U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 2015 Pennsylvania CHIP

Payment Error Rate Measurement (PERM) Cycle 1 Summary Report

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

A. Program and Report Overview

This report gives an analysis and breakdown of Pennsylvania's improper payment rate through the PERM program. The purpose of the Payment Error Rate Measurement (PERM) program is to produce a national-level improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

IPERIA is one of three Acts that require federal agencies to review their programs to:

- Identify programs at risk of improper payments;
- Estimate the amount of improper payments;
- Give those estimates to Congress; and
- Report on the actions taken to reduce the improper payments.

Two programs at high risk of improper payments are Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) measures these improper payments annually through the PERM program. The PERM program reviews three components: 1) Fee-For-Service (FFS) claims, 2) managed care capitation payments, and 3) eligibility determinations and resulting payments. Eligibility determinations, as well as resulting payments are not included in the Fiscal Year (FY) 2015 state calculations.

The PERM program requires 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 to measure improper payments. Each cycle or fiscal year, CMS measures a third of the states and all states are reviewed once every three years. Pennsylvania is a cycle 1 state evaluated in FY 2015.

While every state has operated both Medicaid and CHIP for many years, the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, more commonly known as the Affordable Care Act (ACA), significantly affected each program by adding new requirements, expanding eligibility, and offering additional federal funding to states for eligibility system updates and development. States continue to plan and implement major changes to their Medicaid and CHIP programs to comply with the ACA and to improve accountability and quality of care.

Accordingly, the current methodologies applied to measurement of eligibility determination 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, beginning with FY 2014, CMS put the eligibility component of PERM on hold. For reporting comprehensive national Medicaid and CHIP program improper payment rates, CMS is using an estimated eligibility component rate based on historical data for continuity. This proxy rate will only have an impact on the national-level improper payment rates. All state-specific rates will be comprised of only the FFS and managed care components until eligibility is resumed after the FY 2017 cycle.

This report provides an overview of the FY 2015 findings and presents data analyses of payment errors found in the Pennsylvania CHIP program. These findings, including the projected dollars in error, are meant to support the state during the corrective action process.

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 methods, provider billing errors, and provider compliance with record requests all contribute to the cycle improper payment rates in various ways. PERM identifies and classifies different types of errors, but states must conduct root cause analyses to understand why the errors occurred and determine how to take corrective action. State participation is critical during the corrective action phase of the PERM cycle.

During the PERM measurement, CMS and its contractors reviewed the CHIP FFS claims and managed care capitation payments. The first two sections of this report include the estimated 17-state cycle rates and state improper payment rates based on the results of the reviewed samples. The remaining sections include sample payments in error along with the projected improper payments for Pennsylvania, broken out by CHIP FFS and managed care.[1] For CHIP FFS and managed care, additional analysis from the Review Contractor is included to address CHIP FFS medical record and data processing errors as well as managed care data processing errors.

Note that much of the analysis provided in the document is focused on projected dollars in error, which are an estimate for how much the state paid incorrectly. The projected dollars in error are estimated by multiplying the improper payment rate by the projected paid amount. The projected paid amount is the total payment amount listed on the Medicaid and CHIP CMS 64/21 reports.

States are encouraged to use the projected dollars in error figures, which include both overpayments and underpayments, in the cycle summary reports for purposes of identifying which factors (e.g., error types, provider types) had the biggest contribution to a state's improper payment rate. The number provides a good indication of an improper payment's impact on a state's improper payment rate and can be used to appropriately target corrective actions. However, states are cautioned from taking the projected dollars in error for certain levels of analysis (for example, by error type per provider type) to be an exact reflection of the actual dollars in error because they are estimates using the PERM sample and sometimes have wide confidence intervals.

B. PERM 17-State Cycle 1 CHIP Findings

In FY 2015, the overall Cycle 1 CHIP estimated improper payment rate is **8.2%**. The estimated cycle component improper payment rates are as follows.

- **CHIP FFS - 14.0%.**
- **CHIP managed care - 3.7%.**

C. Pennsylvania's CHIP Findings

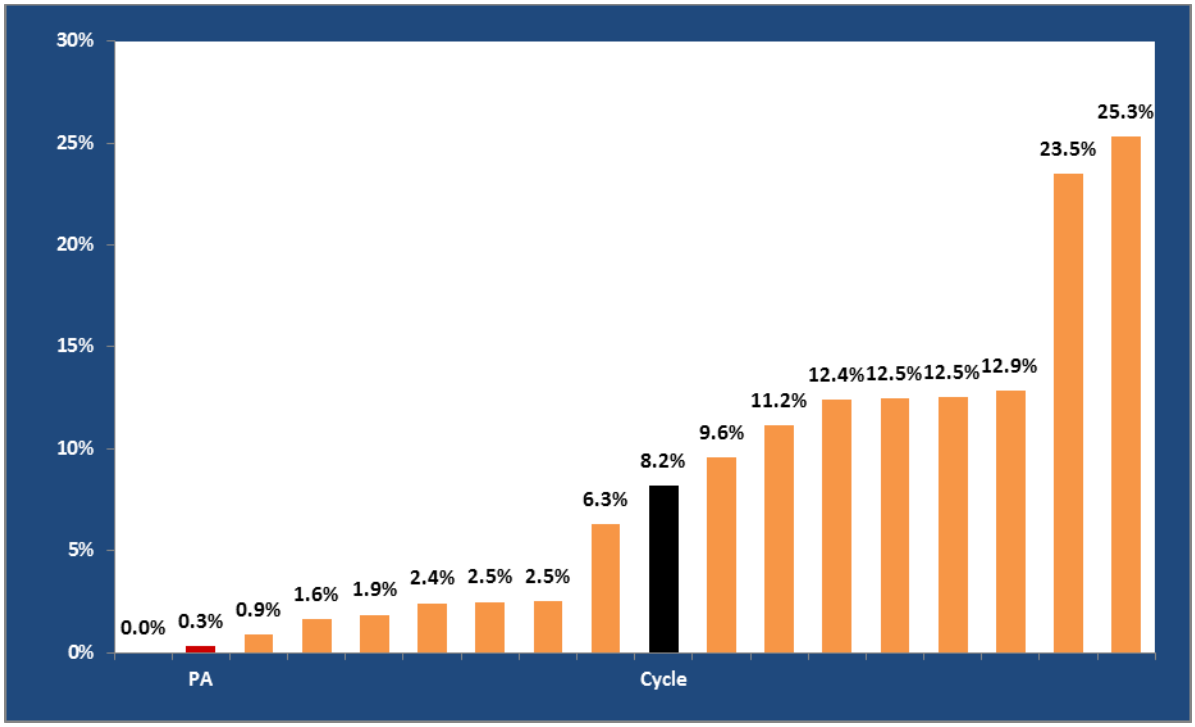
In FY 2015, Pennsylvania's CHIP estimated improper payment rate is **0.3%**. Pennsylvania's sample review findings by component are as follows.

- **There is no CHIP FFS program in Pennsylvania.**
- **Pennsylvania's CHIP managed care estimated improper payment rate is 0.3%.**

[1] PERM combines components (FFS and managed care) into a single universe when a given component accounts for less than two percent of total expenditures included in the PERM universe for that state and program.

Figure 1 shows Pennsylvania's improper payment rate compared to the Cycle 1 improper payment rate and other Cycle 1 states' improper payment rates.

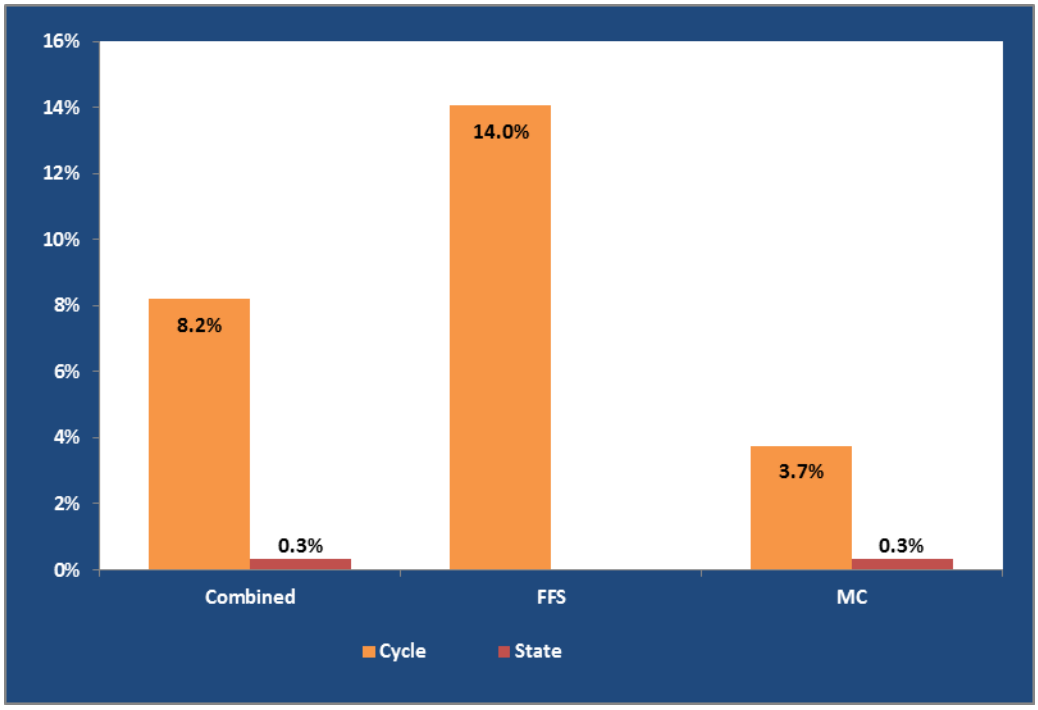
Pennsylvania Figure 1: State Improper Payment Rate Relative to Other States and the Cycle Improper Payment Rate



For the managed care measurement, PERM only reviews the payments made by states to managed care organizations and not claims submitted by providers for services rendered.

Figure 2 compares the 17 Cycle 1 states and Pennsylvania on the combined improper payment rate and the component improper payment rates.

Pennsylvania Figure 2: Cycle and State Combined and Component Improper Payment Rates



D. Sample CHIP Findings and Projected Dollars in Error

The analyses in this section are for sample errors and projected dollars in error. The sample dollars in error are the improper payments found through data processing and medical record review for the PERM claims component. Only CHIP FFS claims are eligible for medical record review. The projected dollars in error are the claim-weighted error amounts that are used to form the numerators for each state's component improper payment rates. The weights for each sampled claim are based on the universe size from which the sample was selected (i.e., universe of CHIP FFS claims and universe of managed care payments). Table 1 summarizes the number of errors and associated dollars for Pennsylvania and the cycle by component. Please note that because each of the component samples is weighted, the proportion of sample dollars in error will be different than the proportion of the projected payments in error.

The **Projected Dollars in Error** amount is an estimate of the total dollars that may have been paid incorrectly across the program during the year. The projection assumes that the errors may be generalized to the CHIP program in proportion to the rate and amount observed in the sample.

Pennsylvania Table 1: CHIP Program Component by State and Cycle Sample Error Payments

CHIP Program Component	State				Cycle			
	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total Projected Dollars in Error	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error ($Millions)	% of Total Projected Dollars in Error
CHIP FFS	N/A	N/A	N/A	N/A	1,229	$1,477,179	$178	74.0%
CHIP Managed Care	1	$224	$1,275,579	100.0%	152	$154,533	$62	26.0%
Note: Details do not always sum to the total due to rounding.								

Table 2 compares Pennsylvania's number of errors, sample dollars in error, and projected dollars in error to those found in the 17 Cycle 1 states by error type for CHIP managed care.

Pennsylvania Table 2: MC Cycle and State Number of Errors and Dollars in Error by Type of Error

	Number of Errors in Sample		Sample Dollars in Error		Projected Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle ($Millions)
MC Data Processing Errors						
Duplicate Claim (DP1)	0	3	$0	$5,860	$0	$0
Non-covered Service/Recipient (DP2)	1	102	$224	$82,841	$1,275,579	$57
Third-party Liability Error (DP4)	0	1	$0	$140	$0	$1
Managed Care Rate Cell Error (DP8)	0	44	$0	$65,693	$0	$4
Data Processing Technical Deficiency (DTD)	0	2	$0	$0	$0	$0
Total	**1**	**152**	**$224**	**$154,533**	**$1,275,579**	**$62**
Note: Details do not always sum to the total due to rounding. For the purposes of this table, Medical Review and Data processing errors are counted separately. Overlaps between the two are reported in both categories, which may result in double counting in this table. Deficiencies, discrepancies found in the review of the claim or of the medical record that did not result in a payment error, are counted as errors throughout this report. Further explanations of error types can be found in Section G Error Type Definitions.						

CHIP FFS Data Analyses

There is no FFS program in Pennsylvania; therefore there are no FFS findings.

CHIP Managed Care Data Analyses

Table 3 shows the number of CHIP managed care errors and dollars in error by overpayments, underpayments, and percentage of total managed care errors.

Pennsylvania Table 3: CHIP Managed Care Data Processing Review Error Type by Overpayments, Underpayments, and Percentage of Data Processing Errors

Error Type	Overpayments			Underpayments			Percentage of Total FFS Data Processing Review Errors		
	# of Errors	Sample Dollars in Error	Projected Dollars in Error	# of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total # of Errors	% of Total Sample Dollars in Error	% of Total Projected Dollars in Error
Non-covered Service/Recipient (DP2)	1	$224	**$1,275,579**	0	$0	**$0**	100.0%	100.0%	**100.0%**
Total	1	$224	**$1,275,579**	0	$0	**$0**	100.0%	100.0%	**100.0%**
Note: Details do not always sum to the total due to rounding.									

Table 4 lists the managed care data processing errors by their more specific cause of error. The error causes are more detailed descriptions as to why a claim was deemed to be in error. Each error is further described in the sections following the table.

Pennsylvania Table 4: Managed Care Data Processing Error by Error Type

Error Type and Cause of Error	# of Errors
Non-covered Service/Recipient (DP2)	
Recipient was ineligible for the applicable program on DOS	1

DP2 – Non-Covered Service/Recipient Error

Recipient was ineligible for the applicable program on DOS

- One error is cited because the sampled claim was paid under the CHIP program, but the recipient was covered under a commercial comprehensive health plan while enrolled in CHIP on the date of service.

E. Types of Payment Errors

The PERM Final Rule allows for classifying data processing errors as state errors and medical review errors as provider errors. This section analyzes Pennsylvania payment errors for FY 2015 in light of this classification. Table 5 shows how the errors aggregate into state and provider payment errors.

Pennsylvania Table 5: CHIP Types of Payment Errors

Error Type	State or Provider Error	# of Errors	% of Total # of Errors	Sample Amount in Error	% of Sample Dollars in Error	Projected Dollars in Error	% of Projected Dollars in Error
Data Processing Errors	State	1	100.0%	$224	100.0%	**$1,275,579**	100.0%
Note: Details do not always sum to the total due to rounding.							

Since Pennsylvania does not have medical review errors, all errors are classified as state errors.

F. Comparison of CHIP FY 2012 and FY 2015

This section provides a brief comparison of the sample findings for Pennsylvania in FY 2012 and FY 2015 for CHIP.

Due to changes in the type of error and service type descriptions, the type of error and service type categories from FY 2012 have been updated to match those found in FY 2015 for the comparisons.

Pennsylvania's CHIP FFS Findings

There is no FFS program in Pennsylvania; therefore there are no FFS comparison analyses.

Sample CHIP Managed Care Comparisons

Figure 3 compares the cycle and Pennsylvania CHIP Managed Care improper payment rates for FY 2012 and FY 2015.

Pennsylvania Figure 3: Cycle and State CHIP Managed Care Improper Payment Rates

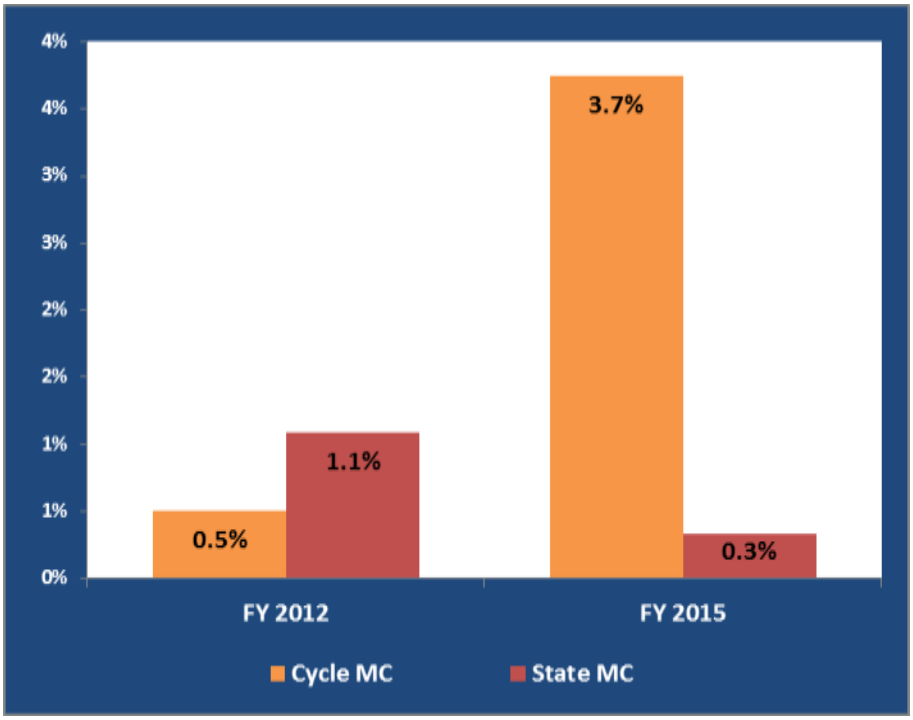


Table 6 shows a comparison of the Managed Care errors from FY 2012 and FY 2015.

Pennsylvania Table 6: CHIP Managed Care FY 2012 and FY 2015 Number of Data Processing Errors by Type of Error and Reason for Error

Error Type and Cause of Error	FY 2012	FY 2015
Non-covered Service/Recipient (DP2)	**3**	**1**
Recipient was ineligible for the applicable program on DOS	3	1
Total	**3**	**1**

G. Error Type Definitions

Error type definitions for medical review error codes and data processing error codes are listed in the following tables.

Pennsylvania Table 7: Medical Review Error Codes

Error Code	Error	Definition
MR1	No Documentation	The provider failed to respond to requests for the medical records or the provider responded that he or she did not have the requested documentation. The provider did not send any documentation related to the sampled payment.
MR2	Incomplete Documentation	The provider submitted some documentation, but the documentation is inconclusive to support the billed service. Based on the medical records provided, the reviewer could not conclude that some of the allowed services were provided at the level billed and/or medically necessary. The additional documentation needed was not submitted.
MR3	Procedure Coding Error	The reviewer determines that the medical service, treatment, and/or equipment was medically necessary and was provided at a proper level of care, but billed and paid based on a wrong procedure code.
MR4	Diagnosis Coding Error	According to the medical record, the principal diagnosis code was incorrect or the DRG paid was incorrect and resulted in a payment error.
MR5	Unbundling	Unbundling includes instances where a set of medical services was provided and billed as separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set, rather than individual services.
MR6	Number of Unit(s) Error	An incorrect number of units was billed.
MR7	Medically Unnecessary Service	There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary. There is affirmative evidence that shows there was an improper diagnosis or deficient treatment plan reasonably connected to the provision of unnecessary medical services or treatment plan for an illness/injury not applicable to improving a patient's condition.
MR8	Policy Violation	A policy is in place regarding the service or procedure performed, and medical review indicates that the service or procedure in the record is inconsistent with the documented policy.
MR9	Inadequate Documentation	Required forms and documents are present, but are inadequately completed to verify that the services were provided in accordance with policy or regulation.
MR10	Administrative/Other	Medical review determined a payment error, but does not fit into one of the other medical review error categories.

Pennsylvania Table 8: Data Processing Error Codes

Error Code	Error	Definition
DP1	Duplicate Item	The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid. Services on a sampled claim conflict with services on another claim during the same date of service (DOS).

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

H. List of PERM IDs

Pennsylvania Table 9: CHIP Managed Care Data Processing Error by Error Type

PERM ID	Error Type	Qualifier
PAC1502M019	Non-covered Service/Recipient (DP2)	Recipient was ineligible for the applicable program on DOS

Return to CHIP Managed Care Data Processing Error by Error Type

I. Recoveries

When a sampled unit is identified as an overpayment error, CMS recovers funds from the state for the federal share. Monthly Final Errors for Recoveries Reports (FEFRs) are posted on the designated CMS Review Contractor's State Medicaid Error Rate Findings (SMERF) website, which lists all claims with an overpayment error and is the official notice sent to the states of

recoveries due. An official letter of notification from CMS is attached to the report notice sent to the states.

States have up to one year from the date of discovery of an overpayment (which is the date of the monthly FEFR report) for Medicaid and CHIP to recover, or to attempt to recover, the overpayment before refunding the federal share. There are exceptions; please reference the State Medicaid Directors Letter (SMDL# 10-014) dated July 13, 2010 at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10014.pdf for more details.

CMS PERM recoveries are reported to the Department of Health & Human Services and Congress. States must return the federal share for overpayments identified in Medicaid and CHIP FFS and managed care. States can find a comprehensive list of these overpayments in the FY 2015 End of Cycle Final Errors for Recoveries Report. In addition, states may find a comprehensive list of Difference Resolutions (DRs) and Appeals filed throughout the cycle, as well as the outcomes of continued processing (which are not reflected in this report) on the SMERF website.

There are circumstances in which exceptions to the requirement to return the federal share of a PERM overpayment may apply. Exceptions include instances where the state adjusted the payment to the correct amount after the 60 days allowed within PERM, the provider submitted documentation after the cycle ended, or the provider successfully appealed a decision to the state. These exceptions are listed in Section 120.3.1 of the CMS PERM Manual, located at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/CMSPERMMAnual1.pdf. States should alert CMS if they believe one of these exceptions applies to their state (note: exceptions will not result in a change in the state's officially cited errors or reported improper payment rate). Please note, the recoveries process is not an opportunity to disagree with error findings. States should complete the DR process within the designated timeframes throughout the PERM cycle, as the end of the cycle is not the time for a state to disagree with error findings.

States are to work with their designated CMS Regional Office PERM recoveries contact to ensure the appropriate federal share is returned timely. Your CMS Central Office PERM recoveries contacts are Megan Curran and your Cycle Manager, Wendy Chesser. They can be reached at 410-786-2280 or Megan.Curran@cms.hhs.gov and 410-786-8519 or Wendy.Chesser@cms.hhs.gov, respectively.

J. Next Steps

The corrective action process begins by establishing a corrective action panel consisting of persons within the organization who have decision-making responsibilities that affect policy and procedural change. This panel should review Pennsylvania's FY 2015 PERM findings, identify programmatic causes of the errors, determine the root causes for the errors, and develop a Corrective Action Plan (CAP) using the CMS provided Pennsylvania CAP template to address the major causes of these errors.

The CAP should include an implementation schedule that identifies major tasks required to implement the corrective action and timelines, including target implementation dates and milestones. Monitoring and evaluation of the corrective action is also essential to ensure that the corrective action is meeting targets and goals and is achieving the desired results.

The CAP is due to the assigned PERM state liaison 90 calendar days after the date on which the state's improper payment rates are posted on the Review Contractor's website. Detailed information and instructions for submitting a CAP can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Corrective-Action-Plan-CAP-Process.html.

CMS appreciates the cooperation extended by Pennsylvania during the FY 2015 measurement and the commitment to safeguarding taxpayers' dollars by ensuring that CHIP services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Pennsylvania during the CAP process. Our aim is to work closely with Pennsylvania to ensure timely submission and implementation of Pennsylvania's corrective action plan. If you have any questions or concerns do not hesitate to contact Tasha Trusty from the PERM CAP Team at Tasha.Trusty@cms.hhs.gov or 410-786-8032.