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PAYMENT ERROR RATE MEASUREMENT PILOT PROJECT

FINAL REPORT

MEDICAID
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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I. EXECUTIVE SUMMARY

In federal fiscal year 2005 (FY 2005), 29 states participated in the Payment Error Rate Measurement (PERM) pilot project. The purpose of this pilot was to further refine the payment error rate methodology in both the fee-for-service (FFS) and managed care components of the Medicaid program and the State Children's Health Insurance Program (SCHIP). Each of the 29 states, including the District of Columbia, conducted their own measurement study. This report contains a range of Medicaid and SCHIP error rates, as reported by all 29 states.

Not all states tested all components of the PERM model. State Medicaid and SCHIP programs offer a wide variation in benefit packages, beneficiary populations and payment systems. Some states provide services in both the FFS and managed care components, while other states offer services in one component or the other. Twenty-three states tested payment error in both Medicaid and SCHIP, three states tested payment error only in Medicaid, and three states tested payment error only in SCHIP.

States were given several options in terms of implementing the pilot:

- Test the error rate of payments in Medicaid, SCHIP, or both programs; and
- Within each program (Medicaid and SCHIP), test the accuracy of payments in the FFS component, managed care component, or both components.

Table 1 below lists the states that participated in the PERM pilot in FY 2005.

Table 1. State Participation in the Payment Error Rate Measurement Pilot

State	Medicaid		SCHIP	
	FFS	Managed Care	FFS	Managed Care
Alabama			•	
Alaska	•		•	
Arizona	•	•	•	•
Arkansas	•		•	
Colorado	•	•	•	•
DC	•	•		•
Delaware	•	•	•	•
Florida	•	•	•	•
Georgia	•		•	
Idaho	•		•	
Indiana	•		•	•
Iowa	•		•	•
Kansas	•			•
Kentucky	•	•	•	•
Maryland	•	•	•	•

Minnesota	•	•		
Missouri	•	•	•	•
Nevada	•	•	•	•
New Mexico	•	•	•	•
New York				•
Oklahoma	•		•	
Pennsylvania	•	•		
South Carolina	•		•	
South Dakota	•		•	
Texas	•	•	•	
Virginia	•	•	•	•
West Virginia			•	
Wisconsin	•	•	•	•
Wyoming	•			
TOTAL	**26**	**15**	**23**	**16**

To estimate payment error, states reviewed a random sample of 150 claims per program. If states chose to review both the FFS and managed care components, the 150 claims were proportionately divided according to the program dollars spent in each component. In the FFS component, states reviewed claims for processing and medical necessity errors. In the managed care component, states reviewed claims for processing errors. States also reviewed a sub-sample of 50 claims for beneficiary eligibility. States then calculated the payment error rate, which is the ratio of the dollar value of payments paid in error in the sample to the dollar value of total payments made in the sample.

The 150-claims sample was not intended to produce state-level estimates at a high level of precision. Although each state was able to calculate a state-level error rate, the findings in this report show that the small sample sizes often resulted in very large confidence intervals, particularly among the fee-for-service error rates.

The sampling unit for each universe is a claim. For purposes of this pilot, a FFS claim is defined as a line item, fixed payment, or individually priced service. A managed care claim is defined as a managed care capitation payment.

Below is a range of error rates for each component of each program:

- Medicaid FFS (26 states reporting): 0.14 percent to 28.41 percent
- Medicaid managed care (15 states reporting): 0.00 percent to 15.59 percent
- SCHIP FFS (23 states reporting): 0.00 percent to 62.41 percent
- SCHIP managed care (16 states reporting): 0.00 percent to 40.37 percent

II. PAYMENT ERROR RATE MEASUREMENT MODEL

The PERM model was designed to estimate payment error rates for the FFS and managed care components of the Medicaid program and SCHIP. Simply defined, payment error is the ratio of the dollar value of payments paid in error in the sample, to the dollar value of total payments in the sample. Improper payments include the gross amount of overpayments plus underpayments.

The basic steps of the payment error rate methodology are:

1. Depending on what programs and components the state chose to measure, it drew a random sample of:

    a. Medicaid FFS claims, stratified by provider type, and/or

    b. Medicaid managed care capitation payments, and/or

    c. SCHIP FFS claims, stratified at state option, and/or

    d. SCHIP managed care capitation payments.

2. Review each sampling unit to determine if payments were made correctly or incorrectly; and

3. Compute a payment error rate based on the sample findings.

A. MEDICAID AND SCHIP SAMPLES

The samples were drawn from a universe of all Medicaid and/or SCHIP claims adjudicated by each state between October 1, 2004, and December 31, 2004, inclusive.

States were expected to draw a sample of 150 claims per program. Some states selectively chose to draw a larger sample size and review those samples. States testing both the FFS and managed care components proportionally divided the 150 claims according to the program dollars spent in each component. For example, if a state's FFS component accounts for two-thirds of expenditures and its managed care component accounts for one-third, 100 items should be sampled from FFS and 50 items should be sampled from managed care. The Medicaid FFS sample was stratified into eight sampling strata, as follows:

- Inpatient hospital services;
- Long term care services;
- Other independent practitioners and clinics;

- Prescription drugs;
- Home and community-based services (HCBS);
- Other services and supplies (e.g., laboratory, x-ray, and transportation services);
- Fixed payments on behalf of individual beneficiaries (e.g., primary care case management payments and Medicare Part A and B premiums); and
- Denials.

Stratification was optional for SCHIP. If states chose to stratify the SCHIP sample, they could have used the Medicaid strata or developed their own strata.

B. REVIEW COMPONENTS

1. PROCESSING REVIEW

Sampled FFS claims were reviewed to validate correct processing, based on information from the claim. The processing review consisted of reviewing each claim, at a minimum, for the following errors:

- Duplicate item (claim);
- Non-covered service;
- Service covered by a managed care organization (MCO);
- Third-party liability;
- Invalid pricing;
- Logical edits (e.g., incompatibility between gender and procedure);
- Beneficiary eligibility (i.e., beneficiary was enrolled);
- Data entry (clerical) error; and
- Other.

Sampled managed care capitation payments were reviewed for, at a minimum, the following processing errors:

- Did not meet criteria for managed care;
- Eligible, but in wrong MCO;

- Incorrect rate cell payment;
- Incorrect MCO payment amount; and
- Other.

2. MEDICAL REVIEW

Sampled FFS claims were also reviewed to validate medical necessity and correct coding. At a minimum, each line item was reviewed for the following errors:

- No response;
- Insufficient documentation;
- Procedure coding;
- Diagnosis coding;
- Unbundling;
- Number of unit(s) error;
- Medically unnecessary service;
- Policy violation; and
- Administrative / Other.

3. ELIGIBILITY REVIEW

A random sub-sample of 50 beneficiaries per program was reviewed to determine if the beneficiary was eligible: 1) for Medicaid or SCHIP in the month the sampled service was provided; and 2) for the service provided. Each case was reviewed, at a minimum, for the following errors:

- Ineligible for program;
- Eligible, but ineligible for service;
- Ineligible, did not meet spend down;
- Eligible with liability error; and
- Eligible, but incorrect capitation.

III. SUMMARY OF MEDICAID FINDINGS

A. FEE-FOR-SERVICE

This final report contains the findings from the 26 states that reported results in their Medicaid FFS program. Table 2 summarizes the estimated Medicaid FFS payment error rate by state. The error rates are based on the results of the processing review, the medical review, and the Medicaid FFS eligibility sub-sample review.

As shown in Table 2, many states have wide confidence intervals. Each state reported an estimated error rate and the confidence interval. It is highly probable that a state's true error rate falls within the lower and upper confidence interval. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe).

Table 2: Summary of Medicaid FFS Payment Error Rates

State	Sample Size	Error Rate	Lower Confidence Interval	Upper Confidence Interval
Alaska	141	25.14%	11.29%	38.99%
Arizona	27	28.41%	9.80%	47.02%
Arkansas	141	10.09%	2.90%	15.78%
Colorado	126	2.09%	0.17%	4.02%
DC	114	3.52%	0.00%	7.03%
Delaware	83	15.62%	6.09%	25.15%
Florida	122	11.50%	3.44%	19.57%
Georgia	150	7.25%	2.86%	11.63%
Idaho	150	9.54%	3.44%	15.63%
Indiana	150	4.09%	0.61%	7.57%
Iowa	150	6.41%	1.89%	10.93%
Kansas	141	4.93%	0.00%	10.50%
Kentucky	132	8.46%	2.48%	14.44%
Maryland	108	2.16%	0.00%	5.60%
Minnesota	111	5.45%	0.32%	10.58%
Missouri	120	6.07%	0.58%	11.55%
Nevada	126	21.04%	6.40%	35.68%
New Mexico	87	0.14%	0.00%	0.37%
Oklahoma	141	9.59%	3.74%	15.44%
Pennsylvania	78	12.61%	4.78%	20.44%
South Carolina	150	5.76%	1.56%	9.95%
South Dakota	150	1.91%	0.00%	4.68%
Texas	558	13.64%	8.70%	18.58%
Virginia	105	8.25%	4.06%	12.43%
Wisconsin	129	2.20%	0.12%	4.28%
Wyoming	150	1.96%	0.16%	3.75%

1. PAYMENT ERROR RATES BY STRATUM

States testing the PERM methodology in Medicaid FFS were expected to draw a proportional, stratified random sample of adjudicated Medicaid claims by provider type. Due to the small sample sizes, there is very little statistical precision in the strata-level findings from each state. Below is a range of state-reported payment error rates for each Medicaid FFS stratum, including the number of claims examined and the amount of money those claims comprised.

- Inpatient hospital services (528 claims, $2,174,398): 0.00 percent to 49.00 percent
- Long term care services (959 claims, $2,692,268): 0.00 percent to 100.00 percent
- Other independent practitioners and clinics (693 claims, $51,892): 0.00 percent to 33.30 percent
- Prescription drugs (586 claims, $34,628): 0.00 percent to 78.71 percent
- Home and community-based services (HCBS) (422 claims, $140,054): 0.00 percent to 56.08 percent
- Other services and supplies (246 claims, $20,798): 0.00 percent to 94.43 percent
- Fixed payments on behalf of individual beneficiaries (87 claims, $35,759): 0.00 percent to 68.50 percent
- Denials (205 claims, $0): No payment error found

2. TYPES OF PAYMENT ERRORS

The 26 states that submitted findings for the Medicaid FFS component of the study reviewed a total of 3,726 claims, valued at $5,149,797[1] for processing errors and medical review errors. A sub-sample of 1,225 claims were also reviewed for beneficiary eligibility. Of the 3,726 claims reviewed, 424 errors were due to overpayment errors, valued at $362,682. Thirty errors were underpayment errors, valued at $14,562. Table 3 below is a summary of the Medicaid FFS review results. A more detailed breakdown of the overpayments and underpayments for Medicaid FFS follows Table 3.

[1] The national FFS error rate should not be calculated by dividing the total dollars in error by the dollars reviewed in the sample. The samples were weighted according to the dollar value of claims in the universe and strata, which included denials. Therefore, the national FFS error rate should be calculated using a method which allows for re-weighting by strata and includes denials.

Table 3: Medicaid FFS Summary Table

Summary Statistic	Value
Total claims reviewed	3,726
Number of overpayment errors	424
Dollar value of overpayment errors	$362,682
Number of underpayment errors	30
Dollar value of underpayment errors	$14,562
Total number of errors	454
Absolute dollar value of errors	$377,244

Among the 3,726 claims, 58 processing errors were found.[2] Of the 58 processing errors, 44 overpayments were found with a total dollar value of $68,099 and 14 underpayments were found with a total dollar value of $570. Over half of the total processing errors were due to improper pricing. The gross improper payment amount attributable to Medicaid FFS processing errors is $68,669.

In addition, 317 medical review errors were found.[3] Of the 317 errors, 306 overpayments were found with a total dollar value of $241,465 and 11 underpayments were found with a total dollar value of $13,686. A majority of the total medical review errors were due to either insufficient documentation or policy violations. The gross improper payment amount attributable to Medicaid FFS medical review errors is $255,151.

States conducted in-depth reviews of eligibility for a subset of beneficiaries in the sample. Of the 1,225 Medicaid FFS claims selected for the eligibility review, 74 overpayments were found with a total dollar value of $53,118 and five underpayments were found with a total dollar value of $306. The overwhelming majority of eligibility errors were due to beneficiaries who were ineligible for the program. The gross improper payment amount attributable to Medicaid FFS eligibility review errors is $53,424.

A breakdown of the types of Medicaid FFS processing, medical review, and eligibility errors reported by the 26 states is presented in Tables 4, 5, and 6 respectively.

[2] Multiple errors may have been found on one claim.
[3] Multiple errors may have been found on one claim.

Table 4: Number and Dollar Amount of Medicaid FFS Processing Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Duplicate item	2	$75	0	$0
Non-covered service	2	$3,207	0	$0
MCO-covered service	0	$0	0	$0
Third party liability	5	$4,017	0	$0
Pricing error	27	$46,865	7	$386
Logical edit	3	$1,443	2	$34
Ineligible recipient	0	$0	0	$0
Data entry errors	3	$842	0	$0
Other	2	$11,650	5	$150
Total	**44**	**$68,099**	**14**	**$570**

Table 5: Number and Dollar Amount of Medicaid FFS Medical Review Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
No response	19	$10,613	0	$0
Insufficient documentation	112	$88,299	0	$0
Procedure coding error	17	$5,640	4	$64
Diagnosis coding error	9	$40,298	3	$9,294
Unbundling	2	$19	0	$0
Number of unit(s) error	22	$2,165	3	$2,156
Medically unnecessary service	22	$41,080	0	$0
Policy violation	99	$52,899	1	$2,172
Administrative/Other	4	$452	0	$0
Total	**306**	**$241,465**	**11**	**$13,686**

Table 6: Number and Dollar Amount of Medicaid FFS Eligibility Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Ineligible for the program	55	$48,397	0	$0
Eligible, but ineligible for service	1	$2,144	0	$0
Ineligible, did not meet spend down	3	$179	0	$0
Eligible with liability error	14	$2,313	5	$306
Eligible, but incorrect capitation	1	$85	0	$0
Total	**74**	**$53,118**	**5**	**$306**

B. MANAGED CARE

This final report contains the findings from the 15 states that reported results for their Medicaid managed care program. Table 7 summarizes the estimated Medicaid managed care payment error rates by state. The error rates are based on the results of the processing review and Medicaid managed care eligibility sub-sample review. Managed care payments are not subject to a medical review because these payments are not based on the individual services provided, rather they are made through capitated payments per enrollee.

As shown in Table 7, many states have wide confidence intervals. Each state reported an estimated error rate and the confidence interval. It is highly probably that a state's true error rate falls within the lower and upper confidence interval. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe).

Table 7: Summary of Medicaid Managed Care Payment Error Rates

State	Sample Size	PERM Rate	Lower Confidence Interval	Upper Confidence Interval
Arizona	264	5.38%	1.63%	9.23%
Colorado	24	5.15%	0.43%	15.64%
DC	27	0.00%	0.00%	0.00%
Delaware	62	0.80%	0.07%	2.46%
Florida	425	0.64%	0.09%	1.32%
Kentucky	18	0.00%	0.00%	0.00%
Maryland	42	0.66%	0.05%	2.05%
Minnesota	42	0.00%	0.00%	0.00%
Missouri	30	15.11%	1.49%	36.83%
Nevada	24	15.59%	1.32%	45.61%
New Mexico	65	0.00%	0.00%	0.00%
Pennsylvania	72	2.33%	0.20%	7.00%
Texas	75	3.06%	0.28%	8.04%
Virginia	39	0.00%	0.00%	0.00%
Wisconsin	20	0.00%	0.00%	0.00%

TYPES OF PAYMENT ERRORS

The 15 states that submitted findings for the Medicaid managed care component reviewed a total of 1,226 capitation payments valued at $240,482[4] for processing errors. A sub-sample of 552 claims were also reviewed for beneficiary eligibility. Of the 1,226 claims reviewed, 29 errors were due to overpayment errors, valued at $4,197. Nine errors were underpayment errors, valued at $440. Table 8, below, is a summary of the Medicaid managed care review results. A more detailed breakdown of the overpayments and underpayments for Medicaid managed care follows Table 8.

[4] The national managed care error rate should not be calculated by dividing the total dollars in error by the dollars reviewed in the sample. The samples were weighted by each state. Therefore, the national managed care error rate should be calculated using a method, which allows for re-weighting by state.

Table 8: Summary of Medicaid Managed Care Errors

Summary Statistic	Value
Total capitation payments reviewed	1,226
Number of overpayment errors	29
Dollar value of overpayment errors	$4,197
Number of underpayment errors	9
Dollar value of underpayment errors	$440
Total number of errors	38
Absolute dollar value of errors	$4,637

Among the 15 states, 11 processing errors were found. Of the 11 processing errors, four overpayments were found with a total dollar value of $90 and seven underpayments were found with a total dollar value of $152. Approximately half of the total managed care processing errors were due to payments made in an incorrect rate cell. The gross improper payment amount attributable to Medicaid managed care processing errors is $242.

States conducted in-depth reviews of eligibility for a subset of beneficiaries in the sample. Of the 552 Medicaid managed care claims selected for the eligibility review, 25 overpayments were found with a total dollar value of $4,107 and two underpayments were found with a total dollar value of $288. The overwhelming majority of eligibility errors, in fact all of the overpayments, were due to beneficiaries who were ineligible for the program. The gross improper payment amount attributable to Medicaid managed care eligibility review errors is $4,395.

The type of error, number, and dollar amount of managed care processing and eligibility errors are presented respectively in Tables 9 and 10 below.

Table 9: Number and Dollar Amount of Medicaid Managed Care Processing Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Did not meet criteria for managed care	0	$0	0	$0
Eligible, but in wrong MCO	2	$76	0	$0
Incorrect rate cell payment	2	$14	4	$73
Incorrect MCO payment amount	0	$0	3	$79
Other	0	$0	0	$0
Total	**4**	**$90**	**7**	**$152**

Table 10: Number and Dollar Amount of Medicaid Managed Care Eligibility Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Ineligible for the program	25	$4,107	0	$0
Eligible, but ineligible for service	0	$0	0	$0
Ineligible, did not meet spend down	0	$0	0	$0
Eligible with liability error	0	$0	1	$10
Eligible, but incorrect capitation	0	$0	1	$278
Total	**25**	**$4,107**	**2**	**$288**

IV. SUMMARY OF SCHIP FINDINGS

A. FEE-FOR-SERVICE

This final report contains findings from the 23 states that reported results for their SCHIP FFS program. Table 11 summarizes the estimated SCHIP FFS payment error rate by state. The payment error rates are based on the results of the processing review, the medical review, and the SCHIP FFS eligibility sub-sample review.

As shown in Table 11, many states have wide confidence intervals. Each state reported an estimated error rate and the confidence interval. It is highly probably that a state's true error rate falls within the lower and upper confidence interval. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe).

Table 11: Summary of SCHIP FFS Payment Error Rates

State	Sample Size	Error Rate	Lower Confidence Interval	Upper Confidence Interval
Alabama	150	3.65%	0.00%	7.52%
Alaska	141	62.41%	44.57%	80.24%
Arizona	5	59.42%	20.27%	98.56%
Arkansas	141	8.66%	0.25%	17.07%
Florida	39	22.57%	0.68%	44.46%
Georgia	150	11.00%	4.7%	17.30%
Idaho	150	25.94%	14.91%	36.98%
Indiana	106	7.56%	0.00%	15.94%
Iowa	50	7.47%	1.11%	13.84%
Kentucky	119	19.65%	10.03%	29.28%
Maryland	51	8.63%	0.00%	17.48%
Missouri	83	13.89%	4.18%	23.60%
Nevada	39	8.72%	2.79%	14.65%
New Mexico	29	0.00%	0.00%	0.00%
Oklahoma	141	5.71%	1.85%	9.57%
South Carolina	150	6.67%	1.10%	12.24%
South Dakota	150	2.79%	0.00%	7.34%
Texas	150	1.42%	0.14%	3.42%
Virginia	48	13.46%	0.00%	29.04%
West Virginia	141	1.72%	0.20%	3.24%
Wisconsin	90	7.65%	1.49%	13.82%

TYPES OF PAYMENT ERRORS

The 23 states that submitted findings for the SCHIP FFS component of the study reviewed a total of 2,236 claims, valued at $1,023,237[5] for processing errors and medical review errors. A sub-sample of 778 claims were also reviewed for beneficiary eligibility. Of the 2,236 claims reviewed, 279 errors were due to overpayment errors valued at $177,759. Twenty-five errors were underpayment errors, valued at $2,981. Table 12 is a summary of the SCHIP FFS review results. A more detailed breakdown of the overpayments and underpayments for SCHIP FFS follows Table 12.

[5] The national FFS error rate should not be calculated by dividing the total dollars in error by the dollars reviewed in the sample. The samples were weighted according to the dollar value of claims in the universe and strata, which included denials. Therefore, the national FFS error rate should be calculated using a method, which allows for re-weighting by strata and includes denials.

Table 12: SCHIP FFS Summary Table

Summary Statistic	Value
Total claims reviewed	2,236
Number of overpayment errors	279
Dollar value of overpayment errors	$177,759
Number of underpayment errors	25
Dollar value of underpayment errors	$2,981
Total number of errors	304
Absolute dollar value of errors	$180,740

Among the 2,236 claims, 51 processing errors were found.[6] Of the 51 errors, 33 overpayments were found with a total dollar value of $15,128.20 and 18 underpayments were found with a total dollar value of $2,376. The majority of the total processing errors were due to improper pricing. The gross improper payment amount attributable to SCHIP FFS processing errors is $17,504.20.

In addition, 141 medical review errors were found.[7] Of the 141 medical review errors, 136 overpayments were found with a total dollar value of $97,369 and five underpayments were found with a total dollar value of $430. Approximately half of the errors were due to: insufficient documentation and policy violations. The gross improper payment amount attributable to the SCHIP FFS medical review errors is $97,799.

States conducted in-depth reviews of eligibility for a subset of beneficiaries in the sample. Of the 778 SCHIP FFS claims selected for the eligibility review, a total of 110 SCHIP FFS eligibility overpayment errors were found with a dollar value of $65,263 and two underpayments were found with a total dollar value of $175. The overwhelming majority of eligibility errors were due to beneficiaries who were ineligible for the program. The gross improper payment attributable to the SCHIP FFS eligibility review errors is $65,438.

A breakdown of the types of processing, medical review, and SCHIP FFS eligibility errors reported by the 23 states is presented in Tables 13, 14, and 15 respectively.

[6] Multiple errors may have been found on one claim.
[7] Multiple errors may have been found on one claim.

Table 13: Number and Dollar Amount of SCHIP FFS Processing Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Duplicate item	1	$14	0	$0
Non-covered service	2	$8,610	0	$0
MCO-covered service	0	$0	0	$0
Third party liability	2	$20	0	$0
Pricing error	11	$1,594	16	$2,300
Logical edit	0	$0	0	$0
Ineligible recipient	8	$262	0	$0
Data entry errors	2	$0.20	0	$0
Other	7	$4,628	2	$76
Total	**33**	**$15,128.20**	**18**	**$2,376**

Table 14: Number and Dollar Amount of SCHIP FFS Medical Review Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
No response	7	$555	0	$0
Insufficient documentation	40	$44,631	0	$0
Procedure coding error	23	$660	3	$133
Diagnosis coding error	0	$0	0	$0
Unbundling	2	$12	0	$0
Number of unit(s) error	6	$182	2	$297
Medically unnecessary service	12	$45,181	0	$0
Policy violation	39	$5,686	0	$0
Administrative/Other	7	$462	0	$0
Total	**136**	**$97,369**	**5**	**$430**

Table 15: Number and Dollar Amount of SCHIP FFS Eligibility Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Ineligible for the program	105	$65,012	0	$0
Eligible, but ineligible for service	1	$33	0	$0
Ineligible, did not meet spend down	0	$0	0	$0
Eligible with liability error	4	$218	2	$175
Eligible, but incorrect capitation	0	$0	0	$0
Total	**110**	**$65,263**	**2**	**$175**

B. MANAGED CARE

This final report contains findings from the 16 states that reported results for their SCHIP managed care program. Table 16 summarizes the estimated SCHIP managed care payment error rates by state. The error rates are based on the results of the processing review and the SCHIP managed care eligibility sub-sample review. Managed care payments are not subject to a medical review because these payments are not based on the individual services provided, rather they are made through capitated payments per enrollee.

As shown in Table 16, many states have wide confidence intervals. Each state reported an estimated error rate and the confidence interval. It is highly probably that a state's true error rate falls within the lower and upper confidence interval. The uncertainty of the estimate may result from the small sample sizes (relative to the universe of claims) reviewed in the pilot and also from the amount of variation in payments in the universe of claims (relative to the mean of the universe).

Table 16: Summary of SCHIP Managed Care Payment Error Rates

State	Sample Size	PERM Rate	Lower Confidence Interval	Upper Confidence Interval
Arizona	294	40.37%	50.15%	69.12%
Colorado	150	12.93%	5.03%	20.87%
Delaware	150	4.07%	0.84%	7.31%
Florida	111	26.40%	10.00%	42.92%
Indiana	44	0.00%	0.00%	0.00%
Iowa	100	0.00%	0.00%	0.00%
Kansas	150	8.74%	1.61%	15.86%
Kentucky	31	7.66%	0.86%	17.37%
Maryland	99	2.97%	0.46%	6.01%
Missouri	67	10.47%	3.32%	17.77%
Nevada	108	3.91%	0.40%	9.31%
New Mexico	121	0.00%	0.00%	0.00%
New York	150	9.19%	4.67%	13.72%
Texas	150	1.42%	0.14%	3.42%
Virginia	99	12.55%	4.87%	20.27%
Wisconsin	60	4.90%	1.04%	9.10%

TYPES OF PAYMENT ERRORS

The 16 states that submitted findings for the SCHIP managed care component reviewed a total of 2,033 capitation payments valued at $159,742[8] for processing errors. A sub-sample of 975 claims were also reviewed for beneficiary eligibility. Of the 2,033 claims reviewed, 225 errors were due to overpayment errors, valued at $19,810. Nine errors were underpayment errors, valued at $1,087. Table 17, below, is a summary of the Medicaid managed care review results. A more detailed breakdown of the overpayments and underpayments for SCHIP managed care follows Table 17.

[8] The national managed care error rate should not be calculated by dividing the total dollars in error by the dollars reviewed in the sample. The samples were weighted by each state. Therefore, the national managed care error rate should be calculated using a method, which allows for re-weighting by state.

Table 17: Summary of SCHIP Managed Care Errors

Summary Statistic	Value
Total capitation payments reviewed	2,033
Number of overpayment errors	225
Dollar value of overpayment errors	$19,810
Number of underpayment errors	9
Dollar value of underpayment errors	$1,087
Total number of errors	234
Absolute dollar value of errors	$20,897

Among the 16 states, 19 processing errors were found. Of the 19 processing errors, 13 overpayments were found with a total dollar value of $353 and six underpayments were found with a total dollar value of $494. Approximately half of the total managed care processing errors were due to incorrect managed care payment amounts to the MCOs. The gross improper payment amount attributable to Medicaid managed care processing errors is $847.

States conducted in-depth reviews of eligibility for a subset of beneficiaries in the sample. Of the 975 Medicaid managed care claims selected for the eligibility review, 212 overpayments were found with a total dollar value of $19,457 and 3 underpayments were found with a total dollar value of $22. The overwhelming majority of eligibility errors were due to beneficiaries who were ineligible for the program. The gross improper payment amount attributable to Medicaid managed care eligibility review errors is $19,479.

The type of error, number, and dollar amount of managed care processing and eligibility errors are presented respectively in Tables 18 and 19 below.

Table 18: Number and Dollar Amount of SCHIP Managed Care Processing Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Did not meet criteria for MC	3	$142	0	$0
Eligible, but in wrong MCO	0	$0	0	$0
Incorrect rate cell payment	0	$0	0	$0
Incorrect MCO payment amount	9	$115	1	$1
Other	1	$96	5	$493
Total	**13**	**$353**	**6**	**$494**

Table 19: Number and Dollar Amount of SCHIP Managed Care Eligibility Errors

Error Code	Overpayments		Underpayments	
	Number of Errors	Dollar Amount of Errors	Number of Errors	Dollar Amount of Errors
Ineligible for the program	196	$18,603	0	$0
Eligible, but ineligible for service	0	$0	0	$0
Ineligible, did not meet spend down	0	$0	0	$0
Eligible with liability error	8	$709	0	$0
Eligible, but incorrect capitation	8	$145	3	$22
Total	**212**	**$19,457**	**3**	**$22**

CONCLUSION

The PERM model was designed to estimate payment error rates for the FFS, managed care, and eligibility components of the Medicaid program and SCHIP. Twenty-nine states participated in the PERM pilot project. This final report discusses the results found by 26 state Medicaid programs and 23 state SCHIP programs.

Due to the small sample sizes in this pilot project, it is difficult to draw conclusions about differences in payment error rates among the different components of the review (e.g., eligibility, processing, medical review), different states, and different strata. Yet, from the results of this report, we view the following to be major causes of error in each component:

Medicaid FFS

- Processing errors: Pricing errors
- Medical review errors: Insufficient documentation
- Eligibility errors: Beneficiaries ineligible for the program

Medicaid Managed Care

- Processing errors: Payments made in an incorrect rate cell
- Eligibility errors: Beneficiaries ineligible for the program

SCHIP FFS

- Processing errors: Pricing errors
- Medical review errors: Insufficient documentation
- Eligibility errors: Beneficiaries ineligible for the program

SCHIP Managed Care

- Processing errors: Incorrect managed care payment amounts to the MCOs
- Eligibility errors: Beneficiaries ineligible for the program