2019 Medicaid & CHIP Supplemental Improper Payment Data

November 2019

Section 1 Table of Contents

Note: Sections 2 and 3 contain their own Supplemental Information Table of Contents.

Section 1: PERM Program Executive Summary

Historical Medicaid and CHIP Cycle-Specific and National Rolling Federal Improper Payment Rates

Table 1. States in Each Cycle

Cycle 1	**Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming**
Cycle 2	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington
Note: States measured in the most recent cycle for the 2019 improper payment rate (i.e., Cycle 1) are in **bold**.	

Table 2A. Inception to Date Cycle-Specific Medicaid Component Federal Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2007 - Cycle 1	4.7%			
2008 - Cycle 2	8.9%	3.1%	2.9%	**10.5%**
2009 - Cycle 3	2.6%	0.1%	6.7%	**8.7%**
2010 - Cycle 1	1.9%	0.1%	7.6%	**9.0%**
2011 - Cycle 2	3.6%	0.5%	4.0%	**6.7%**
2012 - Cycle 3	3.3%	0.3%	3.3%	**5.8%**
2013 - Cycle 1	3.4%	0.2%	3.3%	**5.7%**
2014 - Cycle 2	8.8%	0.1%	2.3%	**8.2%**
2015 - Cycle 3	18.63%	0.08%	N/A	**N/A**
2016 - Cycle 1	9.78%	0.49%	N/A	**N/A**
2017 - Cycle 2	10.55%	0.38%	N/A	**N/A**
2018 - Cycle 3	23.91%	0.02%	N/A	**N/A**
2019 - Cycle 1	15.12%	0.00%	20.60%	**26.18%**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.

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

Year	FFS	Managed Care	Eligibility*	Overall**
onward, the cycle-specific rate represents only the 17 states sampled. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.				

Table 2B. Inception to Date Cycle-Specific CHIP Component Federal Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2012 - Cycle 3	6.9%	0.1%	5.7%	**8.2%**
2013 - Cycle 1	6.1%	0.5%	4.4%	**6.8%**
2014 - Cycle 2	6.2%	0.0%	2.6%	**4.8%**
2015 - Cycle 3	13.13%	0.64%	N/A	**N/A**
2016 - Cycle 1	14.05%	3.75%	N/A	**N/A**
2017 - Cycle 2	7.68%	1.69%	N/A	**N/A**
2018 - Cycle 3	27.77%	0.24%	N/A	**N/A**
2019 - Cycle 1	15.29%	2.91%	32.97%	**37.75%**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

Table 3A. National Rolling Medicaid Component Federal Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2010 Rolling Rates	4.4%	1.0%	5.9%	**9.4%**
2011 Rolling Rates	2.7%	0.3%	6.0%	**8.1%**
2012 Rolling Rates	3.0%	0.3%	4.9%	**7.1%**
2013 Rolling Rates	3.6%	0.3%	3.3%	**5.8%**
2014 Rolling Rates	5.1%	0.2%	3.1%	**6.7%**
2015 Rolling Rates	10.59%	0.12%	3.11%	**9.78%**
2016 Rolling Rates	12.42%	0.25%	3.11%	**10.48%**
2017 Rolling Rates	12.87%	0.30%	3.11%	**10.10%**
2018 Rolling Rates	14.31%	0.22%	3.11%	**9.79%**
2019 Rolling Rates	16.30%	0.12%	8.36%	**14.90%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

Table 3B. National Rolling CHIP Component Federal Improper Payment Rates

Year	FFS	Managed Care	Eligibility*	Overall**
2013 Rolling Rates	5.7%	0.2%	5.1%	**7.1%**
2014 Rolling Rates	6.2%	0.2%	4.2%	**6.5%**
2015 Rolling Rates	7.33%	0.37%	4.22%	**6.80%**
2016 Rolling Rates	10.15%	1.01%	4.22%	**7.99%**
2017 Rolling Rates	10.29%	1.62%	4.22%	**8.64%**
2018 Rolling Rates	12.55%	1.24%	4.22%	**8.57%**
2019 Rolling Rates	13.25%	1.25%	11.78%	**15.83%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.
**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. It is important to note that the 2013 rolling rate for CHIP represents 2 cycles since only 34 states had been sampled at the time. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

Overall 2019 Improper Payment Findings

Figure 1. National Rolling Medicaid Improper Payment Rate by Claim Type[1]

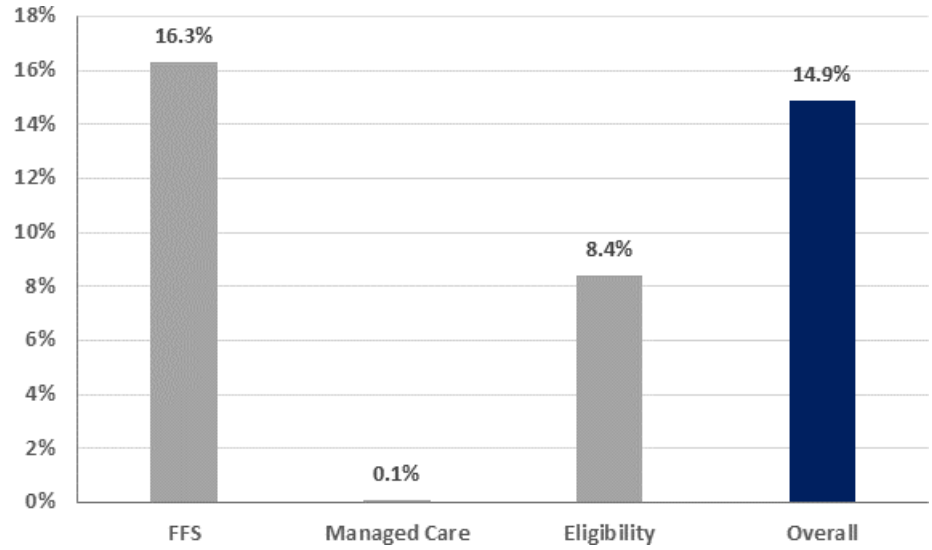
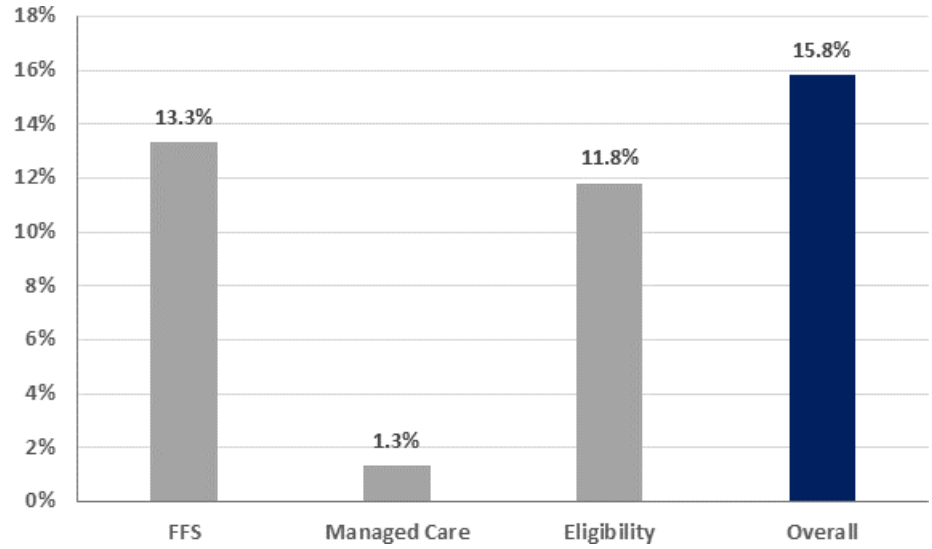


Figure 2. National Rolling CHIP Improper Payment Rate by Claim Type[1]



[1] Please note that the eligibility rate includes both the results from the 17 states measured in 2019 under the new eligibility methodology and the proxy eligibility estimate for the 34 states not yet measured since the reintegration of the PERM eligibility component.

Figure 3. Medicaid Individual Cycle Improper Payments (in Billions)

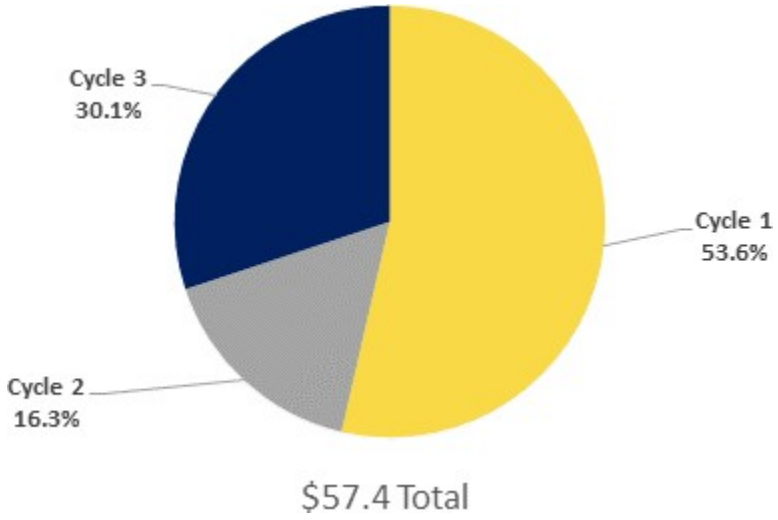


Figure 4. CHIP Individual Cycle Improper Payments (in Billions)

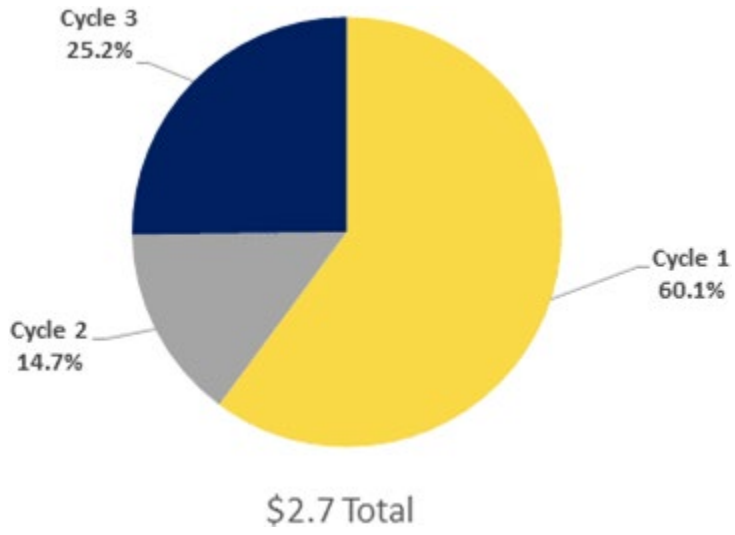


Figure 5. Medicaid Percentage of National Improper Payments by Claim Type[2]

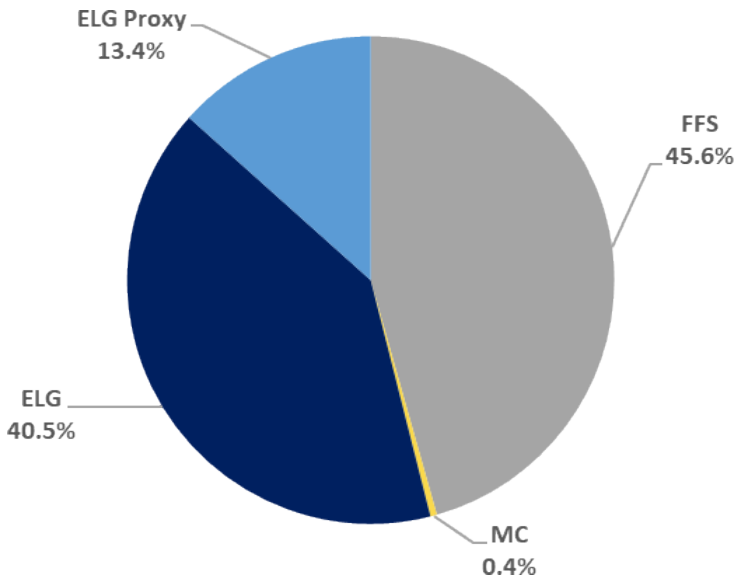
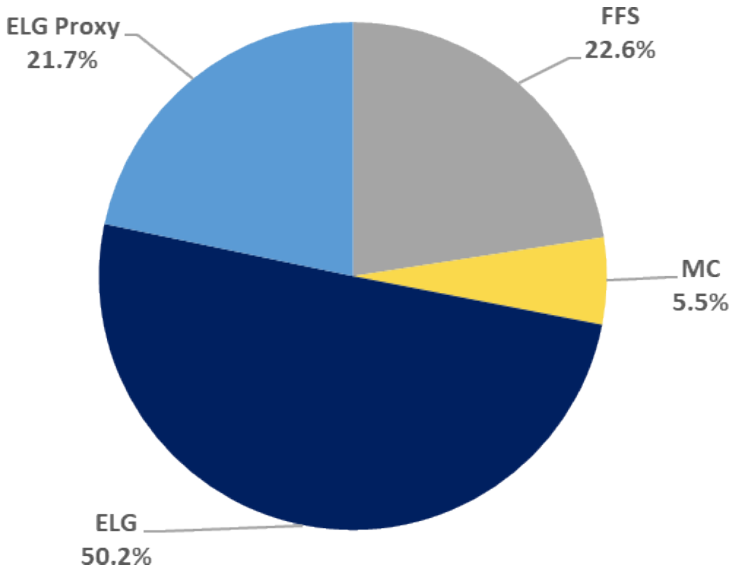


Figure 6. CHIP Percentage of National Improper Payments by Claim Type[2]



2 Percentages may not sum to 100% due to rounding.

Common Causes of 2019 Improper Payments

Figure 7. Medicaid Type of Errors by Percentage of National Improper Payments[3]

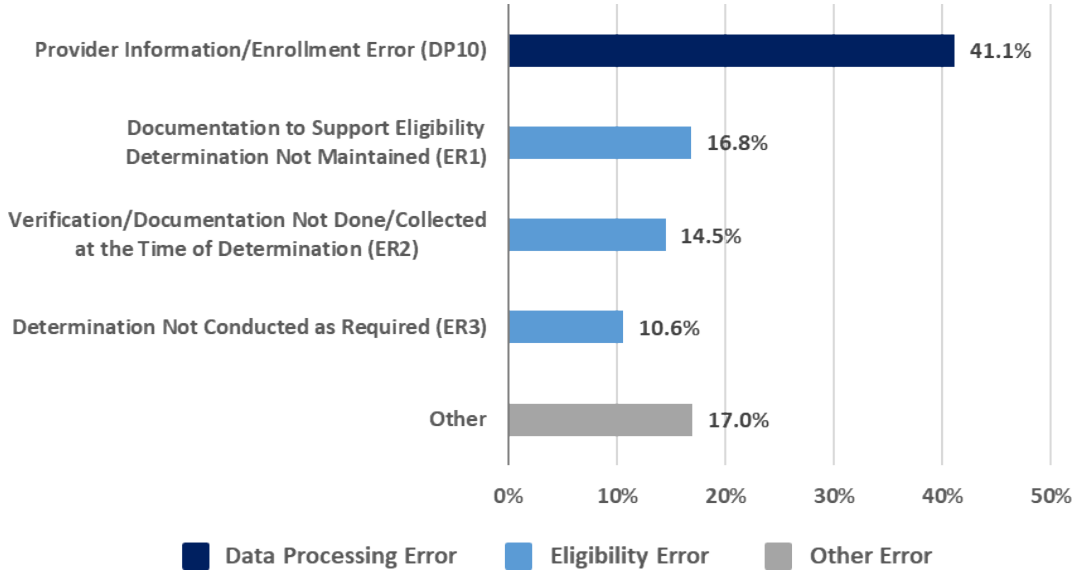
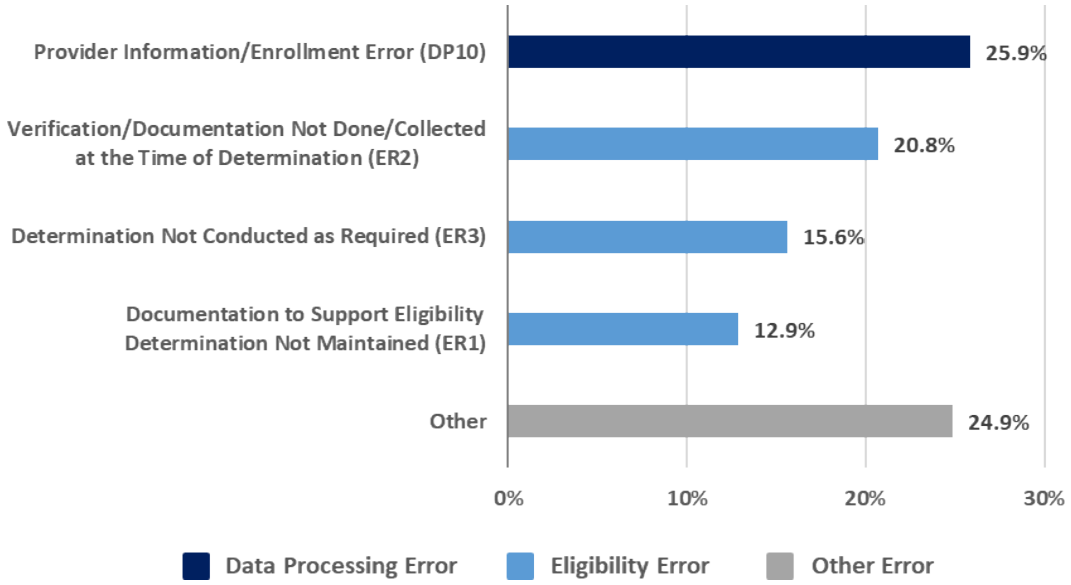


Figure 8. CHIP Type of Errors by Percentage of National Improper Payments[3]



[3] Percentages may not sum to 100% due to rounding.

2019 Monetary Loss Findings[4]

Figure 9. Medicaid Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[5]

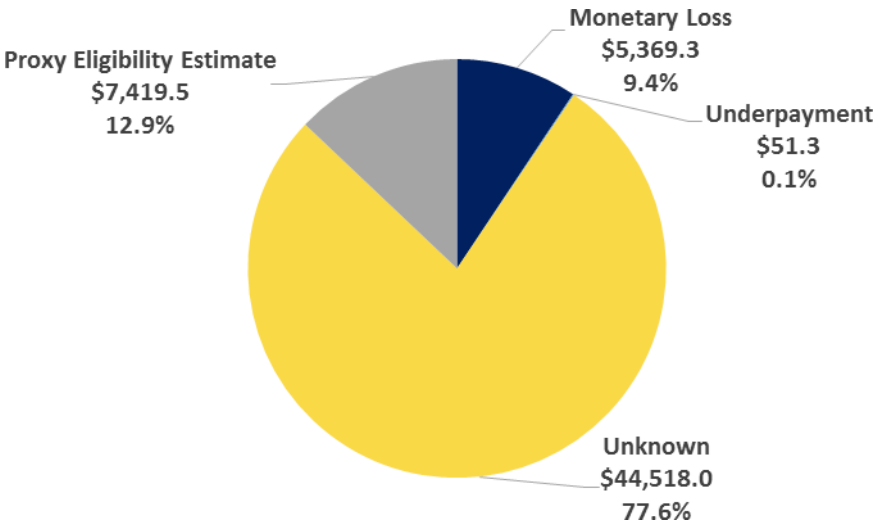
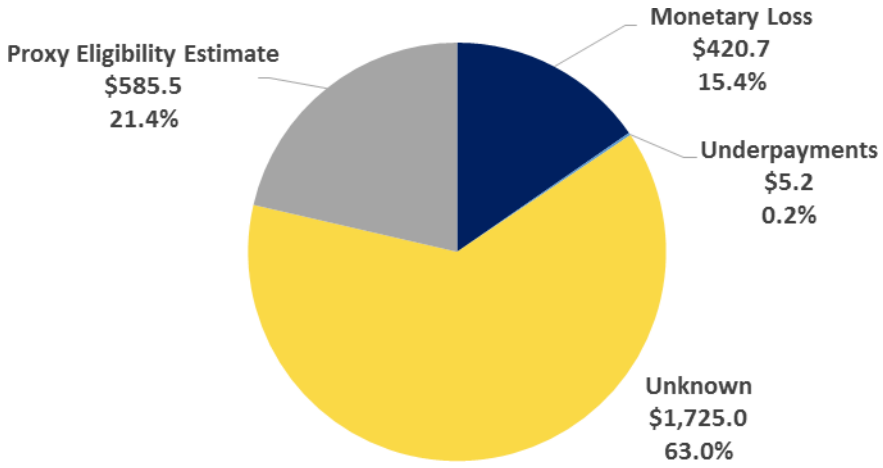


Figure 10. CHIP Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[5]



[4] Eligibility reviews were suspended from 2015 to 2018. Therefore, these figures include only one cycle of the eligibility component measured under new requirements (the 17 states measured in 2019).

[5] Multiple errors on a claim are not counted separately in this figure and may not match other figures in this report. Additionally, percentages may not sum to 100% due to rounding.

2019 FFS Improper Payment Trends

Figure 11. Medicaid and CHIP FFS Improper Payments Timeline Highlighting Key Review Events

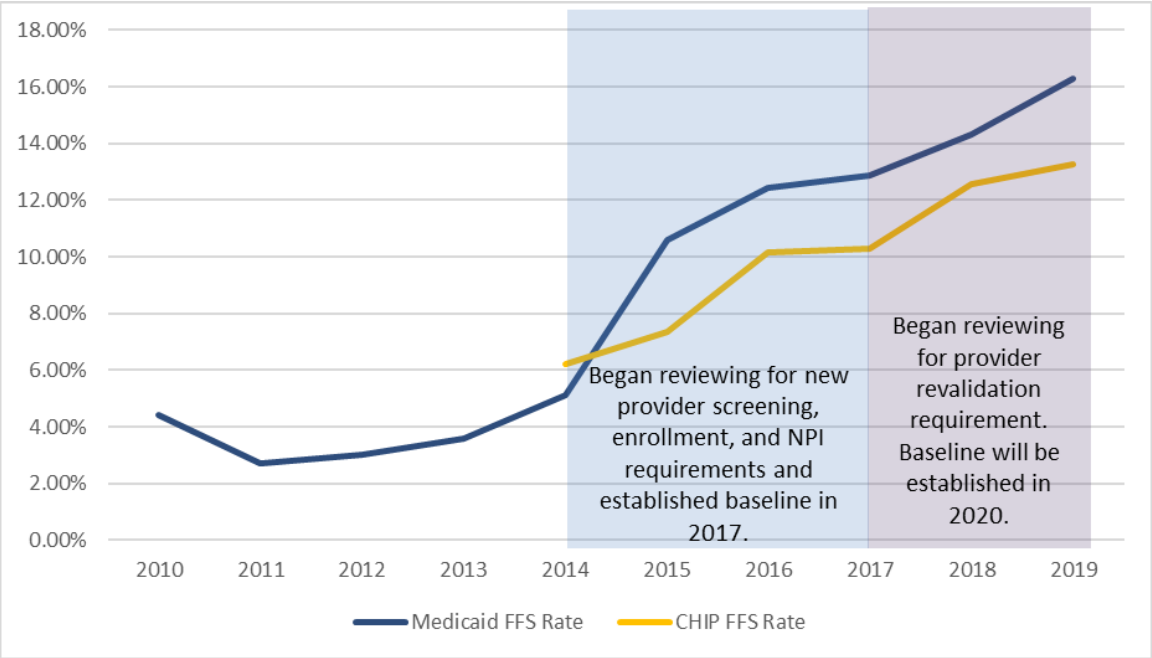


Figure 12. Medicaid Type of Errors by Percentage of Eligibility Component Improper Payments

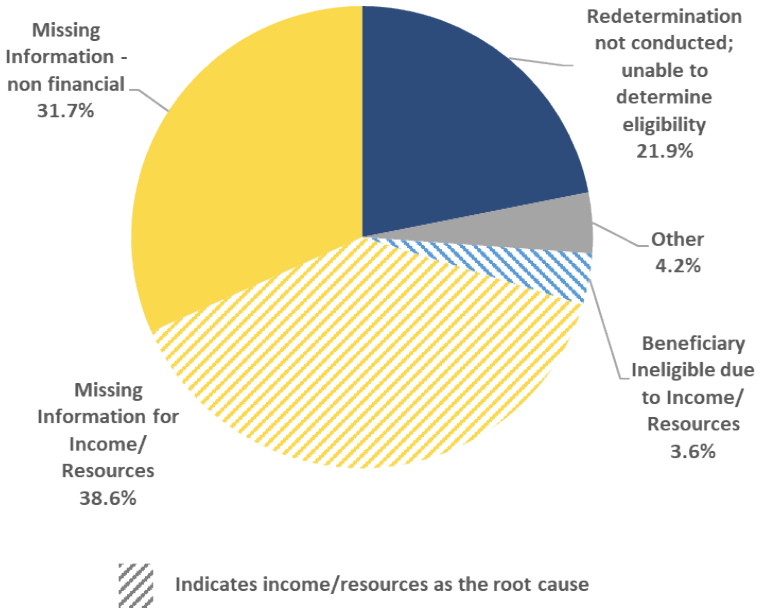


Figure 13. CHIP Type of Errors by Percentage of Eligibility Component Improper Payments

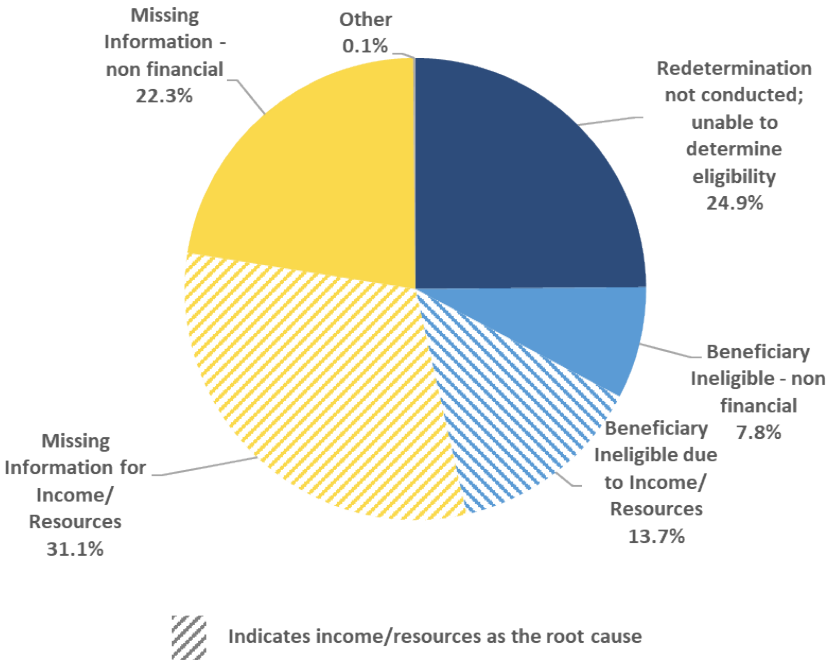


Figure 14. Medicaid Eligibility Monetary Loss Improper Payment Root Causes

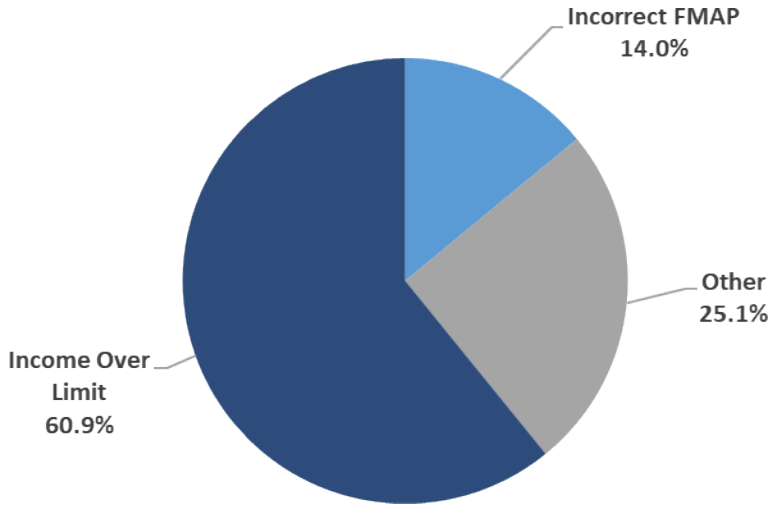
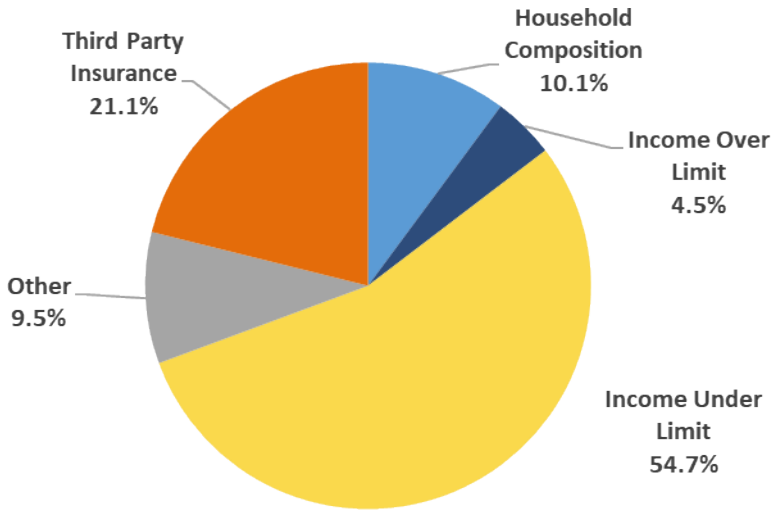


Figure 15. CHIP Eligibility Monetary Loss Improper Payment Root Causes[6]



[6] Please note that errors found in the "Income Under Limit" root cause are a result of the "Wrong Program Errors" described in the next figure.

Figure 16. CHIP Eligibility Wrong Program Error Root Causes

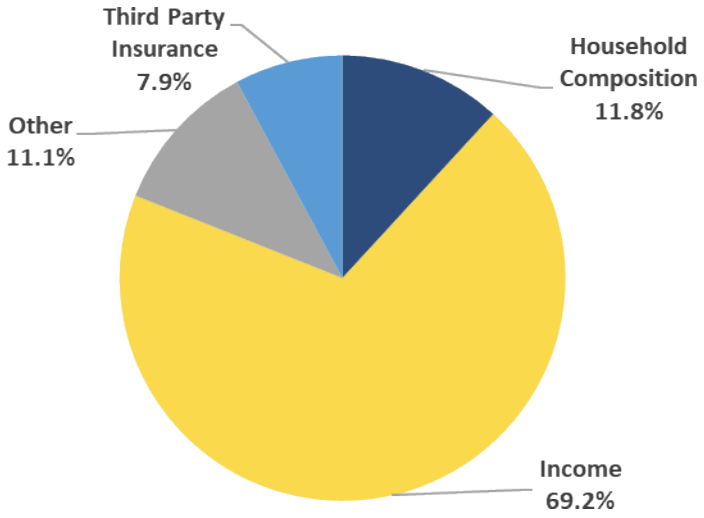
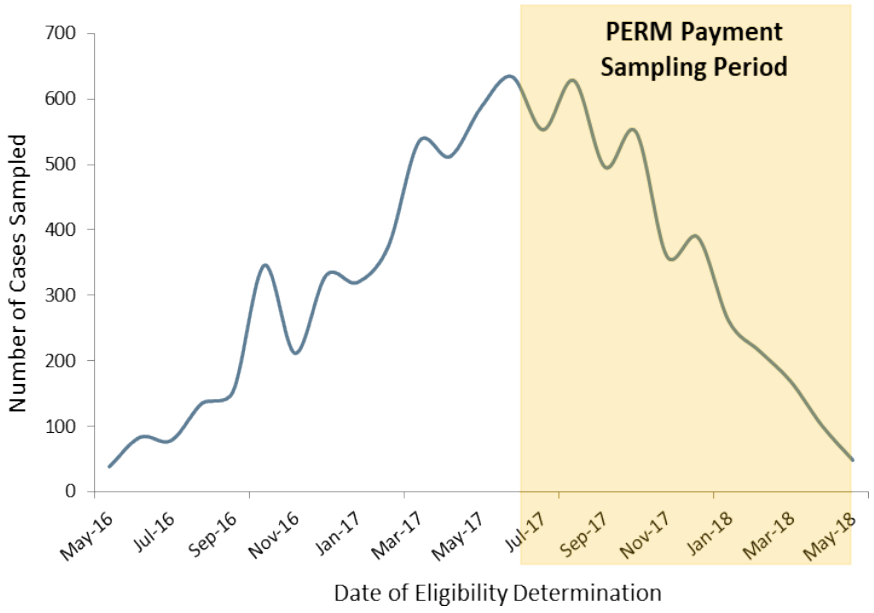


Figure 17. Medicaid and CHIP Eligibility Determination Timeframe for Claims Sampled in the 2019 Review Period



Section 2: 2019 Supplemental Medicaid Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for Medicaid in 2019 based on the 51 states reviewed from 2017-2019. Unless otherwise noted, all tables and figures in Section 2 are based on the rolling rate, except for those providing only eligibility review information.

There was no eligibility component review from 2015-2018. Therefore, the rolling national eligibility estimate is a combination of the eligibility results from the 2019 Cycle 1 measurement and the most recent cycles prior to 2015 for Cycle 2 and Cycle 3 (those not yet measured under the new eligibility review methodology). All other eligibility data provided is specific to the 2019 Cycle 1 measurement.

Medicaid Improper Payments

Table S1. Summary of Medicaid Projected Federal Improper Payments

Category	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
FFS	7,102	35,815	$23,381,842.84	$171,705,111.39	$27,213.32	$166,953.36	16.30%	15.57% - 17.03%
FFS Medical Review	1,027	35,815*	$2,124,246.71	$171,705,111.39	$4,276.07	$166,953.36	2.56%	2.17% - 2.95%
FFS Data Processing	6,305	35,815	$21,621,966.82	$171,705,111.39	$23,679.96	$166,953.36	14.18%	13.55% - 14.82%
Managed Care	53	7,720	$17,754.18	$8,315,913.84	$261.13	$218,043.31	0.12%	0.08% - 0.16%
Eligibility	2,530	23,631	$2,118,239.39	$19,740,045.93	$32,180.15	$384,996.67	8.36%	7.69% - 9.03%
Total	**9,685**	**67,166**	**$25,517,836.41**	**$199,761,071.16**	**$57,358.13**	**$384,996.67**	**14.90%**	**14.21% - 15.58%**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.
*Data Processing review is performed on all sampled FFS claims. However, not all sampled FFS claims receive a Medical Review, as certain exceptions apply where Medical Review is not able to be performed (Medicare Part A and Part B premiums, primary care case management payments, aggregate payments, other fixed payments, denied claims, and zero-paid claims).

Table S2. Medicaid Federal Improper Payments by Type of Improper Payment and Cause of Improper Payment

Type of Improper Payment	Cause of Improper Payment	Federal Improper Payments (billions)	Percentage of Federal Improper Payments
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$1.58	2.75%
	Other Monetary Loss	$1.02	1.77%
	Provider Not Enrolled	$2.78	4.84%
Unknown	Insufficient Information to Determine Eligibility	$15.95	27.80%
	Redetermination Not Conducted	$4.90	8.54%
	Non-Compliance with Provider Screening and NPI Requirements	$17.40	30.33%
	Other Missing Information	$6.15	10.72%
	Other Unknown	$0.13	0.23%
Underpayments		$0.05	0.09%
Proxy Eligibility Estimate		$7.42	12.94%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes). In the table, "Unknown" represents payments where there was no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program. The Proxy Eligibility Estimate is used to represent the eligibility component for the 34 states not yet measured since the reintegration of the PERM eligibility component and includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments.

Medicaid FFS Component Federal Improper Payment Rate

Table S3. Medicaid FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	2,620	2,385	7,516	$3,572,518.12	$11,522,866.16	$8,817.55	$33,508.86	26.31%	24.53% - 28.10%
Personal Support Services	762	648	1,899	$546,882.03	$1,275,417.07	$3,007.38	$11,656.70	25.80%	23.10% - 28.50%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	793	635	1,334	$7,133,253.13	$15,455,908.44	$2,686.88	$5,659.96	47.47%	43.51% - 51.43%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	823	715	5,671	$2,245,278.36	$24,820,423.54	$2,505.48	$26,164.49	9.58%	8.57% - 10.59%
Prescribed Drugs	862	764	3,890	$2,518,232.84	$14,089,909.69	$2,468.36	$17,256.21	14.30%	10.95% - 17.66%
Psychiatric, Mental Health, and Behavioral Health Services	671	540	2,292	$1,332,495.57	$9,051,784.38	$1,783.87	$10,188.74	17.51%	14.65% - 20.36%
Capitated Care/Fixed Payments	87	69	2,300	$17,404.01	$18,248,222.57	$1,122.76	$16,688.61	6.73%	3.67% - 9.78%
Dental and Oral Surgery Services	446	341	739	$72,228.30	$153,185.38	$822.08	$2,496.96	32.92%	26.91% - 38.93%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	129	121	1,219	$37,843.53	$584,404.19	$617.18	$6,245.65	9.88%	1.55% - 18.21%
Clinic Services	115	105	822	$32,122.33	$274,293.45	$563.13	$4,399.96	12.80%	8.18% - 17.42%
Physical, Occupational, Respiratory Therapies (PT, OT, RT); Speech Language Pathology (SLP), Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	142	93	246	$5,693.61	$25,485.82	$549.45	$1,097.31	50.07%	38.00% - 62.15%
Home Health Services	135	108	536	$75,819.37	$361,068.66	$470.22	$2,173.81	21.63%	16.30% - 26.96%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Inpatient Hospital Services	165	157	2,651	$5,354,320.25	$71,456,204.45	$428.23	$14,937.34	2.87%	1.70% - 4.03%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	132	111	378	$123,471.40	$431,851.25	$380.27	$1,542.21	24.66%	18.02% - 31.29%
Outpatient Hospital Services	116	104	1,670	$152,215.56	$2,706,197.07	$269.02	$6,558.03	4.10%	1.81% - 6.40%
Hospice Services	68	52	282	$130,802.31	$905,367.07	$232.29	$1,407.22	16.51%	11.07% - 21.95%
Laboratory, X-ray and Imaging Services	73	58	316	$4,252.60	$24,927.31	$214.06	$925.90	23.12%	15.62% - 30.62%
Transportation and Accommodations	59	56	288	$19,712.19	$187,505.69	$209.59	$1,094.07	19.16%	10.66% - 27.65%
Crossover Claims	39	39	982	$7,297.33	$130,089.21	$65.53	$2,951.36	2.22%	0.04% - 4.40%
Denied Claims	1	1	784	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**8,238**	**7,102**	**35,815**	**$23,381,842.84**	**$171,705,111.39**	**$27,213.32**	**$166,953.36**	**16.30%**	**15.57% - 17.03%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

Medicaid FFS Medical Review Federal Improper Payments

Table S4. Summary of Medicaid FFS Medical Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	450	$1,037,040.95	$2,000.09	$1,627.88	$2,372.29
No Documentation Error (MR1)	350	$838,705.31	$1,470.99	$874.98	$2,067.01
Improperly Completed Documentation (MR9)	118	$209,814.86	$596.60	$445.31	$747.88
Number of Unit(s) Error (MR6)	76	$57,363.31	$222.74	$117.28	$328.20
Procedure Coding Error (MR3)	10	$6,073.35	$67.92	$4.64	$131.20
Policy Violation Error (MR8)	2	$6,037.75	$16.30	-$8.97	$41.57
Administrative/Other Error (MR10)	3	$6,325.81	$10.04	-$1.92	$22.00
Medical Technical Deficiency (MTD)	43	$0.00	$0.00	$0.00	$0.00
Total	**1,052**	**$2,161,361.34**	**$4,384.68**	**$3,657.12**	**$5,112.23**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. However, if there was more than one MR2 error on a claim in 2018, only one MR2 error was included in the calculations. Each individual cause of MR2 errors is listed in further detail in Table S5, below. However, each individual absent document is not identified as a separate issue in this overall data, if multiple documents are absent from the same claim. Further explanation of Medical Review error types can be found in Section 4: Error Codes, Table A1. There were no underpayments cited, so only overpayments are reported in this table.

Medical Review Federal Improper Payments: Document(s) Absent from Record Error (MR2)

Table S5. Medicaid FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
One or more documents are missing from the record that are required to support payment	118	$158,077.11	$668.10	$490.72	$845.47
Provider did not submit required progress notes applicable to the sampled DOS	72	$275,700.14	$289.06	$183.08	$395.05
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	60	$39,602.90	$265.18	$91.23	$439.12
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	25	$34,688.93	$238.63	$21.88	$455.39
Multiple documents are missing from the record that are required to support payment	62	$136,934.98	$169.22	$95.83	$242.61
Provider did not submit the service plan	56	$106,366.21	$161.85	$94.68	$229.02
Individual plan (ITP, ISP, IFSP, IEP, or POC) was present, but not applicable to the sampled DOS	35	$123,359.48	$106.41	$49.96	$162.85
Record does not include a physician's order for the sampled service	29	$84,982.20	$89.36	$37.16	$141.55
Provider did not submit sufficient documentation to support the claim	1	$3,110.40	$33.13	N/A	N/A
Provider did not submit proof of delivery	2	$405.50	$15.28	-$13.41	$43.97
Other	7	$25,696.45	$15.28	$3.47	$27.09
Provider did not submit a valid prescription	4	$4,427.03	$12.13	-$1.22	$25.49
Provider did not submit the required physician certification/recertification of services	1	$97.60	$6.16	N/A	N/A
Provider did not submit the test result	1	$33.25	$2.97	N/A	N/A
Provider did not submit an inpatient admission order	1	$73,428.71	$2.20	N/A	N/A
Total	**474**	**$1,066,910.89**	**$2,074.97**	**$1,701.32**	**$2,448.61**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table S6. Medicaid FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
Progress Notes for All Disciplines/Department (to include physician's 60-day progress notes in effect during sampled date/s of service)	141
Treatment Plan and Goals (ISP, IPP, IFSP, POC in effect during sampled date/s of service)	123
Physician Orders (signed and dated, include all orders relevant to sampled claim)	86
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	49
Individual Education Plan (IEP), Individual Program Plan (IPP), Individual Service Plan (ISP), Individual Family Service Plan (IFSP)	45
Member Pharmacy Signature Log/Proof of Delivery	36
Documentation of Daily Patient Presence (e.g., daily census, attendance log, etc.)	17
Medication Administration Record (MAR)	17
Other	13
Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form: Front and Back (if applicable) - with Patient Name, Date of Birth, Address, Telephone Number, Physician Name, and Signature (signature method as required/permitted by state regulations)	12
Encounter/Clinic Visit Record/Notes (signed and dated)	11
Member Profile with Refill History for the Sampled Medication	11
Documented Proof of Acceptance or Refusal of Counseling	10
Prior Authorization (if required)	8
Mental Health Progress/Therapy Notes/Daily Attendance Logs (with start and stop times)	7
Treatment Administration Record/Notes	7
Physician Certification/Recertification (signed and dated, in effect during sampled date/s of service - include cert/re-cert done prior to date/s of service if not completed during requested time frame)	6
Annual Physical Exam (if required)	5
Case Management Care Plan/Updates and Notes (in effect during sampled date/s of service, including telephonic contact)	5
PT, OT, SLP, Audiology, Vision, and RT: Evaluation and Re-evaluation/Notes	5
Physician Orders and Progress Notes (signed and dated)	3
Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)	3
Ground Mileage/Pick-up & Drop Off Details	2

Documentation Type	Total Count
Timesheet, Completed and Signed (include description of services approved and provided)	2
Dental X-Ray Notes (please do not send x-rays)	1
Dental and Diagnostic Service Records	1
Home Health Aide Notes/Worksheets	1
Hospice Nurse Visit and Progress Notes	1
Nursing Assessments and Notes	1
Nursing Care Plan/Treatment Care Plan	1
Orders from Identified Qualified Provider (if required)	1
Procedure Record/Notes	1
Total	**632**
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Table S7. Medicaid FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Total Count
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	258
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	119
Psychiatric, Mental Health, and Behavioral Health Services	74
Prescribed Drugs	64
Personal Support Services	46
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	27
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	10
Outpatient Hospital Services	10
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	6
Clinic Services	5
Home Health Services	5
Dental and Oral Surgery Services	3
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	3
Hospice Services	1
Inpatient Hospital Services	1
Total	**632**
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Medical Review Federal Improper Payments: No Documentation Error (MR1)

Table S8. Medicaid FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	185	$353,851.26	$502.70	$381.48	$623.92
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	40	$339,947.85	$462.66	-$104.97	$1,030.29
Provider responded that he or she did not have the beneficiary on file or in the system	27	$22,152.94	$134.41	$51.07	$217.75
State could not locate the provider	39	$26,838.82	$125.98	$74.85	$177.11
Provider responded with a statement that the provider had billed in error	27	$32,711.08	$111.67	$46.64	$176.70
Provider responded with a statement that records cannot be located	6	$2,023.59	$51.10	-$4.80	$107.00
Provider submitted a record for wrong DOS	7	$54,274.15	$23.78	$0.78	$46.78
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	6	$2,064.04	$23.69	-$0.62	$48.00
Provider is under fraud investigation or pending litigation	7	$2,349.67	$15.25	-$0.69	$31.19
Provider did not submit medical records, only billing information, which is not enough/sufficient to support the sampled claim	2	$218.72	$6.13	-$2.49	$14.75
Provider did not submit medical records, only the PERM coversheet	1	$4.83	$5.25	N/A	N/A
Other	2	$997.32	$5.19	-$3.17	$13.54
Provider responded with a statement that the record is lost or destroyed due to an unforeseeable and uncontrollable event such as fire, flood, or earthquake	1	$1,271.05	$3.18	N/A	N/A
Total	**350**	**$838,705.31**	**$1,470.99**	**$874.98**	**$2,067.01**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Medicaid FFS Medical Review Errors by Service Type

Table S9. Medicaid FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	279	265	5,671	$894,714.15	$24,820,423.54	$1,155.46	$26,164.49	4.42%	3.64% - 5.20%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	219	217	7,516	$195,367.35	$11,522,866.16	$868.29	$33,508.86	2.59%	1.88% - 3.30%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	46	46	1,219	$28,166.79	$584,404.19	$432.16	$6,245.65	6.92%	(1.43%) - 15.27%
Psychiatric, Mental Health, and Behavioral Health Services	151	143	2,292	$70,714.46	$9,051,784.38	$413.68	$10,188.74	4.06%	2.95% - 5.17%
Prescribed Drugs	102	102	3,890	$211,067.14	$14,089,909.69	$413.35	$17,256.21	2.40%	1.09% - 3.70%
Personal Support Services	83	82	1,899	$31,485.67	$1,275,417.07	$353.91	$11,656.70	3.04%	1.77% - 4.30%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	31	31	1,334	$225,017.48	$15,455,908.44	$110.00	$5,659.96	1.94%	1.00% - 2.89%
Inpatient Hospital Services	9	9	2,651	$394,929.76	$71,456,204.45	$103.39	$14,937.34	0.69%	(0.09%) - 1.47%
Clinic Services	22	22	822	$11,782.79	$274,293.45	$84.84	$4,399.96	1.93%	0.51% - 3.34%
Outpatient Hospital Services	29	29	1,670	$44,337.76	$2,706,197.07	$81.49	$6,558.03	1.24%	0.39% - 2.10%
Home Health Services	14	14	536	$4,652.35	$361,068.66	$69.35	$2,173.81	3.19%	0.91% - 5.47%
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	13	13	246	$762.89	$25,485.82	$53.36	$1,097.31	4.86%	1.22% - 8.51%
Transportation and Accommodations	10	10	288	$326.12	$187,505.69	$40.94	$1,094.07	3.74%	0.40% - 7.09%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Laboratory, X-ray and Imaging Services	12	12	316	$453.82	$24,927.31	$38.41	$925.90	4.15%	0.89% - 7.41%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	18	18	378	$4,879.22	$431,851.25	$25.53	$1,542.21	1.66%	0.28% - 3.03%
Dental and Oral Surgery Services	11	11	739	$1,407.48	$153,185.38	$23.08	$2,496.96	0.92%	0.04% - 1.81%
Hospice Services	3	3	282	$4,181.49	$905,367.07	$8.86	$1,407.22	0.63%	(0.14%) - 1.40%
Capitated Care/Fixed Payments	0	0	2,300	$0.00	$18,248,222.57	$0.00	$16,688.61	0.00%	0.00% - 0.00%
Crossover Claims	0	0	982	$0.00	$130,089.21	$0.00	$2,951.36	0.00%	0.00% - 0.00%
Denied Claims	0	0	784	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**1,052**	**1,027**	**35,815**	**$2,124,246.71**	**$171,705,111.39**	**$4,276.07**	**$166,953.36**	**2.56%**	**2.17% - 2.95%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

Medicaid FFS Data Processing Federal Improper Payments

Table S10. Summary of Medicaid FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	6,019	$22,646,209.20	$23,758.32	$22,816.01	$24,700.63
Administrative/Other Error (DP12)	142	$438,127.11	$1,380.82	$721.52	$2,040.12
Duplicate Claim Error (DP1)	70	$32,413.54	$848.67	$519.61	$1,177.73
Pricing Error (DP5)	160	$324,219.56	$816.38	$501.57	$1,131.18
Non-covered Service/Beneficiary Error (DP2)	76	$351,117.03	$255.93	$50.74	$461.12
Managed Care Payment Error (DP9)	2	$226.95	$103.19	-$54.23	$260.61
System Logic Edit Error (DP6)	2	$8,144.87	$56.96	-$22.96	$136.89
Third-Party Liability Error (DP4)	12	$33,142.53	$48.84	$7.03	$90.64
Claim Filed Untimely Error (DP11)	4	$26,019.75	$8.63	-$4.14	$21.39
Data Entry Error (DP7)	8	$1,596.20	$4.95	$1.14	$8.76
Managed Care Rate Cell Error (DP8)	1	$0.33	$0.10	N/A	N/A
Data Processing Technical Deficiency (DTD)	690	$0.00	$0.00	$0.00	$0.00
Total	**7,186**	**$23,861,217.05**	**$27,282.79**	**$26,043.47**	**$28,522.11**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Data Processing Federal Improper Payments: Provider Information/Enrollment Error (DP10)

Table S11. Medicaid FFS Specific Causes of Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Screening	Provider not appropriately screened using risk based criteria	3,186	$8,463,497.39	$10,537.61	$9,996.18	$11,079.05
National Provider Identifier (NPI)	Attending or rendering provider NPI required, but not listed on claim	656	$4,384,146.08	$3,791.35	$3,344.03	$4,238.67
	ORP NPI required, but not listed on claim	618	$1,824,527.22	$2,329.81	$2,019.32	$2,640.30
	Billing provider NPI required, but not listed on claim	117	$195,049.51	$396.29	$270.81	$521.78
Provider Enrollment	Provider not enrolled	377	$3,380,103.16	$2,837.02	$2,369.29	$3,304.75
Provider License/Certification	Provider license not current for DOS	52	$285,293.66	$277.90	$118.10	$437.70
Missing Provider Information	Missing provider risk based screening information	747	$1,994,497.30	$1,992.79	$1,702.22	$2,283.36
	Missing provider enrollment information	124	$280,463.96	$831.43	$679.44	$983.42
	Missing information to determine if attending NPI submitted on the claim	65	$581,264.80	$368.82	$279.94	$457.70
	Missing information to determine if billing NPI submitted on the claim	40	$515,539.86	$234.99	$163.54	$306.43
	Other missing provider information	16	$16,708.45	$83.76	$38.70	$128.82
	Missing provider license information	15	$107,146.97	$60.68	$28.14	$93.22
	Missing information to determine if provider NPI was submitted on the claim	5	$617,912.97	$8.29	($2.75)	$19.34
	Missing information to determine if ORP NPI submitted on the claim	1	$57.88	$7.57	N/A	N/A
Total		**6,019**	**$22,646,209.20**	**$23,758.32**	**$22,816.01**	**$24,700.63**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table S12. 2019 Cycle 1 DP10 Medicaid FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	225
	Incorrect NPI on the claim	26
	Missing information to determine if NPI submitted on the claim	1
Billing	No NPI on the claim	51
ORP	No NPI on the claim	123
	Incorrect NPI on the claim	3
Rendering	No NPI on the claim	1

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table S13. 2019 Cycle 1 DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Revalidated	606
	Newly Enrolled	126
Provider Risk Level	Limited	636
	Moderate	54
	High	42
Provider Type	Billing	691
	Rendering	22
	ORP	19
Screening Elements Not Completed	No required databases checked	553
	SAM/EPLS not checked	94
	NPPES not checked	84

Breakdown	Additional Detail	Number of Errors
	On-site not conducted	83
	LEIE not checked	54
	DMF not checked	10
Missing Screening Information	Revalidated provider	117
	Newly Enrolled provider	33
	Limited Risk	142
	Moderate Risk	8
	Billing provider	147
	Rendering provider	3
	No required database documentation present	148
	On-site visit documentation not present	7
	NPPES not present	1

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table S14. 2019 Cycle 1 DP10 Medicaid FFS Errors: Provider Not Enrolled Breakdown

Provider Type	Sub-Cause of Error	Number of Errors
Billing	Provider not enrolled	35
	Missing provider enrollment information	3
ORP	Provider not enrolled	12
Attending	Provider not enrolled	2
	Missing provider enrollment information	1

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Medicaid FFS Data Processing Errors by Service Type

Table S15. Medicaid FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	2,401	2,238	7,516	$3,457,095.41	$11,522,866.16	$8,228.27	$33,508.86	24.56%	22.87% - 26.24%
Personal Support Services	679	581	1,899	$523,319.53	$1,275,417.07	$2,694.31	$11,656.70	23.11%	20.58% - 25.65%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	762	622	1,334	$7,020,716.19	$15,455,908.44	$2,637.39	$5,659.96	46.60%	42.66% - 50.53%
Prescribed Drugs	760	687	3,890	$2,376,376.15	$14,089,909.69	$2,095.53	$17,256.21	12.14%	8.98% - 15.31%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	544	482	5,671	$1,434,072.39	$24,820,423.54	$1,496.08	$26,164.49	5.72%	4.99% - 6.44%
Psychiatric, Mental Health, and Behavioral Health Services	520	429	2,292	$1,267,298.09	$9,051,784.38	$1,421.12	$10,188.74	13.95%	11.28% - 16.62%
Capitated Care/Fixed Payments	87	69	2,300	$17,404.01	$18,248,222.57	$1,122.76	$16,688.61	6.73%	3.67% - 9.78%
Dental and Oral Surgery Services	435	339	739	$71,580.30	$153,185.38	$816.98	$2,496.96	32.72%	26.72% - 38.72%
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	129	87	246	$5,198.67	$25,485.82	$524.33	$1,097.31	47.78%	35.62% - 59.95%
Clinic Services	93	85	822	$20,858.69	$274,293.45	$482.92	$4,399.96	10.98%	6.52% - 15.43%
Home Health Services	121	96	536	$71,684.78	$361,068.66	$410.86	$2,173.81	18.90%	13.88% - 23.92%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	114	101	378	$120,424.98	$431,851.25	$363.75	$1,542.21	23.59%	17.07% - 30.10%
Inpatient Hospital Services	156	148	2,651	$4,959,390.49	$71,456,204.45	$324.84	$14,937.34	2.17%	1.30% - 3.05%
Hospice Services	65	50	282	$126,639.77	$905,367.07	$224.39	$1,407.22	15.95%	10.59% - 21.30%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Outpatient Hospital Services	87	78	1,670	$109,439.25	$2,706,197.07	$214.18	$6,558.03	3.27%	1.01% - 5.52%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	83	77	1,219	$9,842.69	$584,404.19	$193.50	$6,245.65	3.10%	1.06% - 5.14%
Laboratory, X-ray and Imaging Services	61	48	316	$3,916.33	$24,927.31	$187.38	$925.90	20.24%	13.07% - 27.41%
Transportation and Accommodations	49	48	288	$19,411.76	$187,505.69	$175.84	$1,094.07	16.07%	8.09% - 24.05%
Crossover Claims	39	39	982	$7,297.33	$130,089.21	$65.53	$2,951.36	2.22%	0.04% - 4.40%
Denied Claims	1	1	784	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**7,186**	**6,305**	**35,815**	**$21,621,966.82**	**$171,705,111.39**	**$23,679.96**	**$166,953.36**	**14.18%**	**13.55% - 14.82%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

Medicaid Managed Care Errors by Type of Error

Table S16. Summary of Medicaid Managed Care Data Processing Projected Federal Dollars by Type of Error

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Administrative/Other Error (DP12)	17	$12,755.70	$207.20	$120.88	$293.53
Managed Care Payment Error (DP9)	28	$1,425.35	$29.97	$16.93	$43.02
Non-covered Service/Beneficiary Error (DP2)	4	$2,576.66	$21.36	-$1.18	$43.89
Duplicate Claim Error (DP1)	1	$981.18	$2.28	N/A	N/A
Managed Care Rate Cell Error (DP8)	1	$15.29	$0.30	N/A	N/A
Data Processing Technical Deficiency (DTD)	2	$0.00	$0.00	$0.00	$0.00
Total	**53**	**$17,754.18**	**$261.13**	**$170.84**	**$351.41**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Data Processing Federal Improper Payments: Administrative/Other Error (DP12)

Table S17. Medicaid Managed Care Specific Causes of Administrative/Other Error (DP12)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
State did not provide documentation needed to complete the review	17	$12,755.70	$207.20	$120.88	$293.53
Total	**17**	**$12,755.70**	**$207.20**	**$120.88**	**$293.53**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Medicaid Eligibility Review Errors by Eligibility Category

Table S18. Medicaid Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
MAGI									
MAGI Total	**927**	**820**	**2,196**	**$555,794.26**	**$2,878,822.61**	**$11,142.78**	**$42,401.24**	**26.28%**	**24.14% - 28.42%**
MAGI - Medicaid Expansion - Newly Eligible	305	265	697	$317,329.77	$1,313,211.30	$5,327.31	$19,761.03	26.96%	23.32% - 30.60%
MAGI - Children under Age 19	344	305	731	$103,900.79	$681,528.79	$3,149.01	$10,526.32	29.92%	25.94% - 33.89%
MAGI - Parent Caretaker	157	146	454	$77,554.79	$402,720.68	$1,857.66	$7,351.89	25.27%	20.31% - 30.22%
MAGI - Medicaid Expansion - Not Newly Eligible	31	30	74	$24,967.16	$155,722.12	$562.49	$1,822.63	30.86%	19.87% - 41.86%
MAGI - Pregnant Woman	70	55	114	$30,407.69	$219,944.07	$127.04	$1,521.74	8.35%	3.49% - 13.20%
Presumptive Eligibility	2	2	9	$32.63	$14,018.11	$61.20	$141.87	43.14%	(9.91%) - 96.19%
1115 Waiver Programs	5	5	50	$393.22	$63,248.31	$42.90	$754.11	5.69%	(1.40%) - 12.78%
MAGI - CHIP	2	2	3	$1,156.84	$8,982.28	$13.51	$71.82	18.81%	(17.86%) - 55.47%
MAGI - Medicaid CHIP Expansion	9	8	39	$51.37	$1,026.69	$1.65	$40.96	4.04%	(1.10%) - 9.18%
Emergency Services (Including for Non-Citizens)	0	0	4	$0.00	$13,706.86	$0.00	$86.47	0.00%	0.00% - 0.00%
Family Planning and Related Services	2	2	15	$0.00	$580.15	$0.00	$223.67	0.00%	0.00% - 0.00%
Other (None of the Above)	0	0	2	$0.00	$325.25	$0.00	$3.41	0.00%	0.00% - 0.00%
SSI Recipients	0	0	4	$0.00	$3,808.00	$0.00	$95.31	0.00%	0.00% - 0.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Non-MAGI									
Non-MAGI Total	**1,282**	**1,068**	**3,807**	**$1,296,157.09**	**$7,076,368.48**	**$10,074.77**	**$60,591.83**	**16.63%**	**15.15% - 18.11%**
Aged, Blind, and Disabled - Mandatory Coverage	310	242	682	$308,304.28	$1,413,253.65	$1,800.35	$8,821.84	20.41%	16.25% - 24.57%
Home and Community-Based Services	268	224	578	$211,995.30	$747,487.44	$1,794.98	$8,279.96	21.68%	17.69% - 25.67%
Aged, Blind, and Disabled - Optional Categorically Needy	179	141	244	$142,602.06	$339,585.73	$1,783.08	$4,148.50	42.98%	35.75% - 50.21%
LTC/Nursing Home	258	218	518	$414,065.40	$1,440,528.40	$1,412.26	$7,639.22	18.49%	14.31% - 22.67%
Other Full Benefit Dual Eligible (FBDE)	80	73	111	$104,095.21	$147,406.78	$1,252.02	$2,226.45	56.23%	44.77% - 67.70%
Transitional Medicaid	48	38	93	$2,907.25	$348,529.11	$509.45	$1,553.43	32.80%	19.70% - 45.89%
SSI Recipients	35	35	1,089	$69,853.10	$1,526,135.95	$474.82	$18,962.38	2.50%	1.54% - 3.47%
Other (None of the Above)	16	16	52	$9,938.69	$81,726.95	$296.74	$1,072.84	27.66%	14.06% - 41.25%
Qualified Individuals	4	4	6	$268.00	$17,401.28	$180.42	$288.69	62.50%	10.64% - 114.36%
QMB	25	23	77	$588.61	$25,846.30	$180.24	$1,854.07	9.72%	1.10% - 18.35%
Newborn	10	10	169	$2,247.66	$625,186.64	$139.17	$3,241.66	4.29%	1.29% - 7.30%
Medically Needy	37	33	85	$13,866.06	$117,235.82	$132.21	$1,067.95	12.38%	4.15% - 20.61%
TEFRA/Katie Beckett	4	4	18	$10,128.08	$36,693.78	$64.69	$273.28	23.67%	(0.65%) - 47.99%
Emergency Services (Including for Non-Citizens)	1	1	2	$4,344.46	$11,272.97	$22.40	$47.18	47.48%	(21.64%) - 116.60%
Title IV-E	3	3	57	$162.53	$148,023.21	$16.02	$700.05	2.29%	(1.29%) - 5.87%
Qualified Disabled and Working Individuals	2	1	1	$790.40	$790.40	$15.92	$15.92	100.00%	100.00% - 100.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
1115 Waiver Programs	1	1	10	$0.00	$25,860.28	$0.00	$142.60	0.00%	0.00% - 0.00%
SLMB	1	1	7	$0.00	$1,160.51	$0.00	$132.54	0.00%	0.00% - 0.00%
Women with Breast or Cervical Cancer	0	0	8	$0.00	$22,243.28	$0.00	$123.27	0.00%	0.00% - 0.00%

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

Medicaid Eligibility Review Federal Improper Payments

Table S19. Summary of Medicaid Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	395	$558,923.51	$8,541.40	$7,623.11	$9,459.69
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	365	$598,013.65	$7,350.51	$6,219.04	$8,481.97
Determination Not Conducted as Required (ER3)	317	$688,834.67	$5,352.79	$4,616.83	$6,088.75
Not Eligible for Enrolled Program - Financial Issue (ER4)	36	$45,302.26	$484.46	$257.11	$711.82
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	18	$2,786.27	$316.17	$147.05	$485.28
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	14	$13,202.62	$220.31	-$7.95	$448.57
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	10	$12,093.93	$197.22	$69.51	$324.93
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	7	$6,800.69	$138.77	$20.40	$257.14
Other Errors (ER10)	50	$3,377.17	$27.97	$4.06	$51.89
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	74	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	923	$0.00	$0.00	$0.00	$0.00
Total	**2,209**	**$1,929,334.77**	**$22,629.61**	**$21,064.83**	**$24,194.39**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3.

Table S20. Summary of Medicaid Eligibility Review – MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	158	$116,541.08	$4,138.41	$3,502.47	$4,774.35

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	207	$340,157.38	$4,025.64	$3,421.13	$4,630.15
Determination Not Conducted as Required (ER3)	117	$73,568.82	$2,535.16	$1,974.18	$3,096.13
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	18	$2,786.27	$316.17	$147.98	$484.35
Not Eligible for Enrolled Program - Financial Issue (ER4)	16	$15,705.40	$290.30	$96.86	$483.74
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	12	$12,277.94	$187.95	-$35.64	$411.55
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	2	$581.57	$53.04	-$20.74	$126.82
Other Errors (ER10)	1	$195.50	$10.58	N/A	N/A
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	28	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	368	$0.00	$0.00	$0.00	$0.00
Total	**927**	**$561,813.96**	**$11,557.24**	**$10,570.11**	**$12,544.37**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3.

Table S21. Summary of Medicaid Eligibility Review – Non-MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	237	$442,382.43	$4,402.99	$3,750.20	$5,055.79
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	158	$257,856.27	$3,324.87	$2,672.30	$3,977.43
Determination Not Conducted as Required (ER3)	200	$615,265.85	$2,817.64	$2,365.39	$3,269.89
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	10	$12,093.93	$197.22	$79.18	$315.25
Not Eligible for Enrolled Program - Financial Issue (ER4)	20	$29,596.86	$194.16	$74.83	$313.49

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	5	$6,219.12	$85.73	-$6.84	$178.30
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	2	$924.68	$32.36	-$13.58	$78.30
Other Errors (ER10)	49	$3,181.67	$17.40	$5.47	$29.33
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	46	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	555	$0.00	$0.00	$0.00	$0.00
Total	**1,282**	**$1,367,520.81**	**$11,072.37**	**$10,101.00**	**$12,043.73**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3.

Eligibility Review Federal Improper Payments: Documentation to Support Eligibility Determination Not Maintained Error (ER1)

Table S22. Specific Causes of Documentation to Support Eligibility Determination Not Maintained Error (ER1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other required forms not on file/incomplete	162	$206,304.03	$3,508.89	$2,897.03	$4,120.74
Income verification not on file/incomplete	93	$82,579.97	$2,513.02	$1,978.52	$3,047.53
Resource verification not on file/incomplete	55	$113,014.93	$844.80	$590.47	$1,099.12
Level of care determination not on file/incomplete	29	$95,491.46	$570.49	$283.65	$857.34
Record of signature not on file - caseworker	24	$23,564.69	$486.40	$272.43	$700.38
Blindness/disability determination documentation not on file/incomplete	10	$14,587.55	$204.99	$63.59	$346.39
Record of signature not on file - system	10	$11,649.12	$137.38	$43.60	$231.16
Household composition/tax filer status not on file/incomplete	2	$421.28	$65.84	-$26.24	$157.93
Immigration verification not on file	1	$2,329.08	$45.10	N/A	N/A

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Citizenship verification not on file	1	$52.60	$41.72	N/A	N/A
Social Security Number verification not on file	1	$52.60	$41.72	N/A	N/A
Contribution to care documentation not on file/incomplete	3	$7,172.59	$31.86	-$7.85	$71.58
SSI enrollment documentation not available	2	$981.37	$19.93	-$8.65	$48.51
Residency verification not on file/incomplete	1	$715.76	$17.10	N/A	N/A
Title IV-E eligibility documentation not available	1	$6.48	$12.15	N/A	N/A
Total	**395**	**$558,923.51**	**$8,541.40**	**$7,623.11**	**$9,459.69**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Eligibility Review Federal Improper Payments: Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Table S23. Specific Causes of Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income not verified - system	94	$227,923.26	$1,778.64	$1,357.67	$2,199.61
Income not verified - caseworker	98	$120,112.90	$1,776.64	$1,347.58	$2,205.69
Resources not verified - caseworker	75	$116,267.54	$1,692.53	$890.17	$2,494.88
When appropriate, signature not recorded at renewal - caseworker	37	$42,051.26	$1,032.04	$609.86	$1,454.23
Other eligibility process(es) not followed - caseworker	17	$13,157.77	$432.00	$144.22	$719.78
Income not verified with appropriate source - caseworker	5	$2,783.89	$114.17	-$3.01	$231.36
Signature not recorded at initial application - caseworker	6	$12,924.07	$104.71	$7.03	$202.39
Level of care not verified - caseworker	4	$22,702.48	$81.89	$1.42	$162.37
Residency not verified - caseworker	3	$1,254.63	$72.76	-$26.92	$172.45
Other eligibility process(es) not followed - system	8	$21,896.03	$63.90	$12.12	$115.68
State did not do required disability/blindness determination - caseworker	3	$1,419.08	$61.33	-$16.82	$139.47

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other element not verified - caseworker	2	$1,263.97	$45.27	-$20.39	$110.93
Contribution to care not verified - caseworker	4	$5,461.06	$37.94	-$12.78	$88.66
Citizenship not verified with appropriate source - caseworker	2	$1,522.51	$19.23	-$15.89	$54.35
Identity not verified - caseworker	1	$53.89	$10.19	N/A	N/A
Social Security Number not verified - caseworker	1	$53.89	$10.19	N/A	N/A
Level of care not verified - system	1	$1,280.00	$8.51	N/A	N/A
Citizenship not verified - caseworker	1	$5,859.65	$4.05	N/A	N/A
Immigration status not verified - caseworker	1	$23.56	$2.18	N/A	N/A
Other element not verified with appropriate source - caseworker	1	$1.00	$1.70	N/A	N/A
Resources not verified - system	1	$1.21	$0.64	N/A	N/A
Total	**365**	**$598,013.65**	**$7,350.51**	**$6,219.04**	**$8,481.97**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table S24. State-Specific Improper Payment Rates for the States Measured in 2019 Cycle 1

Considerations for viewing state-specific PERM rates:

- What is included in PERM rates and represented in this table
    - **Three components** – PERM measures Fee-For-Service (FFS) payments made to providers, managed care capitation payments made to Managed Care Organizations (MCOs), and beneficiary eligibility determinations made by state agencies and combines them to form the overall rate per state. The overall improper payment rate is computed by proportionally combining the FFS and managed care components based on expenditures for each component (the claims rate), then adding the eligibility component and subtracting out the overlap between the claims and eligibility component. Because of this, you cannot simply average the three components to reach the overall rate.
    - **Three cycles** – PERM measures on a three-year, 17 state rotation cycle, meaning that each state is measured once every three years and each PERM cycle measurement includes one third of all states. The most recent three cycles combine to form each year's overall national rate.
    - **Sample vs projection** –
        - *Sample improper payments* – The improper payments associated with the actual reviewed sample of claims. These are then extrapolated out to represent the entire universe of claims (the projected improper payments). The federal share of the sampled overpayments is the only portion that CMS has the authority to recover from the FFS and managed care universes.
        - *Projected improper payments* – The estimated improper payments used for national reporting to represent the entire Medicaid program (derived by projecting out the actual sampled improper payments to represent all Medicaid improper payments).
    - **Insufficient Documentation vs Monetary Loss Errors** –
        - *Insufficient Documentation Errors* **–** Improper payments also include instances where there is insufficient or no documentation to support the payment as proper or improper. A majority of Medicaid improper payments were due to instances where information required for payment or eligibility determination was missing from the claim or state systems (e.g., not properly saving documentation after verification) and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or ineligible beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable.
        - *Monetary Loss Errors* **–** Instances of monetary loss errors occur when CMS has sufficient information to determine that the Medicaid payment should not have occurred or should have been made in a different amount. Monetary loss errors represent a smaller proportion of Medicaid improper payments.
- **State-specific Improper Payment Rates Are Not Comparable**
  States have flexibility to design their policies and operate their programs to meet the individual

needs of the state, such as establishing a managed care delivery system rather than relying on FFS. Variation between states and the resulting methodological differences between states' PERM rates makes it impossible to accurately compare state-specific PERM rates between states. Additional reasons include:

- *State-level precision/confidence interval* – The national PERM rate is established by capturing a statistically valid random sample representative of all Medicaid payments matched with federal funds. The national PERM improper payment rate meets a precision requirement where CMS is 95 percent confident that the Medicaid improper payment rate is within +/- 3 percentage points. The PERM program was not designed to produce that level of precision at the state level. Therefore, state-level precision can vary, leading to wider confidence intervals in some states.
- *Program structure* – PERM has historically seen a lower instance of improper payments in managed care than FFS, based on differences in the review standards that apply to claims from the two service delivery models. Due to the differing review methodology, states' rates are often not comparable due to the varying distribution between FFS and managed care expenditures.
    - The definition of a FFS delivery system used below includes states' direct payment to providers for each service rendered to individual beneficiaries. Managed care is a delivery system in which a state makes a risk-based monthly capitated payment to a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan, which is responsible for managing beneficiary care. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to a data processing review.
- *State Policies* – Policies vary by state, which leads to differences in the states' specific Medicaid rates. These varying policies may include medical documentation and coverage requirements, integration and coordination of payment and eligibility systems, and prioritization of resources based on budget limitation.

- **Other Considerations**
    - This information does not include situations where documentation was received or findings disputes were requested after the cycle cutoff date. However, these instances may be eligible for continued processing and may result in a recalculation of a state's improper payment rate after the officially reported rate.
    - Some states rely solely on FFS and do not have a managed care program at all (those states are marked with "--" in the managed care columns).

State	Overall					Fee-For-Service						
	Projected IP Rate	Projected Monetary Loss IP Rate	Projected Confidence Interval	Projected IP ($ mil)	Sampled IP	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	% of Total Projected Expenditures	Sampled Expenditures
Arkansas	34.0%	7.6%	27.5% - 40.4%	$1,573.3	$249,196.0	17.9%	3.7%	$831.1	$210,944.1	$4,631.3	100.0%	$1,234,286.6
Connecticut	43.8%	3.0%	37.9% - 49.8%	$2,085.6	$437,131.4	13.5%	1.0%	$641.4	$165,482.0	$4,757.3	100.0%	$1,356,435.4
Delaware	31.3%	0.2%	25.4% - 37.2%	$861.8	$603,777.0	42.3%	1.8%	$129.1	$267,381.0	$305.2	11.1%	$2,357,124.3
Idaho	39.8%	2.4%	34.0% - 45.6%	$561.0	$141,248.8	22.8%	0.3%	$295.0	$83,905.0	$1,295.1	91.9%	$774,736.7
Illinois	37.3%	3.4%	32.5% - 42.1%	$4,444.6	$359,741.3	8.3%	2.1%	$348.6	$112,058.1	$4,188.2	35.1%	$2,574,081.1
Kansas	27.8%	1.4%	21.4% - 34.2%	$518.8	$220,248.7	4.4%	0.0%	$6.8	$23,194.3	$153.3	8.2%	$1,095,945.9
Michigan	14.0%	1.2%	10.9% - 17.1%	$1,574.7	$131,167.3	7.7%	0.5%	$274.1	$69,271.9	$3,564.9	31.7%	$1,906,151.3
Minnesota	18.6%	0.8%	15.8% - 21.5%	$1,329.8	$129,779.6	27.5%	0.1%	$964.1	$106,196.7	$3,502.3	49.1%	$611,925.1
Missouri	31.7%	0.9%	28.1% - 35.3%	$2,063.3	$599,531.4	16.4%	0.5%	$791.0	$505,438.9	$4,824.2	74.2%	$2,052,170.8
New Mexico	10.6%	1.5%	8.8% - 12.5%	$412.7	$145,028.2	48.9%	9.0%	$319.5	$136,481.7	$653.9	16.9%	$351,281.0
North Dakota	28.3%	5.1%	23.6% - 33.0%	$229.9	$436,772.3	28.3%	0.6%	$146.8	$376,040.1	$519.5	64.0%	$1,116,177.7
Ohio	44.3%	2.6%	40.4% - 48.2%	$6,835.9	$340,990.5	3.8%	1.0%	$216.9	$53,747.5	$5,671.2	36.7%	$844,358.3
Oklahoma	14.7%	1.3%	9.8% - 19.6%	$384.2	$23,958.5	8.8%	0.0%	$229.3	$13,647.7	$2,614.2	100.0%	$446,419.8
Pennsylvania	14.2%	1.2%	11.5% - 17.0%	$2,282.1	$186,707.5	8.7%	0.5%	$520.0	$90,547.9	$5,949.9	37.1%	$1,446,893.8
Virginia	11.8%	1.7%	9.3% - 14.4%	$530.0	$162,527.2	18.9%	2.8%	$386.5	$126,034.0	$2,041.6	45.6%	$914,727.2
Wisconsin	21.7%	1.0%	18.9% - 24.6%	$1,566.3	$55,006.5	38.7%	0.5%	$1,134.1	$41,336.1	$2,929.4	40.6%	$570,567.5
Wyoming	10.2%	0.9%	5.4% - 15.1%	$30.6	$23,370.7	2.5%	0.0%	$7.3	$12,524.6	$298.2	100.0%	$521,129.5

State	Managed Care			Eligibility					
	Projected IP Rate	Projected IP ($ mil)	Projected Expenditures ($ mil)	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	Sampled Expenditures
Arkansas	--	--	--	19.5%	4.0%	$904.6	$38,251.9	$4,631.3	$280,156.2
Connecticut	--	--	--	35.1%	1.9%	$1,669.3	$271,649.5	$4,757.3	$673,991.7
Delaware	0.0%	$0.0	$2,448.6	27.9%	0.0%	$768.8	$336,395.9	$2,753.8	$655,554.4
Idaho	0.0%	$0.0	$114.3	23.9%	2.1%	$336.4	$57,343.8	$1,409.3	$279,333.1
Illinois	0.0%	$0.0	$7,741.6	35.4%	2.6%	$4,219.3	$247,683.2	$11,929.8	$1,654,246.9
Kansas	0.0%	$0.0	$1,712.7	27.5%	1.4%	$513.8	$197,054.5	$1,866.0	$593,472.2
Michigan	0.0%	$0.0	$7,696.3	11.8%	1.0%	$1,333.0	$61,895.5	$11,261.2	$915,226.4
Minnesota	0.0%	$0.0	$3,628.4	5.9%	0.7%	$422.8	$23,583.0	$7,130.6	$415,449.4
Missouri	0.0%	$0.0	$1,678.3	22.3%	0.5%	$1,448.4	$94,092.5	$6,502.5	$667,764.4
New Mexico	0.0%	$0.0	$3,223.0	2.6%	0.0%	$101.5	$8,546.5	$3,876.9	$329,764.5
North Dakota	0.0%	$0.0	$291.9	12.5%	4.8%	$101.5	$60,732.2	$811.3	$498,471.9
Ohio	0.0%	$0.0	$9,765.4	43.5%	2.2%	$6,713.4	$287,243.0	$15,436.6	$834,009.7
Oklahoma	--	--	--	6.5%	1.3%	$169.8	$10,310.9	$2,614.2	$207,874.5
Pennsylvania	0.0%	$0.0	$10,077.8	11.4%	1.0%	$1,821.2	$96,159.6	$16,027.7	$728,222.3
Virginia	0.0%	$0.0	$2,435.5	3.5%	0.4%	$157.1	$36,493.2	$4,477.1	$534,171.4
Wisconsin	0.0%	$0.0	$4,279.7	7.1%	0.8%	$512.8	$13,670.4	$7,209.1	$526,688.8
Wyoming	--	--	--	8.0%	0.8%	$23.8	$10,846.1	$298.2	$160,793.5

Section 3: 2019 Supplemental CHIP Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for CHIP in 2019 based on the 51 states reviewed from 2017-2019. Unless otherwise noted, all tables and figures in Section 3 are based on the rolling rate, except for those providing only eligibility review information.

There was no eligibility component review from 2015-2018. Therefore, the rolling national eligibility estimate is a combination of the eligibility results from the 2019 Cycle 1 measurement and the most recent cycles prior to 2015 for Cycle 2 and Cycle 3 (those not yet measured under the new eligibility review methodology). All other eligibility data provided is specific to the 2019 Cycle 1 measurement.

CHIP Improper Payments

Table T1. Summary of CHIP Projected Federal Improper Payments

Category	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
FFS	6,518	25,312	$9,132,952.95	$68,334,716.90	$638.21	$4,816.37	13.25%	12.57% - 13.93%
FFS Medical Review	803	25,312*	$621,046.64	$68,334,716.90	$76.32	$4,816.37	1.58%	1.34% - 1.83%
FFS Data Processing	5,939	25,312	$8,622,749.79	$68,334,716.90	$576.31	$4,816.37	11.97%	11.32% - 12.61%
Managed Care	28	6,923	$17,123.73	$1,525,588.05	$156.24	$12,464.58	1.25%	0.91% - 1.59%
Eligibility	3,316	20,698	$1,389,505.65	$10,294,505.24	$2,035.51	$17,280.95	11.78%	11.17% - 12.39%
Total	**9,862**	**52,933**	**$10,539,582.32**	**$80,154,810.19**	**$2,736.38**	**$17,280.95**	**15.83%**	**15.19% - 16.48%**

Note: Details do not always sum to the total due to rounding. Eligibility component statistics reflect the most recent eligibility calculations reported in the 2014 improper payment rate. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.
*Data Processing review is performed on all sampled FFS claims. However, not all sampled FFS claims receive a Medical Review, as certain exceptions apply where Medical Review is not able to be performed (Medicare Part A and Part B premiums, primary care case management payments, aggregate payments, other fixed payments, denied claims, and zero-paid claims).

Table T2. CHIP Federal Improper Payments by Type of Improper Payment and Cause of Improper Payment

Type of Improper Payment	Cause of Improper Payment	Federal Improper Payments (billions)	Percentage of Federal Improper Payments
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$0.30	10.95%
	Other Monetary Loss	$0.09	3.37%
	Provider Not Enrolled	$0.03	1.05%
Unknown	Insufficient Information to Determine Eligibility	$0.71	25.97%
	Redetermination Not Conducted	$0.35	12.65%
	Non-Compliance with Provider Screening and NPI Requirements	$0.51	18.55%
	Other Missing Information	$0.16	5.85%
	Other Unknown	$0.00	0.02%
Underpayments		$0.01	0.19%
Proxy Eligibility Estimate		$0.59	21.40%

Note: The table provides information on CHIP improper payments that are a known monetary loss to the program (i.e., provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes). In the table, "Unknown" represents payments where there was no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program. The Proxy Eligibility Estimate is used to represent the eligibility component for the 34 states not yet measured since the reintegration of the PERM eligibility component and includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments.

CHIP FFS Component Federal Improper Payment Rate

Table T3. CHIP FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Dental and Oral Surgery Services	2,729	1,929	4,211	$399,048.09	$1,369,435.12	$215.61	$796.83	27.06%	24.59% - 29.53%
Prescribed Drugs	1,150	1,040	4,428	$3,032,937.69	$14,253,437.56	$114.84	$874.84	13.13%	11.24% - 15.01%
Psychiatric, Mental Health, and Behavioral Health Services	1,421	1,148	3,491	$2,114,029.70	$9,095,218.98	$94.07	$943.99	9.96%	8.44% - 11.49%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,486	1,082	2,330	$298,212.41	$595,712.24	$65.49	$210.36	31.13%	27.80% - 34.47%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	319	272	2,166	$69,364.84	$624,351.16	$35.96	$426.66	8.43%	6.46% - 10.40%
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	337	208	553	$23,453.64	$49,760.76	$33.61	$180.50	18.62%	14.95% - 22.29%
Outpatient Hospital Services	181	169	2,255	$269,850.98	$3,725,372.30	$21.07	$390.26	5.40%	3.96% - 6.83%
Personal Support Services	241	200	604	$77,734.06	$235,148.09	$16.51	$61.43	26.87%	20.68% - 33.07%
Clinic Services	183	161	1,527	$32,649.12	$377,926.21	$12.66	$223.75	5.66%	3.92% - 7.40%
Inpatient Hospital Services	109	105	1,746	$1,961,408.37	$34,221,015.88	$11.44	$442.66	2.59%	1.76% - 3.41%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	64	56	216	$45,399.61	$218,432.09	$9.01	$44.66	20.17%	12.26% - 28.08%
Capitated Care/Fixed Payments	61	28	723	$552,587.42	$2,971,954.47	$3.02	$158.11	1.91%	(0.13%) - 3.95%
Laboratory, X-ray and Imaging Services	33	30	294	$7,341.24	$32,706.82	$1.82	$37.39	4.86%	1.24% - 8.47%
Home Health Services	39	35	116	$29,000.08	$76,145.88	$1.75	$8.23	21.31%	9.75% - 32.87%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Transportation and Accommodations	14	14	112	$18,202.85	$169,790.58	$0.69	$14.63	4.73%	1.31% - 8.16%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	26	20	28	$195,432.31	$268,355.65	$0.56	$1.76	32.01%	10.72% - 53.30%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	3	2	4	$5,753.29	$24,434.89	$0.05	$0.11	50.57%	2.51% - 98.63%
Crossover Claims	23	18	101	$547.25	$15,388.30	$0.04	$0.12	29.20%	(8.93%) - 67.33%
Denied Claims	1	1	403	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Hospice Services	0	0	4	$0.00	$10,129.90	$0.00	$0.07	0.00%	0.00% - 0.00%
Total	**8,420**	**6,518**	**25,312**	**$9,132,952.95**	**$68,334,716.90**	**$638.21**	**$4,816.37**	**13.25%**	**12.57% - 13.93%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

CHIP FFS Medical Review Federal Improper Payments

Table T4. Summary of CHIP FFS Medical Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	255	$176,867.46	$32.20	$23.80	$40.61
No Documentation Error (MR1)	212	$147,070.82	$23.65	$17.44	$29.85
Improperly Completed Documentation (MR9)	195	$43,001.38	$8.61	$5.83	$11.38
Procedure Coding Error (MR3)	43	$152,552.17	$7.22	$2.58	$11.85
Number of Unit(s) Error (MR6)	33	$104,864.79	$3.90	$1.45	$6.35
Administrative/Other Error (MR10)	7	$2,527.55	$0.82	$0.00	$1.63
Medically Unnecessary Service Error (MR7)	3	$135.07	$0.37	-$0.33	$1.07
Policy Violation Error (MR8)	2	$31.00	$0.12	-$0.07	$0.31
Unbundling Error (MR5)	1	$13.00	$0.03	N/A	N/A
Medical Technical Deficiency (MTD)	68	$0.00	$0.00	$0.00	$0.00
Total	**819**	**$627,063.25**	**$76.90**	**$64.95**	**$88.86**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. However, if there was more than one MR2 error on a claim in 2018, only one MR2 error was included in the calculations. Each individual cause of MR2 errors is listed in further detail in Table T11, below. However, each individual absent document is not identified as a separate issue in this overall data, if multiple documents are absent from the same claim. Further explanation of Medical Review error types can be found in Section 4: Error Codes, Table A1.

Medical Review Federal Improper Payments: Document(s) Absent from Record Error (MR2)

Table T5. CHIP FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	69	$43,210.69	$10.10	$3.47	$16.73
One or more documents are missing from the record that are required to support payment	33	$18,518.67	$6.90	$4.30	$9.50
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	33	$27,305.20	$5.64	$3.28	$8.00
Provider did not submit the service plan	65	$26,053.66	$5.04	$1.98	$8.10
Multiple documents are missing from the record that are required to support payment	22	$59,447.07	$1.63	$0.50	$2.76
Provider did not submit proof of delivery	4	$1,200.69	$1.31	-$0.42	$3.04
Record does not include a physician's order for the sampled service	7	$15,396.16	$1.02	-$0.01	$2.06
Other	22	$2,610.71	$0.86	-$0.08	$1.79
Provider did not submit required progress notes applicable to the sampled DOS	6	$4,947.00	$0.59	$0.01	$1.17
Provider did not submit the test result	2	$858.80	$0.18	-$0.11	$0.47
Individual plan (ITP, ISP, IFSP, IEP, or POC) was present, but not applicable to the sampled DOS	5	$8,721.41	$0.18	$0.01	$0.35
Provider did not submit the face-to-face assessment documentation	1	$299.48	$0.17	N/A	N/A
Total	**269**	**$208,569.54**	**$33.62**	**$25.17**	**$42.08**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table T6. CHIP FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
Treatment Plan and Goals (ISP, IPP, IFSP, POC in effect during sampled date/s of service)	74
Member Pharmacy Signature Log/Proof of Delivery	34
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	29
Documented Proof of Acceptance or Refusal of Counseling	25
Encounter/Office Visit/Clinic Record/Notes (signed and dated)	22
Other	18
Daily documentation of specific tasks performed on the sampled date of service	13
Physician Orders and Progress Notes (signed and dated)	13
Mental Health Progress/Therapy Notes/Daily Attendance Logs (with start and stop times)	10
PT, OT, SLP, Audiology, Vision, and RT: Evaluation and Re-evaluation/Notes	10
Procedure Record/Notes (signed and dated)	11
Plan of Care/Service/Treatment Plan and Goals	9
Individual Education Plan (IEP), Individual Program Plan (IPP), Individual Service Plan (ISP), Individual Family Service Plan (IFSP)	8
Laboratory and Diagnostic Tests/Reports	8
Medication Administration Record (MAR)	8
Physician Orders (signed and dated, include all orders relevant to sampled claim)	8
Prior Authorization (if required)	7
Timesheet, Completed and Signed (include description of services approved and provided)	6
Member Profile with Refill History for the Sampled Medication	5
Case Management Care Plan/Updates and Notes (in effect during sampled date/s of service, including telephonic contact)	3
Documentation of Daily Patient Presence (e.g., daily census, attendance log, etc.)	3
Name of Drug, Dose, Route, Number Dispensed, and Number of Refills	3
Dental or Orthodontic Plan of Care (in effect during sampled date/s of service)	2
Evaluation and Management (E&M)/Counseling Notes (signed and dated)	2
Ground Mileage/Air Mileage Details	2

Documentation Type	Total Count
Admission History & Physical (H&P)	1
Copy of Prescription in Original, Facsimile, Telephonic, or Electronic form: Front and Back (if applicable) - with Patient Name, Date of Birth, Address, Telephone Number, Physician Name, and Signature (signature method as required/permitted by state regulations)	1
Discharge Summary	1
Eyeglass/Optician Invoices	1
Invoice for Services (dated)	1
Optometry and Optical Visit Notes	1
Progress Notes for All Disciplines/Department (to include physician's 60-day progress notes in effect during sampled date/s of service)	1
Total	**340**
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Table T7. CHIP FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Total Count
Psychiatric, Mental Health, and Behavioral Health Services	85
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	79
Prescribed Drugs	63
Outpatient Hospital Services	27
Dental and Oral Surgery Services	25
Clinic Services	15
Personal Support Services	13
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	11
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	8
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	5
Inpatient Hospital Services	3
Laboratory, X-ray and Imaging Services	3
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	2
Transportation and Accommodations	1
Total	**340**
Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.	

Medical Review Federal Improper Payments: No Documentation Error (MR1)

Table T8. CHIP FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	109	$54,820.04	$7.79	$4.96	$10.62
Provider responded with a statement that the provider had billed in error	30	$13,526.79	$4.04	$1.01	$7.08
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	23	$13,553.86	$3.99	$1.60	$6.39
Provider responded that he or she did not have the beneficiary on file or in the system	16	$31,569.43	$2.93	$0.64	$5.22
Provider submitted a record for the wrong beneficiary	4	$565.73	$1.39	-$0.73	$3.50
Provider responded with a statement that records cannot be located	6	$16,142.74	$1.08	-$0.13	$2.29
State could not locate the provider	12	$1,259.36	$0.80	$0.06	$1.53
Provider submitted a record for wrong DOS	6	$11,671.20	$0.75	-$0.64	$2.14
Provider responded with a statement that the record is unavailable due to electronic health record issues	1	$107.33	$0.73	N/A	N/A
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	4	$3,689.73	$0.14	-$0.01	$0.28
Provider responded with a statement that there was no documentation for the encounter/billed service	1	$164.61	$0.01	N/A	N/A
Total	**212**	**$147,070.82**	**$23.65**	**$17.44**	**$29.85**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

CHIP FFS Medical Review Errors by Service Type

Table T9. CHIP FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Psychiatric, Mental Health, and Behavioral Health Services	283	281	3,491	$160,161.56	$9,095,218.98	$18.73	$943.99	1.98%	1.42% - 2.54%
Prescribed Drugs	88	87	4,428	$117,844.80	$14,253,437.56	$12.90	$874.84	1.47%	1.00% - 1.95%
Dental and Oral Surgery Services	90	88	4,211	$17,848.28	$1,369,435.12	$12.74	$796.83	1.60%	0.71% - 2.49%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	82	82	2,166	$36,419.68	$624,351.16	$11.09	$426.66	2.60%	1.39% - 3.81%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	118	108	2,330	$15,990.26	$595,712.24	$7.61	$210.36	3.62%	2.30% - 4.93%
Outpatient Hospital Services	41	41	2,255	$169,072.43	$3,725,372.30	$6.95	$390.26	1.78%	1.02% - 2.55%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	14	14	216	$9,342.04	$218,432.09	$2.45	$44.66	5.48%	0.50% - 10.45%
Clinic Services	23	23	1,527	$8,982.40	$377,926.21	$1.55	$223.75	0.69%	0.26% - 1.13%
Personal Support Services	25	25	604	$9,508.49	$235,148.09	$1.01	$61.43	1.64%	(0.05%) - 3.32%
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	42	42	553	$2,649.91	$49,760.76	$0.71	$180.50	0.39%	0.10% - 0.68%
Laboratory, X-ray and Imaging Services	4	4	294	$836.67	$32,706.82	$0.29	$37.39	0.79%	(0.16%) - 1.74%
Inpatient Hospital Services	2	2	1,746	$54,463.73	$34,221,015.88	$0.11	$442.66	0.03%	(0.02%) - 0.07%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Transportation and Accommodations	3	3	112	$12,169.89	$169,790.58	$0.09	$14.63	0.61%	(0.16%) - 1.37%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	3	2	4	$5,753.29	$24,434.89	$0.05	$0.11	50.57%	2.51% - 98.63%
Home Health Services	1	1	116	$3.21	$76,145.88	$0.05	$8.23	0.61%	(0.59%) - 1.81%
Capitated Care/Fixed Payments	0	0	723	$0.00	$2,971,954.47	$0.00	$158.11	0.00%	0.00% - 0.00%
Crossover Claims	0	0	101	$0.00	$15,388.30	$0.00	$0.12	0.00%	0.00% - 0.00%
Denied Claims	0	0	403	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Hospice Services	0	0	4	$0.00	$10,129.90	$0.00	$0.07	0.00%	0.00% - 0.00%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	0	0	28	$0.00	$268,355.65	$0.00	$1.76	0.00%	0.00% - 0.00%
Total	**819**	**803**	**25,312**	**$621,046.64**	**$68,334,716.90**	**$76.32**	**$4,816.37**	**1.58%**	**1.34% - 1.83%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

Table T10. Summary of CHIP FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	6,219	$8,751,247.70	$634.08	$602.06	$666.09
Administrative/Other Error (DP12)	269	$255,869.05	$25.45	$19.49	$31.41
Pricing Error (DP5)	122	$727,374.31	$13.28	$5.87	$20.70
Non-covered Service/Beneficiary Error (DP2)	89	$713,816.15	$7.78	$3.41	$12.15
Duplicate Claim Error (DP1)	29	$559,028.89	$3.90	$0.42	$7.37
Third-Party Liability Error (DP4)	9	$7,576.18	$1.15	-$0.10	$2.40
Data Entry Error (DP7)	13	$40.77	$0.33	$0.14	$0.52
Claim Filed Untimely Error (DP11)	7	$92,008.58	$0.09	$0.03	$0.16
Data Processing Technical Deficiency (DTD)	844	$0.00	$0.00	$0.00	$0.00
Total	**7,601**	**$11,106,961.62**	**$686.06**	**$652.63**	**$719.49**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Data Processing Federal Improper Payments: Provider Information/Enrollment Error (DP10)

Table T11. CHIP FFS Specific Causes of Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Screening	Provider not appropriately screened using risk based criteria	3,321	$4,597,079.66	$457.60	$430.01	$485.19
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	997	$1,390,280.84	$85.38	$71.31	$99.46
	Attending or rendering provider NPI required, but not listed on claim	61	$115,328.94	$10.60	$5.98	$15.23
	Billing provider NPI required, but not listed on claim	124	$54,920.49	$4.60	$2.05	$7.16
Provider Enrollment	Provider not enrolled	173	$1,131,388.40	$28.89	$20.95	$36.82
Provider License/Certification	Provider license not current for DOS	12	$8,517.33	$2.29	$0.59	$4.00
Missing Provider Information	Missing provider risk based screening information	1,468	$1,441,523.38	$39.86	$35.05	$44.68
	Missing information to determine if ORP NPI submitted on the claim	50	$2,211.97	$3.21	$1.22	$5.20
	Missing provider enrollment information	4	$602.23	$0.98	($0.07)	$2.03
	Missing provider license information	6	$8,983.60	$0.46	($0.22)	$1.13
	Other missing provider information	1	$46.48	$0.16	N/A	N/A
	Missing information to determine if billing NPI submitted on the claim	2	$364.37	$0.04	($0.02)	$0.10
Total		**6,219**	**$8,751,247.70**	**$634.08**	**$602.06**	**$666.09**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Table T12. 2019 Cycle 1 DP10 CHIP FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	1
Billing	No NPI on the claim	15
ORP	No NPI on the claim	211
	Incorrect NPI on the claim	7
Rendering	No NPI on the claim	5
	Incorrect NPI on the claim	4
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.		

Table T13. 2019 Cycle 1 DP10 CHIP Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Revalidated	459
	Newly Enrolled	90
Provider Risk Level	Limited	522
	Moderate	26
	High	1
Provider Type	Billing	459
	ORP	50
	Rendering	40
Screening Elements Not Completed	No required databases checked	281
	SAM/EPLS not checked	200
	LEIE not checked	143
	NPPES not checked	70
	DMF not checked	38
	On-site not conducted	23
Missing Screening Information	Revalidated provider	83
	Newly Enrolled provider	11
	Limited Risk	93
	Moderate Risk	1
	Billing provider	91

Breakdown	Additional Detail	Number of Errors
	ORP	2
	Rendering provider	1
	No required database documentation present	91
	LEIE not present	2
	NPPES not present	2
	SAM/EPLS not present	1
	On-site visit documentation not present	1
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.		

Table T14. 2019 Cycle 1 DP10 CHIP Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Sub-Cause of Error	Number of Errors
Billing	Provider not enrolled	20
ORP	Provider not enrolled	18
Rendering	Missing provider enrollment information	1
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.		

CHIP FFS Data Processing Errors by Service Type

Table T15. CHIP FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Dental and Oral Surgery Services	2,639	1,883	4,211	$387,532.39	$1,369,435.12	$205.76	$796.83	25.82%	23.44% - 28.21%
Prescribed Drugs	1,062	976	4,428	$2,939,181.51	$14,253,437.56	$104.88	$874.84	11.99%	10.14% - 13.83%
Psychiatric, Mental Health, and Behavioral Health Services	1,138	938	3,491	$2,023,976.20	$9,095,218.98	$80.60	$943.99	8.54%	7.16% - 9.92%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,368	1,034	2,330	$287,633.04	$595,712.24	$59.13	$210.36	28.11%	24.91% - 31.30%
PT, OT, RT; SLP, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	295	173	553	$21,570.17	$49,760.76	$33.11	$180.50	18.35%	14.68% - 22.01%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	237	195	2,166	$33,053.92	$624,351.16	$24.98	$426.66	5.86%	4.26% - 7.45%
Personal Support Services	216	181	604	$69,297.14	$235,148.09	$15.89	$61.43	25.86%	19.82% - 31.91%
Outpatient Hospital Services	140	131	2,255	$101,245.18	$3,725,372.30	$14.71	$390.26	3.77%	2.53% - 5.00%
Clinic Services	160	141	1,527	$24,208.68	$377,926.21	$11.37	$223.75	5.08%	3.39% - 6.77%
Inpatient Hospital Services	107	103	1,746	$1,906,944.64	$34,221,015.88	$11.33	$442.66	2.56%	1.73% - 3.39%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	50	46	216	$38,005.56	$218,432.09	$7.10	$44.66	15.89%	9.30% - 22.49%
Capitated Care/Fixed Payments	61	28	723	$552,587.42	$2,971,954.47	$3.02	$158.11	1.91%	(0.13%) - 3.95%
Home Health Services	38	34	116	$28,996.87	$76,145.88	$1.70	$8.23	20.70%	9.18% - 32.21%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Laboratory, X-ray and Imaging Services	29	26	294	$6,504.57	$32,706.82	$1.52	$37.39	4.07%	0.58% - 7.55%
Transportation and Accommodations	11	11	112	$6,032.96	$169,790.58	$0.60	$14.63	4.13%	0.87% - 7.38%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	26	20	28	$195,432.31	$268,355.65	$0.56	$1.76	32.01%	10.72% - 53.30%
Crossover Claims	23	18	101	$547.25	$15,388.30	$0.04	$0.12	29.20%	(8.93%) - 67.33%
Denied Claims	1	1	403	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Hospice Services	0	0	4	$0.00	$10,129.90	$0.00	$0.07	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	4	$0.00	$24,434.89	$0.00	$0.11	0.00%	0.00% - 0.00%
Total	**7,601**	**5,939**	**25,312**	**$8,622,749.79**	**$68,334,716.90**	**$576.31**	**$4,816.37**	**11.97%**	**11.32% - 12.61%**

Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

CHIP Managed Care Errors by Type of Error

Table T16. Summary of CHIP Managed Care Data Processing Projected Federal Dollars by Type of Error

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Administrative/Other Error (DP12)	6	$1,115.47	$84.39	$52.07	$116.71
Non-covered Service/Beneficiary Error (DP2)	19	$15,633.37	$70.07	$43.31	$96.83
Managed Care Payment Error (DP9)	1	$358.05	$1.74	N/A	N/A
Managed Care Rate Cell Error (DP8)	2	$16.84	$0.04	-$0.01	$0.09
Total	**28**	**$17,123.73**	**$156.24**	**$114.14**	**$198.34**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. There were no underpayments cited, so only overpayments are reported in this table.

Data Processing Federal Improper Payments: Administrative/Other Error (DP12)

Table T17. CHIP Managed Care Specific Causes of Administrative/Other Error (DP12)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other	5	$965.37	$82.57	$50.45	$114.69
State did not provide documentation needed to complete the review	1	$150.10	$1.82	N/A	N/A
Total	**6**	**$1,115.47**	**$84.39**	**$52.07**	**$116.71**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Data Processing Federal Improper Payments: Non-covered Service/Beneficiary Error (DP2)

Table T18. CHIP Managed Care Specific Causes of Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Beneficiary was ineligible for the applicable program on the DOS	19	$15,633.37	$70.07	$43.31	$96.83
Total	**19**	**$15,633.37**	**$70.07**	**$43.31**	**$96.83**

Note: Details do not always sum to the total due to rounding. For error causes with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

CHIP Eligibility Review Errors by Eligibility Category

Table T19. CHIP Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
MAGI									
MAGI Total	**2,495**	**2,031**	**3,950**	**$1,212,558.91**	**$6,596,592.55**	**$1,182.89**	**$3,589.22**	**32.96%**	**31.27% - 34.64%**
MAGI - Medicaid CHIP Expansion	1,101	865	1,499	$453,867.31	$3,269,163.09	$738.78	$1,687.84	43.77%	41.04% - 46.50%
MAGI - CHIP	1,297	1,082	2,158	$700,290.57	$2,738,462.39	$409.85	$1,770.38	23.15%	21.08% - 25.22%
MAGI - Pregnant Woman	40	30	53	$2,016.73	$278,163.88	$21.27	$55.89	38.05%	17.70% - 58.40%
Unborn Child (Undocumented Pregnant Women)	43	42	207	$42,400.97	$271,877.81	$8.41	$55.82	15.06%	8.03% - 22.09%
MAGI - Children under Age 19	13	11	27	$3,285.03	$21,058.75	$4.14	$16.69	24.84%	5.58% - 44.10%
Presumptive Eligibility	1	1	4	$10,698.30	$16,976.17	$0.44	$0.75	59.16%	3.00% - 115.33%
1115 Waiver Programs	0	0	1	$0.00	$86.14	$0.00	$1.69	0.00%	0.00% - 0.00%
Emergency Services (Including for Non-Citizens)	0	0	1	$0.00	$804.32	$0.00	$0.16	0.00%	0.00% - 0.00%
Non-MAGI									
Non-MAGI Total	**8**	**4**	**11**	**$238.68**	**$18,462.74**	**$1.92**	**$4.30**	**44.73%**	**32.23% - 57.23%**
Aged, Blind, and Disabled - Mandatory Coverage	7	3	7	$238.68	$1,040.99	$1.92	$3.09	62.20%	45.74% - 78.65%
Newborn	0	0	1	$0.00	$13,698.54	$0.00	$0.18	0.00%	0.00% - 0.00%
SSI Recipients	0	0	1	$0.00	$3,567.98	$0.00	$0.08	0.00%	0.00% - 0.00%
Transitional Medicaid	1	1	2	$0.00	$155.23	$0.00	$0.95	0.00%	0.00% - 0.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Note: Details do not always sum to the total due to rounding. For denied claims or categories with fewer than two claims per sample stratum, a confidence interval is not calculated. For denied claims, there is also no improper payment rate calculated since there is no paid amount associated with the claim. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report. Non-MAGI determinations are always Medicaid; however, there are a small number of Non-MAGI determinations in the CHIP sample due to a mismatch between the eligibility determination and the funding source.									

CHIP Eligibility Review Federal Improper Payments

Table T20. Summary of CHIP Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	443	$335,536.78	$424.08	$364.84	$483.32
Determination Not Conducted as Required (ER3)	273	$360,875.31	$319.23	$222.99	$415.46
Documentation to Support Eligibility Determination Not Maintained (ER1)	235	$280,789.92	$263.00	$224.64	$301.36
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	209	$274,036.96	$213.33	$162.44	$264.22
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	48	$11,573.10	$41.26	$25.56	$56.95
Not Eligible for Enrolled Program - Financial Issue (ER4)	29	$38,595.05	$14.27	$8.03	$20.51
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	$22,812.88	$0.94	N/A	N/A
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	80	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	1,185	$0.00	$0.00	$0.00	$0.00
Total	**2,503**	**$1,324,220.00**	**$1,276.11**	**$1,153.48**	**$1,398.74**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3. There were no underpayments cited, so only overpayments are reported in this table.

Table T21. Summary of CHIP Eligibility Review – MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	442	$335,359.09	$423.77	$364.60	$482.93
Determination Not Conducted as Required (ER3)	273	$360,875.31	$319.23	$222.99	$415.46
Documentation to Support Eligibility Determination Not Maintained (ER1)	234	$280,757.45	$262.24	$223.91	$300.57
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	208	$274,008.44	$212.48	$161.62	$263.35

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	48	$11,573.10	$41.26	$25.56	$56.95
Not Eligible for Enrolled Program - Financial Issue (ER4)	29	$38,595.05	$14.27	$8.03	$20.51
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	$22,812.88	$0.94	N/A	N/A
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	80	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	1,180	$0.00	$0.00	$0.00	$0.00
Total	**2,495**	**$1,323,981.32**	**$1,274.19**	**$1,151.61**	**$1,396.76**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3.

Table T22. Summary of CHIP Eligibility Review – Non-MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	1	$28.52	$0.85	N/A	N/A
Documentation to Support Eligibility Determination Not Maintained (ER1)	1	$32.47	$0.76	N/A	N/A
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	1	$177.69	$0.31	N/A	N/A
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	5	$0.00	$0.00	$0.00	$0.00
Total	**8**	**$238.68**	**$1.92**	**$0.15**	**$3.70**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3. Non-MAGI determinations are always Medicaid; however, there are a small number of Non-MAGI determinations in the CHIP sample due to a mismatch between the eligibility determination and the funding source.

Eligibility Review Federal Improper Payments: Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Table T23. Specific Causes of Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income not verified - caseworker	180	$140,923.36	$176.45	$130.25	$222.64
Income not verified - system	121	$59,683.16	$97.76	$78.41	$117.12
When appropriate, signature not recorded at renewal - caseworker	43	$9,678.38	$48.66	$31.34	$65.97
Third party liability not verified - caseworker	36	$13,059.87	$35.92	$19.75	$52.10
Income not verified with appropriate source - caseworker	15	$4,852.62	$17.61	$1.79	$33.42
Household composition/tax filer status not verified - caseworker	5	$685.21	$7.44	-$0.40	$15.29
Signature not recorded at initial application - caseworker	5	$730.72	$6.32	$0.09	$12.55
Other element not verified - caseworker	5	$863.08	$5.44	-$0.92	$11.80
Social Security Number not verified - caseworker	6	$781.59	$5.42	$0.17	$10.67
When appropriate, signature not recorded at renewal - system	4	$24,150.18	$5.04	-$1.20	$11.28
Other eligibility process(es) not followed - caseworker	7	$2,941.78	$4.37	-$1.24	$9.97
Age not verified - caseworker	1	$180.89	$3.38	N/A	N/A
Resources not verified - caseworker	6	$41,250.27	$3.04	-$0.55	$6.64
Third party liability not verified - system	1	$161.87	$2.42	N/A	N/A
Immigration status not verified with appropriate source - caseworker	1	$189.91	$1.24	N/A	N/A
Citizenship not verified - caseworker	1	$254.13	$1.15	N/A	N/A
Residency not verified - caseworker	2	$15,256.47	$0.96	-$0.38	$2.31
Identity not verified - caseworker	1	$367.54	$0.81	N/A	N/A
Other eligibility process(es) not followed - system	1	$1,423.71	$0.27	N/A	N/A
Signature not recorded at initial application - system	1	$17,930.26	$0.24	N/A	N/A
Immigration status not verified - caseworker	1	$171.78	$0.14	N/A	N/A
Total	**443**	**$335,536.78**	**$424.08**	**$364.84**	**$483.32**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Eligibility Review Federal Improper Payments: Determination Not Conducted as Required Error (ER3)

Table T24. Specific Causes of Determination Not Conducted as Required Error (ER3)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Redetermination was not conducted within 12 months before date of payment for services - caseworker	228	$350,051.23	$270.26	$175.14	$365.38
Redetermination was not conducted within 12 months before date of payment for services - system	41	$7,524.13	$47.05	$30.37	$63.73
Initial determination not conducted	3	$3,177.25	$1.40	-$0.36	$3.17
DOS is after Presumptive Eligibility Period expired; full determination not conducted - caseworker	1	$122.70	$0.51	N/A	N/A
Total	**273**	**$360,875.31**	**$319.23**	**$222.99**	**$415.46**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table.

Section 4: Error Codes

Table A1. Medical Review Error Codes

Error Code	Error	Definition
MR1	No Documentation Error	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	Document(s) Absent from Record	Claim errors are placed into this category when the submitted medical documentation is missing required information, making the record insufficient to support payment for the services billed. 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. Additional documentation 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 Error	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 as individual services.
MR6	Number of Unit(s) Error	An incorrect number of units was billed.
MR7	Medically Unnecessary Service Error	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 Error	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	Improperly Completed 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 Error	Medical review determined a payment error, but does not fit into one of the other medical review error categories.
MTD	Medical Technical Deficiency	Medical review determined a deficiency that did not result in a payment error. DOS billing errors are included as deficiencies when the DOS on the record is less than 7 days prior to or after the DOS on the claim.

Table A2. Data Processing Error Codes

Error Code	Error	Definition
DP1	Duplicate Claim Error	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 DOS.
DP2	Non-covered Service/Beneficiary Error	The state's policy indicates that the service billed on the sampled claim is not payable by the Medicaid program or CHIP and/or the

Error Code	Error	Definition
		financial system reflects incorrect beneficiary eligibility status for the coverage category for the service.
DP3	FFS Payment for a Managed Care Service Error	The beneficiary is enrolled in an MCO that includes the service on the sampled claim under capitated benefits, but the state inappropriately paid for the sampled service.
DP4	Third-Party Liability Error	Medicaid/CHIP paid the service on the sampled claim 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 properly administer state policy or the system edit was in place, but was not working correctly and the sampled line item/claim was paid inappropriately.
DP7	Data Entry Error	The sampled 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 on the sampled DOS 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/CHIP according to federal regulations and state policy or required provider information was missing from the sampled claim.
DP11	Claim Filed Untimely Error	The sampled claim was not filed in accordance with the timely filing requirements defined by state policy.
DP12	Administrative/Other Error	A payment error was discovered during data processing review, but the error was not a DP1 – DP11 error.
DTD	Data Processing Technical Deficiency	A deficiency was found during data processing review that did not result in a payment error.

Table A3. Eligibility Error Codes

Error Code	Error	Definition
ER1	Documentation to Support Eligibility Determination Not Maintained	The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicated that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.
ER2	Verification/Documentation Not Done/Collected at the Time of Determination	The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.

Error Code	Error	Definition
ER3	Determination Not Conducted as Required	The state could not provide evidence the state conducted an eligibility determination or the state completed an eligibility determination that was not in accordance with timeliness standards (does not apply to application timely processing) defined in federal regulation.
ER4	Not Eligible for Enrolled Program – Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the financial elements of the eligibility determination.
ER5	Not Eligible for Enrolled Program – Non-Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the non-financial elements of the eligibility determination.
ER6	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP)	The beneficiary is not eligible for the enrolled program (i.e., Medicaid or CHIP), but is eligible for the other program.
ER7	Not Eligible for Enrolled Eligibility Category – Incorrect FMAP Assignment	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.
ER8	Not Eligible for Enrolled Eligibility Category – Ineligible for Service	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category, which results in the individual receiving services for which they were not eligible.
ER9	FFE-D Error	Not applicable to states; used for errors when the FFE incorrectly determined eligibility for the beneficiary.
ER10	Other Errors	The beneficiary is improperly denied or terminated, or the contribution to care calculation is incorrectly calculated.
ERTD1	Incorrect Case Determination, But There was No Payment on Claim	The beneficiary is ineligible for any of the reasons cited in the ER1 – ER10, but no payment was made for the claim.
ERTD2	Finding Noted with Case, But Did Not Affect Determination or Payment	The state incorrectly applied federal or state regulations; federal policy or procedure; or made an error during the eligibility determination; however, the beneficiary remains eligible for the enrolled program or category.

Table A4. Acronym Glossary

Acronym	Definition
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
DMF	Social Security Death Master File
DOS	Date Of Service
DP	Data Processing
DRG	Diagnosis-Related Group
ER	Eligibility Review
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FR	Federal Register
ICF	Intermediate Care Facility
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IID	Individuals with Intellectual Disabilities
IP	Improper Payment
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
LTC	Long-Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MR	Medical Review
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PERM	Payment Error Rate Measurement
POC	Plan Of Care
QMB	Qualified Medicare Beneficiary
SAM/EPLS	System for Award Management/Excluded Parties List System
SLMB	Specific Low-income Medicare Beneficiary
SSI	Supplemental Security Income
TD	Technical Deficiency

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2019 Department of Health and Human Services Agency Financial Report.