Specific Causes of "Administrative/Other" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
State did not provide documentation needed to complete the review	16	\$1,450.6	\$4.9	-\$0.4	\$10.2
Claim was filed untimely	3	\$15,465.1	\$0.2	\$0.0	\$0.4
Total	19	\$16,915.7	\$5.1	-\$0.2	\$10.3
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Pricing Error

Table T18. Specific Causes of "Pricing Error" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
System defect caused incorrect pricing	17	\$11,107.6	\$1.5	\$0.3	\$2.6
System input error caused incorrect pricing	47	\$22,597.4	\$1.4	\$0.2	\$2.5
Incorrect manual calculation was made	4	\$5,883.3	\$0.7	-\$0.4	\$1.7
System calculation was incorrect	108	\$5,778.6	\$0.1	\$0.0	\$0.2
Co-pay should not have been deducted from payment	12	\$40.0	\$0.0	\$0.0	\$0.1
Other	3	\$3.7	\$0.0	\$0.0	\$0.1
Co-pay should have been deducted from payment	1	\$20.0	\$0.0	N/A	N/A
Incorrect co-pay was deducted from payment	1	\$25.0	\$0.0	N/A	N/A
Total	193	\$45,455.5	\$3.7	\$1.8	\$5.6
Note: Details do not always sum to the total due to rounding.					

CHIP FFS Data Processing Errors by Service Type

Table T19. CHIP FFS Data Processing Error by Service Type

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
Prescribed Drugs	394	3,169	\$460,869.6	\$2,640,554.0	\$62.8	\$724.3	8.7%	6.6% - 10.8%
Dental and Other Oral Surgery Services	584	2,852	\$90,747.1	\$397,807.3	\$44.6	\$733.6	6.1%	4.5% - 7.6%
Inpatient and Outpatient Hospital	240	3,328	\$1,161,068.1	\$18,066,321.1	\$33.8	\$1,002.4	3.4%	2.4% - 4.4%
Physicians and Other Licensed Practitioner Services	95	1,896	\$9,545.4	\$255,540.5	\$18.8	\$468.7	4.0%	2.4% - 5.6%
Psychiatric, Mental Health, and Behavioral Health Services	138	2,219	\$555,931.2	\$4,149,806.7	\$17.4	\$569.4	3.1%	2.3% - 3.8%
Outpatient Hospital Services and Clinics	81	1,774	\$10,098.1	\$257,217.0	\$14.7	\$415.8	3.5%	1.4% - 5.7%
Therapies, Hearing and Rehabilitation Services	49	231	\$3,155.7	\$16,865.0	\$5.2	\$35.4	14.6%	8.1% - 21.1%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	31	189	\$2,317.7	\$29,287.1	\$3.6	\$28.2	12.8%	7.7% - 17.9%
Denied Claims	7	1,567	\$659.3	\$0.0	\$1.7	\$0.0	N/A	N/A
Home Health Services	62	361	\$7,756.8	\$63,271.8	\$1.6	\$17.4	9.3%	4.6% - 14.0%
Laboratory, X-ray and Imaging Services	63	728	\$1,652.7	\$18,522.9	\$1.0	\$35.9	2.8%	1.5% - 4.1%
Vision: Ophthalmology, Optometry and Optical Services	12	327	\$612.2	\$13,638.1	\$0.9	\$63.4	1.5%	0.6% - 2.4%
Transportation and Accommodations	8	156	\$987.1	\$58,818.1	\$0.5	\$23.8	1.9%	0.5% - 3.3%
Personal Support Services	11	546	\$1,137.3	\$85,770.1	\$0.4	\$70.8	0.6%	0.2% - 1.1%
Habilitation and Waiver Programs, School Services	8	1,220	\$1,284.9	\$187,705.6	\$0.3	\$157.7	0.2%	0.0% - 0.3%
Crossover Claims	82	261	\$5,652.6	\$23,639.8	\$0.1	\$0.3	39.2%	29.3% - 49.2%

Category	Number of Sample Improper Payments	Number of Claims Sampled	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Projected Paid Amount (millions)	Improper Payment Rate	95% CI
ICF for the Mentally Retarded and Group Homes	5	28	\$7,584.7	\$28,445.1	\$0.0	\$0.2	4.8%	1.0% - 8.5%
Capitated Care/Fixed Payments	3	835	\$201.5	\$4,807,482.4	\$0.0	\$115.2	0.0%	(0.0%) - 0.0%
Hospice Services	1	4	\$148.8	\$1,053.0	\$0.0	\$0.5	1.2%	N/A
Managed Care	0	2	\$0.0	\$92.2	\$0.0	\$9.8	0.0%	N/A
Nursing Facility, Intermediate Care Facilities	0	13	\$0.0	\$47,335.2	\$0.0	\$0.2	0.0%	0.0% - 0.0%
Total	1,874	21,706	\$2,321,410.8	\$31,149,173.0	\$207.5	\$4,473.0	4.6%	4.0% - 5.3%
Note: Details do not always sum to the total due to rounding.								

CHIP Managed Care Component Improper Payment Rate

Table T20. CHIP Managed Care Data Processing Improper Payment Rates by State

State	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Improper Payment Rate	95% CI
National	98	\$5,314.6	\$1,969,293.8	0.4%	0.1% - 0.6%
ST1	4	\$1,104.3	\$36,013.5	1.7%	(0.1%) - 3.4%
ST2	3	\$341.3	\$25,170.3	1.3%	(0.1%) - 2.7%
ST3	2	\$338.5	\$93,204.8	1.2%	(0.5%) - 2.9%
ST4	3	\$558.6	\$53,016.5	1.1%	(0.1%) - 2.3%
ST5	2	\$189.6	\$32,646.6	1.1%	(0.4%) - 2.6%
ST6	2	\$725.1	\$69,148.5	0.5%	(0.2%) - 1.3%
ST7	1	\$92.2	\$23,698.4	0.5%	(0.4%) - 1.4%
ST8	72	\$121.8	\$29,596.3	0.4%	(0.4%) - 1.3%
ST9	1	\$148.8	\$38,491.9	0.3%	(0.3%) - 1.0%
ST10	1	\$118.5	\$53,971.9	0.3%	(0.3%) - 1.0%
ST11	2	\$82.4	\$52,713.5	0.2%	(0.2%) - 0.7%
ST12	2	\$1,462.1	\$209,715.8	0.1%	(0.1%) - 0.4%
ST13	3	\$31.5	\$10,789.0	0.1%	(0.1%) - 0.3%
ST14	0	\$0.0	\$23,327.6	0.0%	0.0% - 0.0%
ST15	0	\$0.0	\$26,481.2	0.0%	0.0% - 0.0%
ST16	0	\$0.0	\$27,337.2	0.0%	0.0% - 0.0%
ST17	0	\$0.0	\$43,631.1	0.0%	0.0% - 0.0%
ST18	0	\$0.0	\$102,333.5	0.0%	0.0% - 0.0%
ST19	0	\$0.0	\$27,437.1	0.0%	0.0% - 0.0%
ST20	0	\$0.0	\$4,759.4	0.0%	0.0% - 0.0%
ST21	0	\$0.0	\$19,095.8	0.0%	0.0% - 0.0%
ST22	0	\$0.0	\$39,137.7	0.0%	0.0% - 0.0%
ST23	0	\$0.0	\$26,683.3	0.0%	0.0% - 0.0%
ST24	0	\$0.0	\$49,891.9	0.0%	0.0% - 0.0%
ST25	0	\$0.0	\$37,656.4	0.0%	0.0% - 0.0%
ST26	0	\$0.0	\$21,721.5	0.0%	0.0% - 0.0%
ST27	0	\$0.0	\$21,264.7	0.0%	0.0% - 0.0%
ST28	0	\$0.0	\$242,633.1	0.0%	0.0% - 0.0%
ST29	0	\$0.0	\$62,370.0	0.0%	0.0% - 0.0%

State	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Improper Payment Rate	95% CI
ST30	0	\$0.0	\$39,410.0	0.0%	0.0% - 0.0%
ST31	0	\$0.0	\$54,294.3	0.0%	0.0% - 0.0%
ST32	0	\$0.0	\$77,539.6	0.0%	0.0% - 0.0%
ST33	0	\$0.0	\$42,378.6	0.0%	0.0% - 0.0%
ST34	0	\$0.0	\$76,738.8	0.0%	0.0% - 0.0%
ST35	0	\$0.0	\$31,447.7	0.0%	0.0% - 0.0%
ST36	0	\$0.0	\$29,119.7	0.0%	0.0% - 0.0%
ST37	0	\$0.0	\$21,761.2	0.0%	0.0% - 0.0%
ST38	0	\$0.0	\$28,706.0	0.0%	0.0% - 0.0%
ST39	0	\$0.0	\$63,959.6	0.0%	0.0% - 0.0%

Note: Details do not always sum to the total due to rounding.

CHIP Managed Care Errors by Type of Error

Table T21. Summary of CHIP Managed Care Data Processing Projected Dollars by Type of Error

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	22	\$5,057.3	\$5,223.8	\$31.4	\$9.2	\$53.6
Rate Cell Error	3	\$153.5	\$202.3	\$1.4	-\$1.3	\$4.1
Third-party Liability	1	\$89.2	\$89.2	\$0.4	N/A	N/A
MC Payment Error	72	\$14.6	\$9,870.3	\$0.0	\$0.0	\$0.0
Total	98	\$5,314.6	\$1,969,293.8	\$33.3	\$10.9	\$55.6

Note: Details do not always sum to the total due to rounding.

CHIP Managed Care Data Processing Payment Errors

Table T22. Summary of CHIP Managed Care Data Processing Overpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service	22	\$5,057.3	\$5,223.8	\$31.4	\$9.2	\$53.6
Rate Cell Error	3	\$153.5	\$202.3	\$1.4	-\$1.3	\$4.1
Third-party Liability	1	\$89.2	\$89.2	\$0.4	N/A	N/A
MC Payment Error	0	\$0.0	\$9,870.3	\$0.0	\$0.0	\$0.0
Total	26	\$5,300.0	\$1,969,293.8	\$33.3	\$10.9	\$55.6
Note: Details do not always sum to the total due to rounding.						

Table T23. Summary of CHIP Managed Care Data Processing Underpayments

Error Type	Number of Sample Improper Payments	Sample Improper Payments	Sample Paid Amount	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
MC Payment Error	72	\$14.6	\$9,870.3	\$0.0	\$0.0	\$0.0
Non-covered Service	0	\$0.0	\$5,223.8	\$0.0	\$0.0	\$0.0
Rate Cell Error	0	\$0.0	\$202.3	\$0.0	\$0.0	\$0.0
Third-party Liability	0	\$0.0	\$89.2	\$0.0	N/A	N/A
Total	72	\$14.6	\$1,969,293.8	\$0.0	\$0.0	\$0.0
Note: Details do not always sum to the total due to rounding.						

Data Processing Payment Errors: Non-covered Service

Table T24. Specific Causes of "Non-covered Service" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Recipient was ineligible for the applicable program on DOS	22	\$5,057.3	\$31.4	\$9.2	\$53.6
Total	22	\$5,057.3	\$31.4	\$9.2	\$53.6
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Rate Cell Error

Table T25. Specific Causes of "Rate Cell Error" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Recipient moved into a different MCO area	1	\$148.8	\$1.4	N/A	N/A
Incorrect rate cell used for aid category	2	\$4.7	\$0.0	\$0.0	\$0.1
Total	3	\$153.5	\$1.4	-\$1.3	\$4.1
Note: Details do not always sum to the total due to rounding.					

Data Processing Payment Errors: Third-party Liability

Table T26. Specific Causes of "Third-party Liability" Error

Cause of Error	Number of Sample Improper Payments	Sample Improper Payments	Projected Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other	1	\$89.2	\$0.4	N/A	N/A
Total	1	\$89.2	\$0.4	N/A	N/A
Note: Details do not always sum to the total due to rounding.					

Appendix 5: Medicaid and CHIP Review Methodology

Medicaid and CHIP FFS claims were subject to data processing review and, if applicable, medical review. Medicaid and CHIP managed care payments were subject only to data processing review. If an error was identified during medical review or data processing review, states were given the opportunity to participate in difference resolution and appeal to CMS. Medicaid and CHIP eligibility cases were reviewed by states.

Medical Review Methodology

From a state’s quarterly sample selection, detailed information on each sampled claim was requested from the state and copies of the relevant medical records were requested from the providers. The medical records were used to perform medical reviews on the claims to validate whether the claim was paid correctly. Each claim was assessed to determine:

- Adherence to state guidelines and policies related to the service type;
- Completeness of medical record documentation to substantiate the claim;
- Medical necessity of the service provided;
- Validation that the service was provided as ordered and billed; and
- Correctness in the coding of the claim.

A medical review error is a payment error that is determined from a review of the medical documentation submitted, the relevant state policies, and a comparison to the information presented on the claim. The medical reviews consisted of reviewing sampled FFS claims for the errors listed in Table Appx.1.

Table Appx.1. Medical Review Error Codes

Error Code	Error	Definition
MR01	No Documentation	The provider did not respond to the request for records or the provider responded that he/she did not have the requested documentation.
MR02	Insufficient Documentation	The provider did not return information requested or did not submit sufficient documentation for the reviewer to determine whether the allowed services were provided at the level billed and/or medically necessary.
MR03	Procedure Coding Error	The provider performed a procedure or provided a medical service that was medically necessary and provided at the proper level of care, but billed and was paid using an incorrect procedure code.
MR04	Diagnosis Coding Error	The provider billed and was paid using an incorrect principal diagnosis code and/or DRG.
MR05	Unbundling	The provider billed for separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set, rather than as individual services.
MR06	Number of Unit(s) Error	The provider billed for an incorrect number of units for a particular procedure/service, NDC code, or revenue code.

Error Code	Error	Definition
MR07	Medically Unnecessary	The provider billed for a service determined to have been medically unnecessary based upon the information regarding the patient's condition in the medical record.
MR08	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.
MR09	Administrative/Other	A payment error was discovered during a medical review, but it was not an MR01 – MR08. The specific nature of the error is recorded.

Data Processing Review Methodology

Data processing reviews were also conducted to validate that each sampled payment was processed correctly based on information found in the state's claims processing system when it was adjudicated compared with:

- State specific policies and fee schedules in effect at the time of payment;
- Beneficiary enrollment; and
- Provider participation in the Medicaid program.

A data processing error is a payment error resulting in an overpayment or underpayment that could be avoided through the state's Medicaid Management Information System (MMIS) or other payment system. Claims not processed through a state's MMIS were subject to validation through a paper audit trail, state summary or other proof of payment. The data processing reviews consisted of reviewing the sampled claims for the errors listed in Table Appx.2.

Table Appx.2. Data Processing Error Codes

Error Code	Error	Definition
DP01	Duplicate Item	An exact duplicate of the claim or payment was previously paid.
DP02	Non-covered Service	The provider was not enrolled in Medicaid/CHIP according to federal regulations and state policy; a claim was missing required attending, referring, or ordering provider NPIs; and/or state policies indicate that the service is not payable under the state plan or for the coverage category under which the person is eligible.
DP03	Managed Care Service	The recipient is enrolled in a managed care plan and the managed care plan should have covered the service rather than being paid under FFS.
DP04	Third-party Liability	Medicaid or CHIP paid for the service as the primary payer, but a third-party carrier should have paid for the service.
DP05	Pricing Error	Payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.
DP06	Logic Edit	A system edit was not in place to follow state policy or a system edit was in place, but was not working correctly and the claim was paid inappropriately.
DP07	Data Entry Error	A claim was paid in error due to clerical errors in the data entry of the claim.
DP08	Rate Cell Error	The recipient was enrolled in managed care and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell.

Error Code	Error	Definition
DP09	Managed Care Payment Error	The recipient was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.
DP10	Administrative/Other	A payment error was discovered during a data processing review, but the error was not a DP01 – DP09 error. The specific nature of the error is recorded.

Difference Resolution

If an error was identified that affected payment, the state was notified and given an opportunity to review the documentation associated with the payment and dispute the error finding. An independent difference resolution review was performed to consider the state’s information and to make a final determination. If the state determined additional review was necessary, the state could then appeal the error finding to CMS.

Errors that were not challenged by the states or upheld following the difference resolution and appeal process were included in the improper payment rate calculation. If a payment error was found in both the data processing review and medical review for a specific claim, the total error amount reported was adjusted to not exceed the total paid amount for the claim, unless the underpayment amount exceeded the original claim amount, such as in the case of zero-paid claims.

Eligibility Review Methodology

The Affordable Care Act created significant changes to Medicaid and CHIP eligibility applicable to all states. 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, for FY 2014 - 2017 (Cycles 3, 1, 2, and 3 respectively), which will be reported in 2015 – 2018, CMS is putting the eligibility component of PERM on hold. During this time Medicaid and CHIP Eligibility Review Pilots will take the place of the PERM state eligibility determination reviews.

All states will participate in Medicaid and CHIP Eligibility Review Pilots to provide more targeted, detailed information on the accuracy of eligibility determinations. The Medicaid and CHIP Eligibility Review Pilots will use targeted measurements to: (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors.

The pilots will also provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS’s approach to rulemaking that it will undertake prior to the resumption of the PERM eligibility measurement component, which will be reported in 2019. PERM managed care and FFS payment reviews are continuing during this period and CMS is continuing to report Medicaid and CHIP improper payment rates based on that data. For reporting comprehensive Medicaid and CHIP program improper payment rates, CMS is using an estimated eligibility component rate based on historical data. This proxy rate will only have an

impact on the national-level improper payment rates, as all state-specific rates will be comprised of only the FFS and managed care components until eligibility is resumed for reporting in 2019.

Claim Categories

Claim categories are listed in Table Appx.3.

Table Appx.3. Claim Categories

Claim Category Code	Claim Category Description
1	Inpatient and Outpatient Hospital
2	Psychiatric, Mental Health, and Behavioral Health Services
3	Nursing Facility, Intermediate Care Facilities
4	ICF for the Mentally Retarded and Group Homes
5	Clinics
6	Physicians and Other Licensed Practitioner Services
7	Dental and Other Oral Surgery Services
8	Prescribed Drugs
9	Home Health Services
10	Personal Support Services
11	Hospice Services
12	Therapies, Hearing and Rehabilitation Services
13	Habilitation and Waiver Programs, School Services
14	Laboratory, X-ray and Imaging Services
15	Vision: Ophthalmology, Optometry and Optical Services
16	Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices and Environmental Modifications
17	Transportation and Accommodations
18	Denied Claims
19	Crossover Claims
30	Capitated Care/Fixed Payments
50	Managed Care
99	Unknown

Appendix 6: Statistical Sampling and Formulae

The sampling process for PERM follows a stratified two-stage design. First, all 50 states plus the District of Columbia were stratified into three strata of 17 states each based on historical total Medicaid FFS expenditures. The top strata consisting of the 17 states with the greatest expenditures were further divided into two strata: a nine state stratum of the largest expenditure states and a stratum with the remaining eight states. The states from each state stratum were selected by random sampling. States were selected to be reviewed on a three year rotation such that 17 different states would be reviewed each year and all states would be reviewed over a three year time span. This sampling of states constitutes the first stage of the sample. Within each sampled state the universe of claims was then further stratified. The sampled claims were subject to medical and data processing reviews, as appropriate, to identify proper and improper payments. As a result of the reviews, state level improper payment rates were calculated.

The state level improper payment rate is estimated by the following equation.

$$\hat{R}_i = \frac{\hat{t}_{e_i}}{\hat{t}_{p_i}}$$

In the equation, \hat{R}_i is the estimated improper payment rate for state i; \hat{t}_{e_i} is the estimated dollars in error projected for state i; and \hat{t}_{p_i} is the estimated total payments for state i. Then,

$$\hat{t}_{e_i} = \sum_{j=1}^J \frac{M_{i,j}}{m_{i,j}} E_{i,j}$$

and

$$\hat{t}_{p_i} = \sum_{j=1}^J \frac{M_{i,j}}{m_{i,j}} P_{i,j}$$

In these equations, $M_{i,j}$ is the number of items in the universe for state i in strata j and $m_{i,j}$ is the number of items in the sample for state i in stratum j. The ratio of items in the universe to items in the sample (i.e., the weight for that stratum, quarter, and state) is the inverse of the sampling frequency. Dollars in error in the sample for stratum j and state i, denoted $E_{i,j}$, is weighted by the inverse of the sampling frequency to estimate dollars in error in the universe for that stratum. For example, if there are 10,000 items in the universe in stratum j, and the sample size in j is 200 items, the weight for the dollars in error in the stratum j sample is 50 (10,000 divided by 200). The estimated total dollars in error are then added across each of the J strata to obtain total dollars in error for the universe. Total payments are estimated in the same way, where $P_{i,j}$ is the total payments in the sample in stratum j for state i.

Cycle-Specific Statistics

To go from the improper payment rates for individual states to a cycle-specific improper payment rate, each state is first benchmarked to its reported payments. Then, the error and payment amounts are summed across the cycle states and divided to calculate the cycle rate. This ensures that the states' payment and error amounts will be proportional to the size of the state. In other words, a larger state would contribute more to the cycle-specific improper payment rate than a smaller state.

The formula for the 17 state cycle improper payment rate is as follows.

$$\hat{R}_H = \frac{\sum_{i=1}^u t_{pi} \hat{R}_i}{t_h}$$

where:

\hat{R}_H = 17 state cycle improper payment rate.

t_{pi} = total payments for state i.

\hat{R}_i = estimated improper payment rate for state i.

u = total number of states sampled in the cycle (17 for Medicaid and CHIP).

t_h = total universe payments for the 17 states in the cycle.

Rolling National Improper Payment Rates

The rolling national improper payment rates are calculated using the same approach as for the 17 state cycle improper payment rate. In 2015, the rolling national improper payment rates for Medicaid and CHIP are calculated from data sampled in 2013, 2014, and 2015. Each of the rolling improper payment rates (i.e., total program, FFS, MC, and Eligibility) is calculated with the same methodology. As previously mentioned, for the current measurement, eligibility reviews are on hold and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology.

Data from 2013, 2014, and 2015 are combined and weighted by each state's expenditures from the year they were sampled. The formula for the rolling improper payment rate is as follows.

$$\hat{R}_T = \frac{\sum_{i=1}^s t_{p_i} \hat{R}_i}{t_p}$$

where:

\hat{R}_T = rolling improper payment rate.

t_{p_i} = total payments for state i.

\hat{R}_i = estimated improper payment rate for state i.

s = total number of states sampled (51 for Medicaid and CHIP).

t_p = total universe payment.

Combining Claims Review Improper Payment Rates across Program Components

Combining the claims review improper payment rates, (i.e., combining the FFS and managed care improper payment rates for Medicaid) is relatively straightforward because the population payments are known from federal financial management reports. Note that CMS does not utilize true population payments in calculating state rates for each program component. The reason for this is two-fold. First, the combined ratio estimator used allows for correction in possible bias if the sampled average payment amount differs from the universe average payment amount. However, if CMS utilized a combined ratio estimator to combine the program components at the state level, one program component that realized high sample average payment amount compared to the universe average would have too much influence in projections. For this reason, combining program component rates using the shares of expenditures as weights reduces the variance in the estimates from this source. Furthermore, following this method allows the same method for combining program component claims review rates at the state, cycle-specific, and national level.

The following equations utilize the estimated state, cycle-specific, or national improper payment rates calculated in the previous three sections.

Let the overall claims review improper payment rate for Medicaid/CHIP be defined as:

$$\hat{R}_C = \frac{t_{p_{FFS}} \hat{R}_{FFS} + t_{p_{MC}} \hat{R}_{MC}}{t_p}$$

where:

$$t_p = t_{p_{FFS}} + t_{p_{MC}}$$

In this equation, \hat{R} is the estimated improper payment rate for FFS, managed care, or combined (C) and t represents total payments for FFS, managed care, or the total, depending upon the subscript.

Improper Payment Rate Formula

Sampled claims or cases are subject to reviews and an improper payment rate is calculated based on those reviews. The improper payment rate is an estimate of the proportion of improper payments made in the Medicaid/CHIP program to the total payments made.

The national rolling improper payment rate was computed using a separate ratio estimator, which combines the improper payment rates from each state using the federally reported Medicaid/CHIP expenditures for those states. This method projects the improper payments and total payments using the sampling frequency of units from the state. State, cycle-specific, and national rolling rates are calculated for each program component—FFS, managed care, and eligibility—and are also combined into an overall rate, representing the total improper payment rates for the program at the state, cycle-specific, and national levels.

For the calculation of state level statistics, the improper payment rate estimator is a combined ratio estimator. The numerator consists of estimated dollars in error in the universe and the denominator is estimated total payments, both projected from the sample on the basis of the sampling weights (i.e., the inverses of the sampling frequencies). The sample is drawn from a universe that is divided into the strata relevant to that universe, as described above. The sample dollars in error and sample payments are weighted by the inverse of the strata sampling frequencies to estimate universe values. The sampling frequencies, which are the rates at which items were sampled, vary by stratum.

To calculate the cycle-specific or national rolling improper payment rate based on the individual state improper payment rates, each state is first benchmarked to its reported payments. Then, the error and payment amounts are summed across the cycle states or all 51 states and divided in order to calculate the improper payment rate.

Eligibility Improper Payment Rate Formula

From 2015 – 2018, eligibility reviews are on hold and the 2014 national eligibility improper payment rate (results from the most recent cycles prior to 2015) is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology. The eligibility rates used as a proxy in the 2015 improper payment rate were the same eligibility rates used in the 2014 improper payment rate, comprising findings from states participating in the 2012, 2013, and 2014 PERM cycle measurements.

Combining the Claims and Eligibility Improper Payment Rates

After combining the FFS and managed care components into one overall claims improper payment rate for Medicaid at the state, cycle-specific, and national rolling levels, these combined claims and managed care improper payment rates are then combined with the respective eligibility improper payment rates. The combining of the claims improper payment rate and the eligibility improper payment rate is referred to as the combined improper payment rate. The

following procedure is followed at the state, cycle-specific, and national rolling levels. That is, the claims improper payment rates are combined at the state level and combined in separate instances at the cycle-specific level and then at the national level. The estimated combined improper payment rate is given by:

$$\hat{R}_T = \hat{R}_C + \hat{R}_E - \hat{R}_E \hat{R}_C$$

where:

\hat{R}_T denotes the estimated Total, or Combined Improper Payment Rate.

\hat{R}_C denotes the estimated Claims Improper Payment Rate.

\hat{R}_E denotes the estimated Eligibility Improper Payment Rate.

Note that the current national rolling improper payment rate uses a proxy rolling eligibility component rate from 2014.