Medicaid and CHIP 2013 Improper Payments Report

EXECUTIVE SUMMARY

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), requires the heads of federal agencies to annually review programs that they administer to:

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

The Centers for Medicare & Medicaid Services (CMS) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. CMS measures Medicaid and CHIP improper payments annually through the Payment Error Rate Measurement (PERM) program. The PERM program reviews three payment components: fee-for-service (FFS) claims, managed care capitation payments, and the payments resulting from eligibility determinations.

The PERM program uses a 17-state three-year rotation cycle for measuring improper payments, such that CMS measures a third of the states each fiscal year (FY). Official Medicaid and CHIP program error rates are rolling error rates that 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. Table 1, below, summarizes the 2013 national Medicaid and CHIP error rate findings and projected improper payments by component.[1]

[1] Note that the reported CHIP rate in Table 1 reflects only two measurement cycles (34 states), as the Children's Health Insurance Program Reauthorization Act of 2009 and the Medicaid Extenders Act of 2010 suspended the PERM measurement for CHIP from 2009 through 2011.

Table 1. 2013 National Medicaid and CHIP Improper Payment Rates

Component	Error Rate	Total Projected Improper Payments ($Billions)	Federal Share Projected Improper Payments ($Billions)
MEDICAID			
FFS	3.6%	$10.9	$6.3
Managed Care	0.3%	$0.4	$0.2
Eligibility	3.3%	$14.0	$8.1
Overall	**5.8%**	**$24.9**	**$14.4**
CHIP			
FFS	5.7%	$0.3	$0.2
Managed Care	0.2%	$0.0	$0.0
Eligibility	5.1%	$0.7	$0.5
Overall[2]	**7.1%**	**$0.9**	**$0.6**

While the cause of any given error is often specific to each state in the measurement, there are high-level findings that were consistent across all states, as outlined below.

- **Eligibility was the primary driver of the error rate for Medicaid and CHIP:** Consistent with previous years, the eligibility component was the most significant contributor to the overall estimate of projected improper payments. For both Medicaid and CHIP, individuals enrolled who were ineligible for the respective program was the main source of error.
- **Overpayments constituted the overwhelming majority of Medicaid and CHIP improper payments:** Underpayments accounted for just 3.1% of all improper Medicaid payments and 1.8% of all improper CHIP payments.
- **Managed care was less prone to PERM errors than FFS for Medicaid and CHIP:** Managed care continued to be the smallest contributor to the overall error rate. 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. Based on data processing reviews, far fewer processing errors were identified for managed care payments than FFS payments (for which PERM looks at the FFS payments states make to providers).
- **Medicaid FFS improper payments were primarily due to provider documentation:** Most Medicaid FFS projected improper payments resulted from providers failing to submit the necessary documentation to support the claim.
- **Medicaid FFS improper payments primarily occurred in Habilitation and Waiver Programs:** Most Medicaid FFS projected improper payments occurred in claims submitted for Habilitation and Waiver programs.

[2] The overall program payment error 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.

- **CHIP FFS improper payments were primarily due to policy violations:** Most CHIP FFS projected improper payments resulted from provider documentation that failed to abide by a state's policies in existence at the time of the claim's payment.
- **CHIP FFS improper payments primarily occurred in Pharmacy services:** Most CHIP FFS projected improper payments occurred in pharmacy claims.

The national Medicaid error rate has decreased each year since the 2010 baseline Medicaid error rate of 9.4%. Each group of 17 states has been reviewed under PERM twice. For each group of states, the error rate decreased from the first PERM review to the second PERM review. Specifically, the group of 17 states measured in 2013 decreased their Medicaid error rate from 9.0% in 2010 to 5.7% in 2013.

Similar analysis for the national and cycle CHIP error rates cannot be completed until a cycle of states is reviewed under PERM a second time. Since only 34 states have been measured for CHIP, we cannot attribute increases or decreases in the rolling CHIP rate to improvement/regression in a given cycle of states. Once all 50 states and DC have been measured in 2014 and states are measured for a second time beginning in 2015, we can attribute changes in the rolling rate to improvement/regression from the last time a cycle of states was measured.

PERM Program Background and Results

PERM Program Objectives

The federal government is the primary source of funding for the Medicaid and CHIP programs and is 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.

The PERM program is a joint effort between CMS and the states to calculate the Medicaid and CHIP program improper payment rates. To meet this objective, the PERM program uses a 17-state three-year rotation cycle for measuring improper payments, so that CMS measures each state once every third fiscal year. The states in each cycle are shown in Table 2 below.

Table 2. States in Each Cycle

Cycle 1 (Measured in 2013)	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2 (Measured in 2011)	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 (Measured in 2012)	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington.

PERM Improper Payment Rate Calculation Process

Measuring improper payments in Medicaid and CHIP is complex. Each state has considerable flexibility in structuring its program, which results in variation even among Medicaid and CHIP programs that are similar in size and population. However, the PERM methodology supports a consistent measurement across states and programs through standardized data collection, rigorous quality control review of submitted data, and a sampling methodology that ensures a statistically valid random sample is used to calculate improper payments. The resulting improper payment error rate reflects all Medicaid and CHIP benefit payments matched with federal funds during the report period.[3] It is important to note that, given the time necessary to complete reviews and calculate rates, the 2013 Medicaid and CHIP improper payment rates represent a review period (i.e., the time period from which the sampled claims were actually paid) encompassing FY 2009 through FY 2012.

[3] Because the PERM program utilizes a random selection process, provider billing patterns or trends that may indicate potential fraud cannot be identified. Therefore, the PERM program can neither label a claim fraudulent nor identify the rate of fraud.

PERM measures improper payments in three components of Medicaid and CHIP: FFS claims, managed care payments,[4] and 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. Below we describe each step of the calculation process and high-level review findings regarding the 2013 Medicaid and CHIP error rates.

Sample Selection

Selecting the random sample is the first step in the PERM process. Federal contractors take random samples of FFS and managed care payment data that states submit on a quarterly basis.[5] For the eligibility reviews, states select monthly random samples of active and negative cases. Active cases contain information on a beneficiary who is enrolled in the Medicaid or CHIP program in the sample month. Negative cases contain information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated in the sample month.

This sampling methodology complies with all statutory requirements and Office of Management and Budget (OMB) guidance. 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 error rate and standard error.[6] The maximum sample size is set at 1,000 for each component in each state. Table 3 shows the combined sample size selected from the 17 states in each cycle for the three most recent reporting years by component.

Table 3. Sample Sizes by Cycle and Claim Type[7]

Claim Type	2011 Cycle 2	2012 Cycle 3	2013 Cycle 1
MEDICAID			
FFS	9,222	6,562	6,696
Managed Care	4,492	2,917	3,214
Eligibility Active	7,243	7,834	8,286
Overall	**20,957**	**17,313**	**18,196**

4 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.

5 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 five states for Medicaid and in three states for CHIP across the three cycles.

6 Standard error is a measure of variability for the estimated error rate.

7 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 error rate has no associated payments and is not included in the payment weighted rolling rate, the sample sizes are not provided in Table 3.

Claim Type	2011 Cycle 2	2012 Cycle 3	2013 Cycle 1
CHIP			
FFS	N/A	7,599	7,993
Managed Care	N/A	3,391	3,906
Eligibility Active	N/A	8,469	8,621
Overall	**N/A**	**19,459**	**20,520**

Once the samples are selected, the claims and cases are reviewed for accuracy. The following sections include specific information on each review type and its implications for the states as well as additional information on the review process.

Data Processing Reviews

The federal contractor conducts data processing reviews on each sampled FFS claim and managed care payment. 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 are subject to validation through a paper audit trail, state summary, or other proof of payment. Below, both FFS and managed care data processing review errors are discussed in more detail.

FFS Data Processing Errors

Medicaid and CHIP claims payments and certain fixed payments are reviewed to determine whether the payment was made for the correct amount, for the correct and eligible beneficiary, and to the correct and eligible provider. During the data processing FFS review, the reviewers determine: the aid category of the beneficiary for the date of service; 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, or if another insurance should have covered the service; and whether that payment was properly considered. The providers (billing, servicing, and referring/ordering) have their Medicaid enrollment and licensing (when required) verified. The claim is then manually re-priced based on state policy. Claim history is also checked to identify adjustments made within 60 days of the original payment and any potential duplicate payments.

Table 4 below shows the count of payment errors by error type as well as the corresponding projected improper payments for Medicaid and CHIP FFS data processing errors in all 50 states and the District of Columbia.

Table 4. Percentage and Projected Dollar Amount of FFS 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				
Logic Edit	22	6.6%	$1,631.2	47.1%
Non-Covered Service	109	32.6%	$923.1	26.7%
Pricing Error	138	41.3%	$374.4	10.8%
Administrative/Other	21	6.3%	$235.1	6.8%
FFS Claim for Managed Care Service	21	6.3%	$152.2	4.4%
Third-Party Liability	13	3.9%	$124.7	3.6%
Duplicate Item	9	2.7%	$19.4	0.6%
Data Entry Error	1	0.3%	$0.4	0.0%
Managed Care Payment Error	0	0.0%	$0.0	0.0%
Rate Cell Error	0	0.0%	$0.0	0.0%
Total	**334**	**100.0%**	**$3,460.5**	**100.0%**
CHIP				
Non-Covered Service	102	24.9%	$36.4	46.2%
Administrative/Other	58	14.2%	$20.7	26.2%
FFS Claim for Managed Care Service	32	7.8%	$9.2	11.7%
Pricing Error	169	41.3%	$8.5	10.8%
Logic Edit	24	5.9%	$2.8	3.6%
Third-Party Liability	18	4.4%	$0.9	1.1%
Duplicate Item	6	1.5%	$0.3	0.4%
Data Entry Error	0	0.0%	$0.0	0.0%
Managed Care Payment Error	0	0.0%	$0.0	0.0%
Rate Cell Error	0	0.0%	$0.0	0.0%
Total	**409**	**100.0%**	**$78.8**	**100.0%**
Note: Details do not always sum to the total due to rounding.				

For Medicaid claims sampled, the top three error types, representing 84.6% of total projected dollars in error, were: Logic Edit; Non-Covered Service; and Pricing. For CHIP claims sampled, the top three error types, representing 84.1% of total projected dollars in error, were: Non-Covered Service; Administrative/Other; and FFS Claim for Managed Care Service. With respect to both Medicaid and CHIP, Pricing Errors had the highest count of data processing errors, but accounted for significantly fewer projected dollars in error than other error types, probably because pricing errors tended to be smaller dollar errors.

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.

Example #1: In one state, if a provider files a claim after the timeframe allowed from when the service was provided, they have to enter a code indicating the "good cause" reason for why the claim is being submitted late. The provider entered a code indicating delayed eligibility determination was the reason for the delayed billing. However, the system showed the recipient had been continuously eligible since 1990. There was no system edit in place to evaluate the validity of the reason code entered.

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 for the service. The most common reasons a recipient would not be eligible for the service include: the recipient is not eligible for the program billed; the recipient was deceased on the date of service; the service billed is not covered for the recipient; the recipient has moved out of state; or the service requires a prior authorization which was not on record for the date of service. There are many reasons why a provider might not be eligible for payment, including: the provider was not enrolled or licensed on the date of service; the provider did not have a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file; or the provider did not meet some other criteria required by the state to receive payment.

Due to new regulations under the Affordable Care Act (ACA) and the implementation of these new regulations at the state level, a number of Non-Covered Service errors were cited because not all states implemented these new regulations in a timely manner.

Example #1: The prescribing provider on a claim was not enrolled as a participating Medicaid provider. Per the federal regulation which implemented the ACA, all ordering or referring physicians are required to be enrolled as participating providers. Services that require an ordering/prescribing/referring provider must include the National Provider Identifier (NPI) of the provider on the claim and that provider must be enrolled in Medicaid before the claim can be paid.[8] If the NPI is not on the claim or the provider is not enrolled, the claim must be denied. The state was awarded an extended period of time to implement the new federal regulations under the ACA through a state plan amendment; however, this claim was paid several months after that extension expired and therefore was not exempted and deemed an error.

Example #2: A claim paid for a 22-year-old recipient in a CHIP aid category but the recipient was not eligible for CHIP due to age (CHIP recipients in this state are no longer eligible when they reach 19 years of age). The claim was paid with federal CHIP funds; however, the recipient had "aged out" of the program three years earlier. Thus, the claim was cited in error.

[8] 42 C.F.R. § 455.410

Administrative/Other Errors

The Administrative/Other type of error is used when the error does not accurately fit within the other error types. The most common types of errors cited under this category are errors for paying claims that were not filed timely or when the state has been unable to the supply the supporting documentation to support the payment. This could include recipient information, provider information, or pricing methodology.

Example #1: The pricing of a CHIP claim could not be verified against the published fee schedules for the dates of service. Since the state did not have documentation to support the paid amount, it was cited as an error. Additionally, for this claim the state did not have other critical documentation such as documentation of the infant formula provided, the rate on file at the time the claim was adjudicated, documentation of the servicing (rendering) provider's name, and verification of Medicaid/CHIP provider enrollment for the dates of service.

Pricing Errors

A Pricing error can occur for a number of reasons, including: the system calculation may have been programmed incorrectly or a manual calculation may be incorrect; the rate was entered or one component of the rate computation may have been entered incorrectly, resulting in a wrong payment; or a copayment is deducted when it does not apply to the recipient or type of claim. For the Long-Term Care program, errors are often caused when the patient liability amount is incorrect, not deducted, or deducted from recipient and not subject to cost sharing.

Example #1: A recipient copayment was deducted from an inpatient hospital claim for a pregnancy-related service. Per federal regulation, services furnished to pregnant women are excluded from cost-sharing obligations if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy. Cost-sharing cannot be imposed for pregnancy-related services except for services specified in the state's plan amendment as not pregnancy-related. Because federal regulations do not allow copayments to be charged for pregnancy-related services, an error resulted for the amount of the copayment.

Managed Care Data Processing Errors

Capitation payments made to at-risk managed care health plans are also sampled for review. 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 location. 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 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. The payment is also reviewed for duplicates and adjustments made within 60 days of the original payment under review.

Table 5 shows the breakdown of data processing errors in managed care for both Medicaid and CHIP identified in all 50 states and the District of Columbia.

Table 5. 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	28	25.9%	$341.9	87.3%
Duplicate Item	4	3.7%	$38.4	9.8%
Pricing Error	6	5.6%	$5.6	1.4%
Managed Care Payment Error	68	63.0%	$4.4	1.1%
Logic Edit	1	0.9%	$1.0	0.3%
Rate Cell Error	1	0.9%	$0.1	0.0%
Administrative/Other	0	0.0%	$0.0	0.0%
Data Entry Error	0	0.0%	$0.0	0.0%
FFS Claim for Managed Care Service	0	0.0%	$0.0	0.0%
Third-Party Liability	0	0.0%	$0.0	0.0%
Total	**108**	**100.0%**	**$391.5**	**100.0%**
CHIP				
Non-Covered Service	10	8.6%	$18.5	98.2%
Pricing Error	1	0.9%	$0.2	1.2%
Managed Care Payment Error	105	90.5%	$0.1	0.6%
Administrative/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%
Rate Cell Error	0	0.0%	$0.0	0.0%
Third-Party Liability	0	0.0%	$0.0	0.0%
Total	**116**	**100.0%**	**$18.9**	**100.0%**
Note: Details do not always sum to the total due to rounding.				

Non-Covered Service errors represented 87.3% of the total projected dollars in error for Medicaid and 98.2% of the total projected dollars in error for CHIP.

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 either CHIP or Medicaid for the period under review, or had passed away prior to the capitation payment to the health plan. For the CHIP program, some errors were cited because the recipient had "aged out" of the CHIP program.

Example #1: A state relied on the State Department of Vital Statistics to report or verify deaths, and the department was up to nine months behind in reporting. The state made a payment for a recipient that passed away eight months prior to the managed care capitation coverage month. The state continued to pay the capitation payments after the date of death because it was not notified or could not verify the date of death. Thus, the payment was an error.

Example #2: A payment was made for a recipient that was Medicaid eligible and enrolled before the CHIP capitation payment processed and therefore should have been disenrolled from CHIP. Per federal regulation, if a CHIP application is made for a child but the child is found to be Medicaid eligible, the child must be enrolled in Medicaid. In this case the state made CHIP capitation payments for a child terminated from the CHIP program because the child had been approved for Medicaid. The system was not updated timely in changing the recipient from CHIP to Medicaid, resulting in payments made from CHIP funds instead of Medicaid funds. Thus, the payment was cited as an error for CHIP.

Medical Reviews

FFS Medical Review Errors

After a FFS claim is 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[9].

The initial request for medical records is made via letter. Phone calls are also made to validate the provider's contact information and to address any questions or concerns pertaining to the documentation request. If the provider fails to respond to the initial request, the PERM program sends reminder requests. If no documentation is received within 75 days of the initial request, the claim is cited as an improper payment due to a "no documentation error." Any documentation received after the 75th day is considered late documentation. If late documentation is received by the PERM contractor prior to the cut-off date for the receipt of documentation, the records are reviewed in the same fashion as if the documentation was submitted timely.

[9] 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 error 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 error 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.

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 from a review of the medical documentation submitted, any relevant federal and state policies, and a comparison with the information presented on the claim. These reviews are conducted to assure completeness of documentation to substantiate the claims, medical necessity of the services performed, validation the services were provided as ordered and billed, and the claims were correctly coded.

Table 6 shows the medical review errors found by error type and the associated projected dollars in error identified in all 50 states and the District of Columbia.

Table 6. Percentage and Projected Dollar Amount of FFS Medical Review 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				
Insufficient Documentation	310	40.3%	$3,647.0	47.8%
Policy Violation	100	13.0%	$1,383.9	18.2%
No Documentation	123	16.0%	$1,348.1	17.7%
Administrative/Other	30	3.9%	$442.9	5.8%
Number of Unit(s) Error	125	16.3%	$420.8	5.5%
Diagnosis Coding Error	58	7.5%	$277.6	3.6%
Procedure Coding Error	18	2.3%	$91.3	1.2%
Medically Unnecessary	5	0.7%	$12.5	0.2%
Unbundling	0	0.0%	$0.0	0.0%
Total	**769**	**100.0%**	**$7,624.1**	**100.0%**
CHIP				
Policy Violation	153	28.4%	$95.9	47.3%
Insufficient Documentation	161	29.9%	$46.7	23.0%
No Documentation	91	16.9%	$29.0	14.3%
Administrative/Other	33	6.1%	$11.0	5.4%
Diagnosis Coding Error	13	2.4%	$7.2	3.6%
Number of Unit(s) Error	54	10.0%	$6.5	3.2%
Procedure Coding Error	30	5.6%	$5.5	2.7%
Medically Unnecessary	4	0.7%	$0.7	0.3%
Unbundling	0	0.0%	$0.0	0.0%
Total	**539**	**100.0%**	**$202.5**	**100.0%**
Note: Details do not always sum to the total due to rounding.				

The top three error types, representing 83.7% of all projected dollars in error, in the order of significance, for Medicaid claims sampled were: Insufficient Documentation; Policy Violation; and

No Documentation. The top three error types, representing 84.6% of all projected dollars in error, in the order of significance, for CHIP claims sampled were: Policy Violation; Insufficient Documentation; and No Documentation. The most significant error types for both programs were identical, but the order of significance varied by program.

Insufficient Documentation Errors

Insufficient Documentation means there is not enough documentation to support the service. The provider did not supply sufficient documentation to determine the medical necessity of the claim, or the medical records do not contain documentation of tasks performed on the date of service (DOS) billed, for example, physician orders and progress notes for each encounter. Insufficient Documentation errors accounted for 48% of the total projected dollars in error for Medicaid and 23% of the total projected dollars in error for CHIP. The most common causes of this error type were:

- Missing physician, dental, and/or encounter progress notes;
- Missing physician orders; and
- Missing service plans, plans of care, or treatment plans.

Example #1: A Medicaid provider submitted a claim for a physician visit to a beneficiary located in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/MR).[10] The provider did not submit the required physician's progress notes to support that a physician visited the resident timely. Therefore, the claim was cited in error.

Example #2: A CHIP provider submitted a claim for mental health services provided but did not submit the required progress note for the sampled date of service. State policy requires that documentation must be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, must consist of records that include: specific services rendered; date and actual time the services were rendered; place the services were rendered; length of service; and progress notes for each service provided, which includes information on patient response to treatment rendered. Therefore, the claim was cited in error.

Example #3: A Nursing/Intermediate Care Facility claim was submitted and the documentation did not support room and board services on the sampled dates of service. The provider did not submit documentation of daily patient presence in the facility, physician orders, nursing/treatment notes, or flow-sheets. Per state policy, the date and reason for a service must be included and the documentation must support the level of service billed. The claim was determined to be an Insufficient Documentation error.

Policy Violation Errors

Claims in error are placed into this error type when the medical documentation submitted is not in compliance 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

[10] Note that the program name is now referred to as the Intermediate Care Facilities for Individuals with Intellectual Disabilities but Federal regulations and statute still use the term "Mental Retardation" and the acronym renams ICF/MR.

specific policies to qualify for reimbursement. Policy Violation errors accounted for 18% of the total projected dollars in error for Medicaid and 47% of the total projected dollars in error for CHIP. The most common causes of this error type in order of significance were:

- No record of patient counseling offered, accepted, or rejected for dispensed prescriptions;
- No signature logs maintained for proof of delivery or pickup of prescriptions;
- No signature on plans of care/service plans authorizing treatment or service;
- Physician progress notes not maintained timely, signed, and/or dated; and
- No service start and stop times recorded to verify total time billed for procedures or services.

Example #1: A Medicaid provider submitted a claim for room and board services provided to a beneficiary residing in a Nursing/Intermediate Care Facility. The physician's progress notes submitted by the provider were dated one month after the dates of service under review. In accordance with state policy and federal regulations, physician progress notes must be written at the time of each visit, dated, and signed by the physician. Progress notes must be written at least every 60 days on skilled care patients and every 120 days on others. No additional progress notes were submitted to cover the date of service on the claim. Therefore, the claim was not supported as billed.

Example #2: A CHIP provider did not submit the requested documentation of the client or their representative's signature for receipt of the prescription for 125 units of a drug as required in state policy. Pharmacy providers must obtain a signature of the client or their representative upon receipt of a covered medication by the client or representative. The state reserves the right to recoup monies paid when a signature is not on file. Therefore, the claim was not supported as billed.

Example #3: A CHIP provider submitted a pharmacy claim for hydrocortisone cream. Documentation of client/representative acceptance/refusal of verbal counseling was not included in the records. As required per state policy, a pharmacist, or a pharmacy intern or student participating in an approved College of Pharmacy coordinated practical experience program and working under the direct supervision of a pharmacist, shall, with each new medication dispensed, provide verbal counseling to the patient or the patient's agent on pertinent medication information. Since no documentation was submitted to confirm that medication counseling was offered, the claim was not supported as billed.

No Documentation Errors

Claims are placed into this category when either the provider or supplier fails to respond to repeated attempts to obtain the supporting documentation or the provider or supplier responds that they do not have the requested records or submit illegible records. No Documentation errors accounted for 18% of the projected dollars in error for Medicaid and 14% of the projected dollars in error for CHIP.

Service Type Analysis

Table 7 shows the national FFS error rate and projected improper payments broken down by service type. The table presents the top ten service types in terms of projected dollars in error and combines

the remaining service types for Medicaid and CHIP. It includes both data processing and medical review errors.

Table 7. FFS Error Rate and Projected Improper Payments by Service Type

Service Type	Number of Sample Payment Errors		Projected Dollars in Error		Error Rate
	Number of Sample Payment Errors	% of Total Number of Errors	Projected Dollars in Error ($Millions)	% of Projected Dollars in Error	
Medicaid					
Habilitation and Waiver Programs	226	21.0%	$2,248.2	20.7%	5.8%
Nursing Facility, Intermediate Care Facilities	126	11.7%	$1,504.8	13.9%	2.5%
Prescribed Drugs	101	9.4%	$1,139.3	10.5%	3.7%
Psychiatric, Mental Health, and Behavioral Health Services	64	6.0%	$893.7	8.2%	5.3%
ICF for the Mentally Retarded and Group Homes	38	3.5%	$766.8	7.1%	7.4%
Outpatient Hospital Services and Clinics	76	7.1%	$732.0	6.7%	4.2%
Personal Support Services	72	6.7%	$707.9	6.5%	2.9%
Inpatient Hospital	134	12.5%	$528.1	4.9%	1.5%
Physicians and Other Licensed Practitioner Services	65	6.0%	$525.5	4.8%	3.9%
Dental and Other Oral Surgery Services	20	1.9%	$442.8	4.1%	6.1%
All Other Service Types	153	14.2%	$1,367.1	12.6%	2.9%
Total	**1,075**	**100.0%**	**$10,856.1**	**100.0%**	**3.6%**
CHIP					
Prescribed Drugs	223	24.8%	$104.5	40.1%	8.2%
Physicians and Other Licensed Practitioner Services	105	11.7%	$34.9	13.4%	6.9%
Outpatient Hospital Services and Clinics	91	10.1%	$26.3	10.1%	4.3%
Inpatient Hospital	80	8.9%	$23.5	9.0%	3.4%
Psychiatric, Mental Health, and Behavioral Health Services	108	12.0%	$23.2	8.9%	5.0%
Dental and Other Oral Surgery Services	69	7.7%	$11.4	4.4%	2.1%
Habilitation and Waiver Programs	55	6.1%	$11.1	4.3%	10.7%
Therapies, Hearing and Rehabilitation Services	21	2.3%	$10.2	3.9%	29.1%
Home Health Services	23	2.6%	$3.7	1.4%	16.5%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices and Environmental Modifications	8	0.9%	$3.1	1.2%	8.3%
All Other Service Types	117	13.0%	$8.7	3.3%	2.9%
Total	**900**	**100.0%**	**$260.6**	**100.0%**	**5.7%**
Note: Details do not always sum to the total due to rounding.					

FFS claims are determined correctly paid or in error based on reviews of claims processing systems' payments and medical records' documentation to support claims as billed. Service type error analysis is only informative for medical review errors since data processing errors are typically caused by system programming or lack of edits. These types of errors are generally not tied to a provider type or provider billing issue.

Under medical review for Medicaid claims sampled, errors were identified across the top nine service types, in order of their projected dollars in error: Habilitation and Waiver Program; Nursing Facility/Intermediate Care Facilities; Prescribed Drugs; Psychiatric, Mental Health, and Behavioral Health Services; ICF/MR Facilities and Group Homes; Outpatient Hospital Services and Clinics; Personal Support Services; Inpatient Hospital Services; and Physicians and Other Licensed Practitioner Services. These service types represented 83.3% of total projected dollars in error for the Medicaid program.

Under medical review for CHIP claims sampled, errors were identified across the top five service types: Prescribed Drugs; Physicians and Other Licensed Practitioner Services; Outpatient Hospital Services and Clinics; Inpatient Hospital; and Psychiatric, Mental Health, and Behavioral Health Services. These service types represented 81.5% of total projected dollars in error for CHIP.

The types of errors that occurred in these service types were mainly Insufficient Documentation, Policy Violation, and No Documentation errors.

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 and 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 determines additional review is necessary, the state can then appeal the error finding to CMS.

Errors that were not challenged by the states or were upheld following the difference resolution and appeal process were included in the payment error 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

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 information available at the time the last action occurred according to state and federal eligibility policies.

For each case sampled in the active case universe, claims data is collected for payments made on behalf of the beneficiary 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. Table 8 summarizes the number of sample payment errors and the associated projected dollars for active cases for all 50 states and the District of Columbia.

Table 8. Total Number and Dollar Amounts of Eligibility Errors for Active Cases

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	660	60.9%	$9,140.4	65.2%
Undetermined	203	18.7%	$2,556.5	18.2%
Liability Understated	110	10.2%	$1,661.5	11.8%
Eligible with Ineligible Services	52	4.8%	$386.6	2.8%
Liability Overstated	44	4.1%	$247.3	1.8%
Managed Care Error, Ineligible for Managed Care	5	0.5%	$24.1	0.2%
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	9	0.8%	$6.5	0.0%
Total	**1,083**	**100.0%**	**$14,023.0**	**100.0%**
CHIP				
Not Eligible	1,074	75.7%	$597.9	90.9%
Undetermined	97	6.8%	$31.3	4.8%
Liability Understated	160	11.3%	$14.4	2.2%
Liability Overstated	70	4.9%	$7.2	1.1%
Eligible with Ineligible Services	12	0.8%	$6.5	1.0%
Managed Care Error, Eligible for Managed Care but Improperly Enrolled	5	0.4%	$0.6	0.1%
Managed Care Error, Ineligible for Managed Care	0	0.0%	$0.0	0.0%
Total	**1,418**	**100.0%**	**$657.9**	**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: eligibility category and 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 17 cycle 1 states measured in 2013.

There were three primary Medicaid eligibility categories that each contributed 15% or more to the total Medicaid eligibility projected improper payments for cycle 1:

- Aged, Blind, and Disabled Categorically Needy;
- Nursing Home; and

- Families with Dependent Children (General).

In CHIP, both Medicaid Expansion and CHIP stand-alone cases were substantially represented in the total eligibility improper payments.

In terms of causes of error, the state agency miscalculating countable assets represented 40% of total Medicaid eligibility improper payments in cycle 1. Other state procedural errors (15%) and cases where the eligibility criteria could not be verified (13%), which is associated with undetermined cases, also contributed significantly to the total Medicaid eligibility improper payments.

For CHIP, CHIP cases not properly screened for Medicaid eligibility were the leading cause of error, representing 19% of total CHIP eligibility improper payments. Clients ineligible due to Third Party Liability and state agencies miscalculating countable income, were the next highest CHIP causes of error, each comprising 15% of total CHIP eligibility improper payments.

There are no claims data collected for negative payments, as there are no claims or payments associated with a termination or denial of eligibility. Table 9 shows the number of negative cases found in error and the number found correct.

Table 9. Eligibility Review Findings for Negative Cases

Negative Case Action	Number of Sample Cases in Error	Percentage of Sample Cases
Medicaid		
Improper Termination	510	4.3%
Improper Denial	208	1.8%
Correct	11,017	93.9%
Total	**11,735**	**100.0%**
CHIP		
Improper Termination	149	2.1%
Improper Denial	91	1.3%
Correct	6,703	96.5%
Total	**6,943**	**100.0%**
* Note: Due to rounding, the sum may not equal 100%.		

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.

The national Medicaid and CHIP program improper payment rates are calculated by combining the individual state improper payment rates. In previous years, the national error rate was calculated using current cycle data for 17 states to produce cycle specific rates, then cycle rates were combined across years using yearly expenditures as a relative weight. After consultation with the Office of

Management and Budget, beginning in 2013, the national rolling error rate is calculated using error information from sampled cases from all 50 states and the District of Columbia (34 states in the case of CHIP). For the current year, the rate calculation includes errors from current cycle states and from the two most recent years so that all states are represented in the national error rate. More information on the national rolling error rate and how it is calculated is discussed in the section below, entitled *Reporting the Results: Official National Rolling Improper Payment Rates and Cycle-Specific Improper Payment Rates*.

Another change made to the error rate calculation methodology involves the data used to calculate the error rate. In previous cycles, the data used for error rate purposes was the data available as of the cycle cutoff date.[11] After consultation with OMB, beginning in 2013, all data used from the first two cycles of the rolling rate reflects any changes to the data that occurred after the respective cycle cutoff dates. Data changes could occur after the cycle cutoff date for a limited number of reasons including continued claim processing[12] or corrections to data to resolve previously undiscovered data inaccuracies. Due to the timing of error rate calculation reporting, the most recent cycle in the rolling error rate does not include any changes made to the data based on continued processing since they occur after the error rate is reported.

National component improper payment rates and the Medicaid and CHIP program 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[13] improper payment rates. A small correction factor ensures that eligibility improper payments do not get "double counted."

The PERM program considers both overpayments and underpayments to be improper payments. Table 10 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.

Table 10. 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	746	$7,554.5	23	$69.6
FFS Data Processing	258	$2,985.3	76	$475.2
Managed Care	46	$384.8	62	$6.7

11 Typically, the cycle cutoff date is the second July 15 of a measurement cycle. However, the cycle manager may delay the cycle end date depending on the progress of the cycle.

12 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.

13 PERM calculates three eligibility error rates per program: an active case payment error rate, an active case error rate, and a negative case error rate. The active case payment error 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.

Category	Overpayments		Underpayments	
	Number of Sample Payment Errors	Projected Dollars in Errors ($Millions)	Number of Sample Payment Errors	Projected Dollars in Errors ($Millions)
Eligibility	795	$13,775.7	43	$247.3
Total	**1,845**	**$24,700.3**	**204**	**$798.8**
CHIP				
FFS Medical Review	531	$200.9	8	$1.6
FFS Data Processing	340	$70.6	69	$8.2
Managed Care	11	$18.7	105	$0.1
Eligibility	1,105	$650.7	70	$7.2
Total	**1,987**	**$941.0**	**252**	**$17.1**
Note: Details do not always sum to the total due to rounding.				

The national improper payment rate should be reviewed with the understanding that states have considerable flexibility in designing their programs within federal rules and differ widely in program structure, eligibility, financing, and the level of sophistication and integration of management information systems. The net result is that there is a significant level of state-by-state variation. The measurement of improper payments is, therefore, correspondingly difficult, 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 state size. For example, states with proportionately larger managed care programs are likely to have lower overall improper payment rates, since they are processing more monthly payments to plans rather than service level transactions to providers via a FFS delivery system. Not only does this cause differences in error rates among states in a cycle, but it could cause differences in error rates between cycle measurements for the same state if in future years the state chooses to adopt managed care programs instead of using a FFS model. The PERM findings should be considered in the context of these differences and operational realities.

Reporting the Results: Official National Rolling Improper Payment Rates and Cycle-Specific Improper Payment Rates

At the conclusion of each measurement cycle, CMS uses findings from the cycle to calculate two primary types of error rates. The first error rate is the official national rolling improper payment rate. This rate combines the findings from the three prior measurement cycles to produce the error rate for the current fiscal year which is published in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The second calculated error rate is the cycle-specific rate which looks only at the findings from the 17 states in the most recent measurement cycle. The following sections provide more detail on each type of 2013 error rate calculation.

Official National Rolling Improper Payment Rate

The official national rolling error 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 2013 cycle was the second year of CHIP measurement since 2008 so the CHIP improper payment rate was calculated using data from the 34 states that have been sampled for CHIP. A CHIP rate based on findings from all 50 states and the District of Columbia will be reported in 2014.

Table 11 below summarizes the 2013 rolling national Medicaid and CHIP error rate findings.

Table 11. 2013 National Medicaid and CHIP Improper Payment Rates Summary

	2013 Medicaid Rolling Error Rate	2013 CHIP Rolling Error Rate
Error Rate	5.8%	7.1%
Total Projected Improper Payments ($Billions)	$24.9	$0.9
Federal Share Projected Improper Payments ($Billions)	$14.4	$0.6

The 2013 national Medicaid rolling improper payment rate, which is based on measurements that were conducted in 2011, 2012, and 2013, is 5.8%. This represents an estimated $14.4 billion in estimated improper federal expenditures and $24.9 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 underpayments and overpayments identified through review of claims and eligibility decisions.

The 2013 Medicaid improper payment rate is lower than the CMS target of 6.4%. Additionally, the rate dropped from 7.1% in 2012, meaning that the error rate for the 17 cycle 1 states measured in 2013 was lower than their 2010 error rate.

Under the old calculation methodology the 2013 national Medicaid error rate would have been 6.1% or $15.0 billion instead of the 5.8% or $14.4 billion reported in 2013 using the new calculation methodology enhancements.

The 2013 national CHIP rolling improper payment rate, which is based on measurements that were conducted in 2012 and 2013, is 7.1%. 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.

Under the old calculation methodology the 2013 national CHIP error rate would have been 7.5% or $0.7 billion instead of the 7.1% or $0.6 billion reported in 2013 using the new calculation methodology enhancements.

To better understand the drivers of the overall national error rates, the error rates for each component are calculated and reviewed. As can be seen in Table 12, FFS and eligibility were the

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

Table 12. 2013 Medicaid and CHIP Error Rates by Component

Component	2013 Medicaid Rolling Error Rate	2013 CHIP Rolling Error Rate
FFS	3.6%	5.7%
Managed Care	0.3%	0.2%
Eligibility	3.3%	5.1%
National	**5.8%**	**7.1%**
*The national payment error 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 2013 national Medicaid and 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 error rates, CMS calculates the projected improper payments and the dollars associated with the federal share, as shown in Table 13. To understand the reasonability of this estimate, the 90 % confidence levels are displayed. These ranges represent the projected dollar values that would be seen 90% of the time if the study were repeated many times.

Table 13. 2013 Medicaid Error Rate and CHIP Error Rate Applied to Total Expenditures and the Federal Share (Dollars in Billions)

Component	2013 Expenditures ($Billions)	Projected Improper Payments ($Billions)	Lower 90% Confidence Limit ($Billions)	Upper 90% Confidence Limit ($Billions)
Medicaid				
FFS Total	$303.0	$10.9	$9.6	$12.1
Federal Share	$174.6	$6.3	$5.5	$7.0
Managed Care Total	$125.4	$0.4	$0.2	$0.6
Federal Share	$72.3	$0.2	$0.1	$0.4
Eligibility Total	$428.3	$14.0	$10.4	$17.6
Federal Share	$246.9	$8.1	$6.0	$10.2
National Total*	**$428.3**	**$24.9**	**$21.2**	**$28.7**
Federal Share*	**$246.9**	**$14.4**	**$12.2**	**$16.5**

Component	2013 Expenditures ($Billions)	Projected Improper Payments ($Billions)	Lower 90% Confidence Limit ($Billions)	Upper 90% Confidence Limit ($Billions)
CHIP				
FFS Total	$4.6	$0.3	$0.1	$0.4
Federal Share	$3.3	$0.2	$0.1	$0.3
Managed Care Total	$8.4	$0.0	$0.0	$0.0
Federal Share	$5.8	$0.0	$0.0	$0.0
Eligibility Total	$13.0	$0.7	$0.5	$0.8
Federal Share	$9.1	$0.5	$0.3	$0.6
National Total*	**$13.0**	**$0.9**	**$0.7**	**$1.1**
Federal Share*	**$9.1**	**$0.6**	**$0.5**	**$0.8**

*The national payment error amounts (projected improper payments) are the product of the payment error 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.

Cycle-Specific Improper Payment Rate

A cycle rate is an improper payment rate based on the 17 states measured in a cycle. The cycle error 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 14 lists the cycle rates from the three most recent PERM cycles which are the measurements included in the 2013 rolling rate.

Table 14. 2011 – 2013 Medicaid and CHIP Improper Payment Cycle Rates

	2011 Cycle 2	2012 Cycle 3	2013 Cycle 1
MEDICAID			
Error Rate	6.7%	5.8%	5.7%
CHIP			
Error Rate	N/A	8.2%	6.8%

As seen in Table 14, the 2013 Medicaid cycle 1 improper payment rate is 5.7%. The 2013 CHIP cycle 1 improper payment rate is 6.8%. The cycle 1 states reviewed in 2013 were the same states reviewed in 2010. The Medicaid cycle 1 improper payment rate dropped substantially from the 2010 cycle 1 improper payment rate of 9.0% for these states. This suggests that, as a whole, this cycle of states was able to reduce its overall improper payments since the last PERM measurement. The reduction in the cycle 1 improper payment rate caused the rolling error rate to decrease from

7.1% in 2012 to 5.8% in 2013. The reduction in the cycle 1 error rate was solely due to improvement in the eligibility component.[14]

Table 15 shows the Medicaid cycle 1 rates by component in 2010 compared to the current cycle rates in 2013.

Table 15. 2010 and 2013 Medicaid Cycle Rates by Component

Component	2010 Cycle 1 Error Rate	2013 Cycle 1 Error rate
FFS	1.9%	3.4%
Managed Care	0.1%	0.2%
Eligibility	7.6%	3.3%
National	**9.0%**	**5.7%**

Since only 34 states have been measured for CHIP, we cannot attribute increases or decreases in the rolling CHIP rate to improvement/regression in a given cycle of states. Once all 50 states and DC have been measured in 2014 and states are measured for a second time beginning in 2015, we can attribute changes in the rolling rate to improvement/regression from the last time a cycle of states was measured.

In addition to the national error rates, each state receives the overall error 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 other states in the cycle, its performance in comparison to the national rate, and its performance in comparison to previous PERM cycles.

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. 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.

[14] Reduction in eligibility error rates can also be attributed to changes in PERM regulation based on the Children's Health Insurance Program Reauthorization Act (CHIPRA) that occured after the 2010 cycle 1 measurement. CMS changed the eligibility review process to allow reviewers to accept beneficiary self-declared information for purposes of validating income in accordance with state policy. Many (but not all) undetermined errors identified in the 2010 cycle were due to the inability of reviewers to independently verify self-declared information. However, the 2010 cycle 1 eligibility error rate excluding undetermined errors was 3.6%. Comparing this to the 2013 cycle 1 error rate of 3.3% (which includes undetermined errors) confirms there was improvement made outside of the eligibility review process change.

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. The PERM process identifies and classifies different types of errors, but states must conduct root cause analyses to identify why the errors occur to implement effective corrective action plans. CMS is also working on multiple fronts to reduce improper payments in an effort to meet improper payment rate targets,[15] as shown in Table 16. CMS continuously reviews the causes of errors and implements national and state-focused activities to decrease Medicaid and CHIP improper payments.

Table 16. Medicaid Improper Payment Rate Targets

2014	2015	2016
5.6%	5.5%	5.4%

Below we provide 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 error 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;

[15] Out-year targets for CHIP cannot be set until a baseline CHIP improper payment rate incorporating findings from all states is calculated in 2014.

- 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. States must submit updates on previous corrective action from prior PERM cycles and evaluate effectiveness of previous corrective actions.

Impact of Corrective Actions and Other CMS Activities on Error Findings

It is important to note that for Medicaid, the 17 states reviewed in 2013 were the same 17 states reviewed in 2010 (cycle 1 states). The improper payment rate for these states dropped from 9.0% in 2010 to 5.7% in 2013, causing the 2013 Medicaid rolling improper payment rate to decrease from 7.1% in 2012 to 5.8% in 2013. The improvement in the cycle 1 states was solely in the eligibility component which dropped from 7.6% in 2010 to 3.3% in 2013. The cycle 1 states submitted CAPs following their 2010 PERM measurement and can evaluate effectiveness based on their 2013 results. The re-measurement of this group of states reflects the impact of effective corrective actions to decrease eligibility improper payments.

The cycle 1 states that experienced the biggest decrease in their eligibility error rate implemented corrective actions such as:

- Implemented an electronic document management system to reduce the occurrence of missing documentation and, thus, help prevent undetermined errors;
- Conducted informational sessions at quarterly supervisor meetings. Sessions included discussions surrounding utilizing proper policies and procedures and verifying requested information; and
- Created an e-mail address for eligibility supervisors to submit inquiries and requests for training needs on a regular basis.

Reduction in eligibility error rates can also be attributed to changes in PERM regulation based on the Children's Health Insurance Program Reauthorization Act (CHIPRA).[16] Per the requirements

[16] Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required CMS to publish a new final rule for the PERM program incorporating changes to the program, particularly with respect to eligibility. On August 11, 2010, CMS published the final PERM regulation at 42 CFR Parts 431, 447, and 457.

of CHIPRA, CMS changed the eligibility review process to allow reviewers to accept beneficiary self-declared information for purposes of validating income in accordance with federal and state policy.

The cycle 1 states will submit CAPs based on the 2013 PERM reviews and will be reviewed again in 2016.

Documentation of State 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

When pricing and logic errors occurred in states' processing systems, they worked to ensure that those systems glitches were fixed to avoid future improper payments. States often made system updates as data processing errors were identified during a PERM cycle to immediately address issues.

Eligibility Corrective Actions

The eligibility component was the most significant contributor to the 2013 Medicaid and CHIP national improper payment rates. The three main sources of Medicaid and CHIP eligibility errors in terms of their impact on the national rates were: 1) not eligible, 2) undetermined, and 3) liability understated. 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 beneficiary.

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 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 began "mini-PERM audits" with three 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 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 error 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 continues to offer training, technical assistance, and support to state Medicaid program officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2013, the MII provided training to over 4,000 state employees and officials from 50 states, the District of Columbia, and Puerto Rico.
- 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.[17] 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, 2013, 45 states and the District of Columbia implemented Medicaid RAC programs. The remaining five

[17] 76 Fed. Reg. 57807 (Sept. 16, 2011).

states have CMS-approved exceptions. As states continue to implement their state Medicaid RAC programs, state Medicaid RAC federal-share recoveries reported by states increased from $57.6 million in FY 2012 to $74.5 million in FY 2013. States have increased the total federal and state share combined amount of Medicaid RAC recoveries from $95.6 million in FY 2012 to $124.3 million in FY 2013.

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 monthly to T-MSIS in 2014. 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.

PERM Process Improvements

CMS has also implemented a number of 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 error 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 beneficiary level, and instead make some aggregate payments.
- The ACA required significant changes to Medicaid and CHIP eligibility determination processes 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 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.

In addition, eligibility review pilot results will be reported in the 2015 – 2017 AFRs and annual PERM error rate reports.

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 beneficiary 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 beneficiary or provider).

Data entry error - Clerical error in the data entry of the sampling unit.

Rate cell error - The beneficiary was enrolled in managed care and payment was made, but for the wrong rate cell.

Managed care payment error - The beneficiary 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 beneficiary meets the state's categorical and financial criteria for receipt of benefits under the program.

Eligible with ineligible services - An individual beneficiary 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 beneficiary 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 beneficiary case subject to a Medicaid eligibility determination under PERM about which a definitive determination could not be made.

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

Liability understated - The beneficiary 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 beneficiary is enrolled in managed care but is not eligible for managed care.

Managed care error, eligible for managed care but improperly enrolled - Beneficiary 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 beneficiary who is enrolled in the Medicaid or CHIP program 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 beneficiary 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 error rate: An error 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 or CHIP programs.

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 beneficiary, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts.

Managed care: A system 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 and limited resources.

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 beneficiary for which there is Medicaid or CHIP FFP. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulations or policy.

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

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

PERM+: A claims and payment data submission method where the state submits claims, provider, and beneficiary data to the Statistical Contractor. 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 program error rates that 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)

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Corrective action plan (CAP)

Fiscal Year (FY)

Fee-for-service (FFS)

Improper Payments Elimination and Recovery Act of 2010 (IPERA)

Improper Payments Information Act of 2002 (IPIA)

Medicaid and CHIP State Information Sharing System (MCIS)

Medicaid Eligibility Quality Control (MEQC)

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)