2020 Medicaid & CHIP Supplemental Improper Payment Data

November 2020

List of Sections

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 2020 improper payment rate (i.e., Cycle 2) 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%**
2020 - Cycle 2***	12.67%	0.16%	22.32%	**27.47%**

*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 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.

***Under provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared on March 13, 2020 that, as a result of the effects of the Coronavirus Disease 2019 (COVID-19), a national emergency exists, retroactive to March 1, 2020. On January 31, 2020, Secretary Azar of the Department of Health & Human Services (HHS) declared a nationwide public health emergency, retroactive to January 27, 2020. On April 2, 2020, CMS announced that it was exercising its enforcement discretion to adopt a temporary policy regarding the Payment Error Rate Measurement (PERM) program. Accordingly, CMS suspended all improper payment-related engagement/ communication or data requests to providers and state agencies. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. However, for Cycle 2 (2020), CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the public health emergency impact, the Cycle 2-specific rates may not be comparable to other cycles. However, the public health emergency only impacts one of the three cycles (Cycle 2) that combine to form the national rolling rate for 2020.

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%**
2020 - Cycle 2***	10.67%	1.15%	32.95%	**36.46%**

*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 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.

***Under provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared on March 13, 2020 that, as a result of the effects of the Coronavirus Disease 2019 (COVID-19), a national emergency exists, retroactive to March 1, 2020. On January 31, 2020, Secretary Azar of the Department of Health & Human Services (HHS) declared a nationwide public health emergency, retroactive to January 27, 2020. On April 2, 2020, CMS announced that it was exercising its enforcement discretion to adopt a temporary policy regarding the Payment Error Rate Measurement (PERM) program. Accordingly, CMS suspended all improper payment-related engagement/ communication or data requests to providers and state agencies. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. However, for Cycle 2 (2020), CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the public health emergency impact, the Cycle 2-specific rates

may not be comparable to other cycles. However, the public health emergency only impacts one of the three cycles (Cycle 2) that combine to form the national rolling rate for 2020.

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%**
2020 Rolling Rates***	16.84%	0.06%	14.94%	**21.36%**

*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.

***Under provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared on March 13, 2020 that, as a result of the effects of the Coronavirus Disease 2019 (COVID-19), a national emergency exists, retroactive to March 1, 2020. On January 31, 2020, Secretary Azar of the Department of Health & Human Services (HHS) declared a nationwide public health emergency, retroactive to January 27, 2020. On April 2, 2020, CMS announced that it was exercising its enforcement discretion to adopt a temporary policy regarding the Payment Error Rate Measurement (PERM) program. Accordingly, CMS suspended all improper payment-related engagement/ communication or data requests to providers and state agencies. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. However, for Cycle 2 (2020), CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the public health emergency impact, the Cycle 2-specific rates may not be comparable to other cycles. However, the public health emergency only impacts one of the three cycles (Cycle 2) that combine to form the national rolling rate for 2020.

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%**
2020 Rolling Rates***	14.15%	0.49%	23.53%	**27.00%**

*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. 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.

***Under provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared on March 13, 2020 that, as a result of the effects of the Coronavirus Disease 2019 (COVID-19), a national emergency exists, retroactive to March 1, 2020. On January 31, 2020, Secretary Azar of the Department of Health & Human Services (HHS) declared a nationwide public health emergency, retroactive to January 27, 2020. On April 2, 2020, CMS announced that it was exercising its enforcement discretion to adopt a temporary policy regarding the Payment Error Rate Measurement (PERM) program. Accordingly, CMS suspended all improper payment-related engagement/ communication or data requests to providers and state agencies. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. However, for Cycle 2 (2020), CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the public health emergency impact, the Cycle 2-specific rates may not be comparable to other cycles. However, the public health emergency only impacts one of the three cycles (Cycle 2) that combine to form the national rolling rate for 2020.

Overall 2020 Improper Payment Findings

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

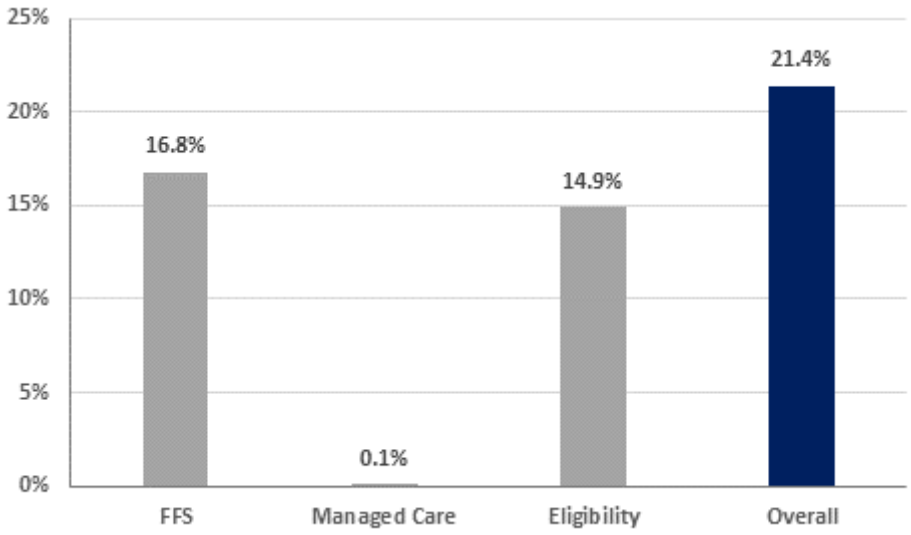
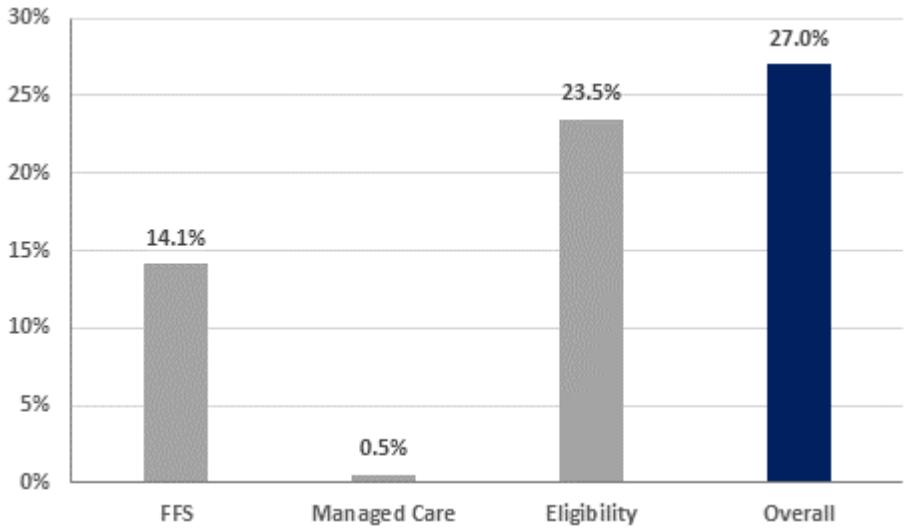


Figure 2. National Rolling CHIP Improper Payment Rate by Claim Type[1]



[1] Please note that the eligibility rate includes both the results from the 34 states measured in 2019 and 2020 under the new eligibility methodology and the proxy eligibility estimate for the 17 states not yet measured since the reintegration of the PERM eligibility component.

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

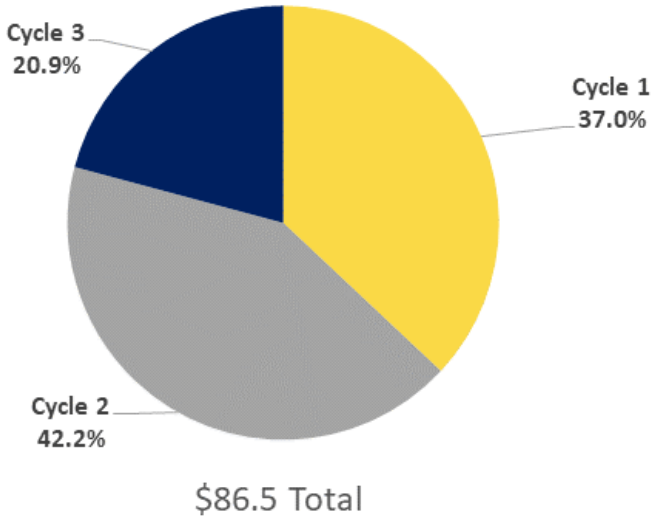


Figure 4. CHIP Individual Cycle Improper Payments (in Billions)

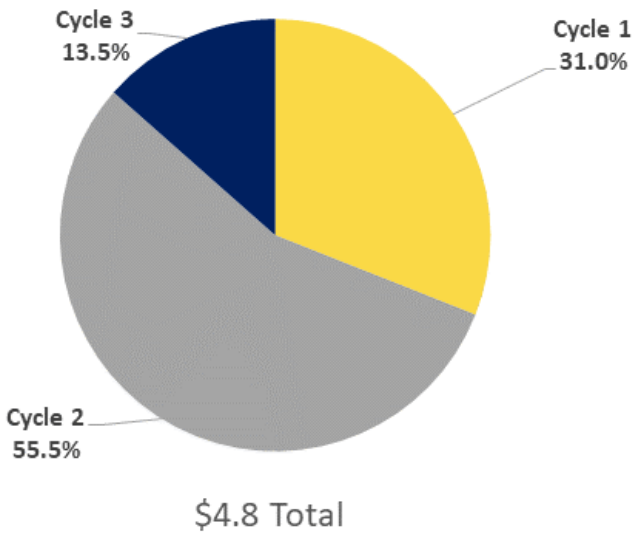


Figure 5. Medicaid Percentage of National Improper Payments by Claim Type[2]

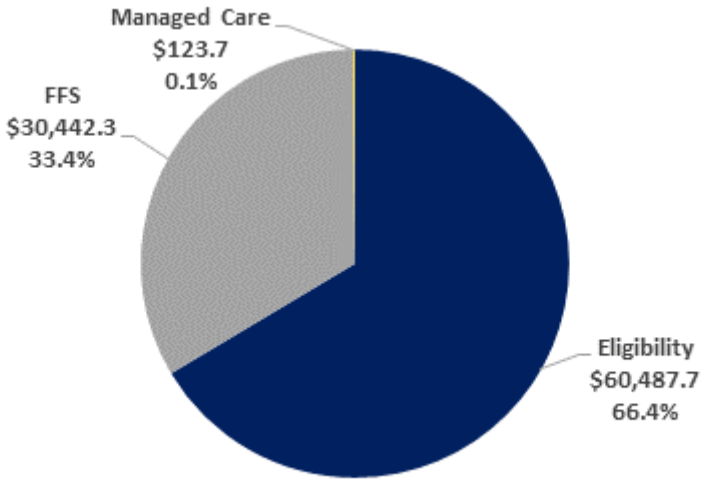
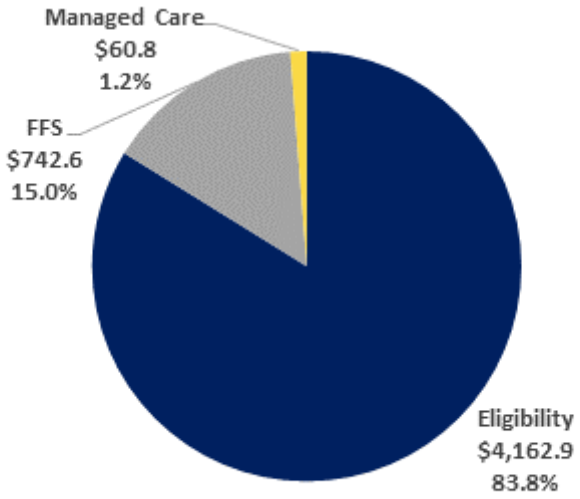


Figure 6. CHIP Percentage of National Improper Payments by Claim Type[2]



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

Common Causes of 2020 Improper Payments

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

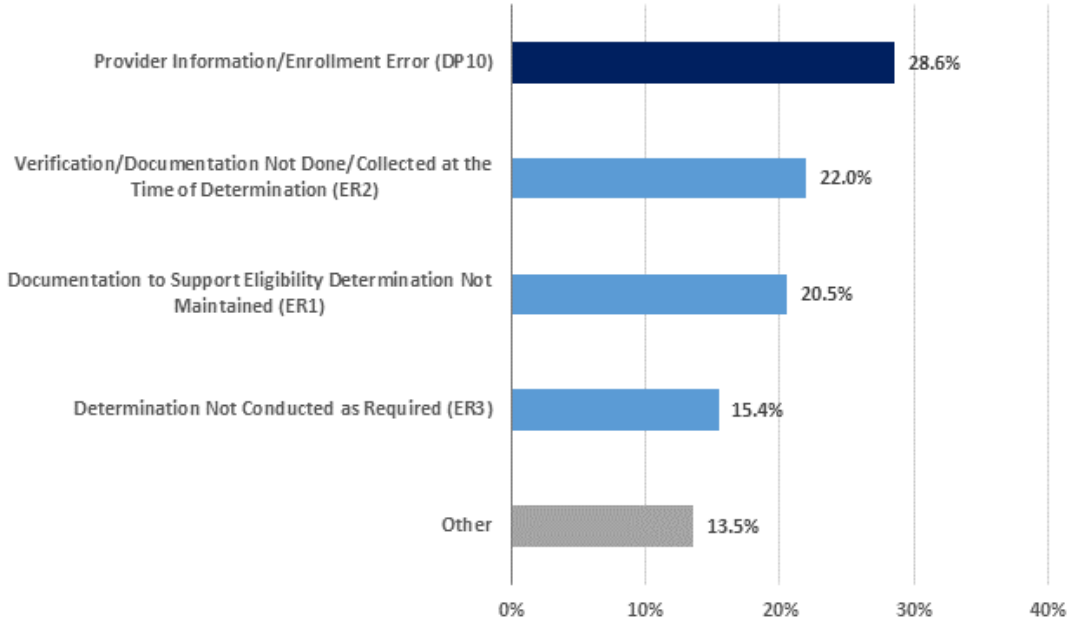
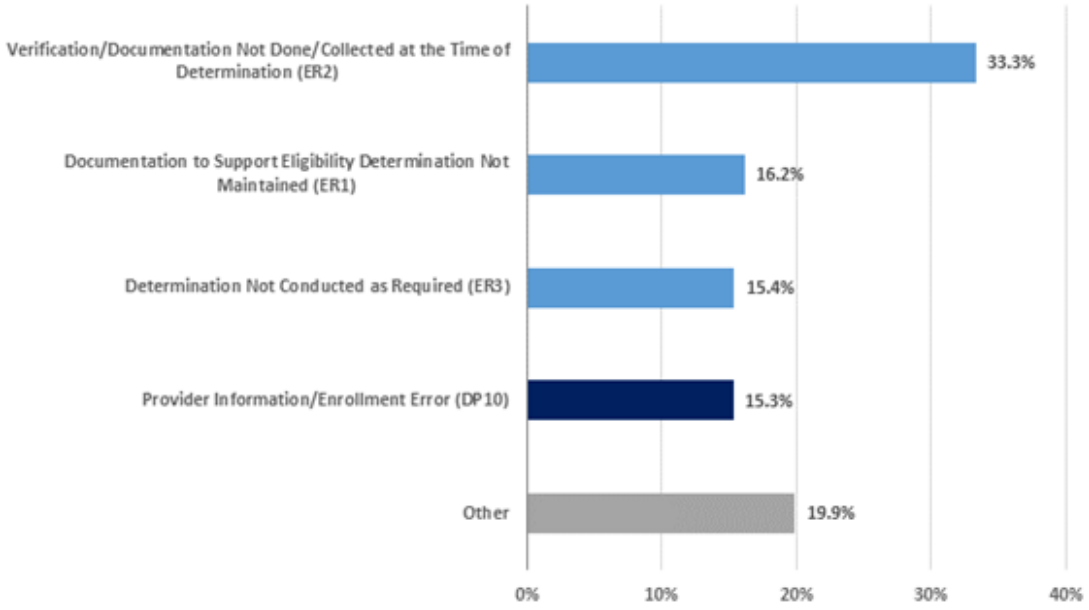


Figure 8. CHIP Type of Errors by Percentage of National Improper Payments[3]



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

Monetary Loss Findings[4]

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

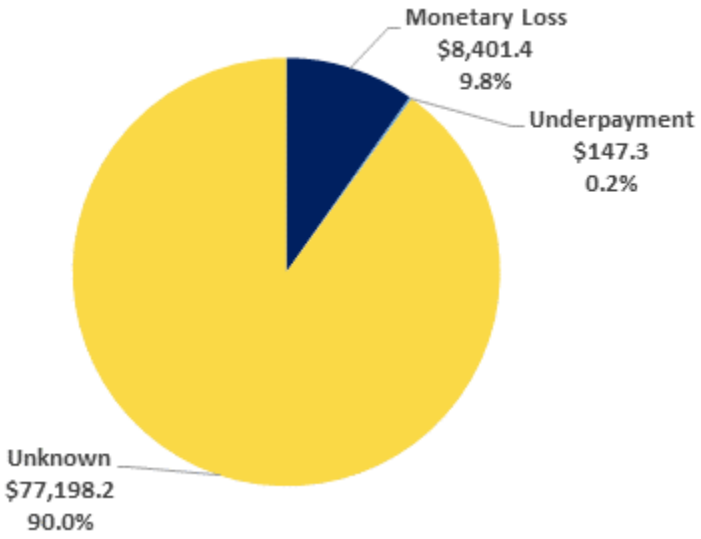
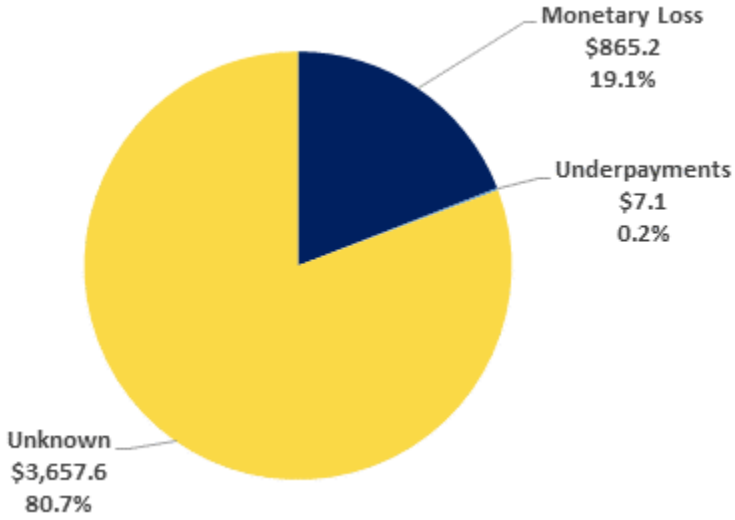


Figure 10. CHIP Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[5]

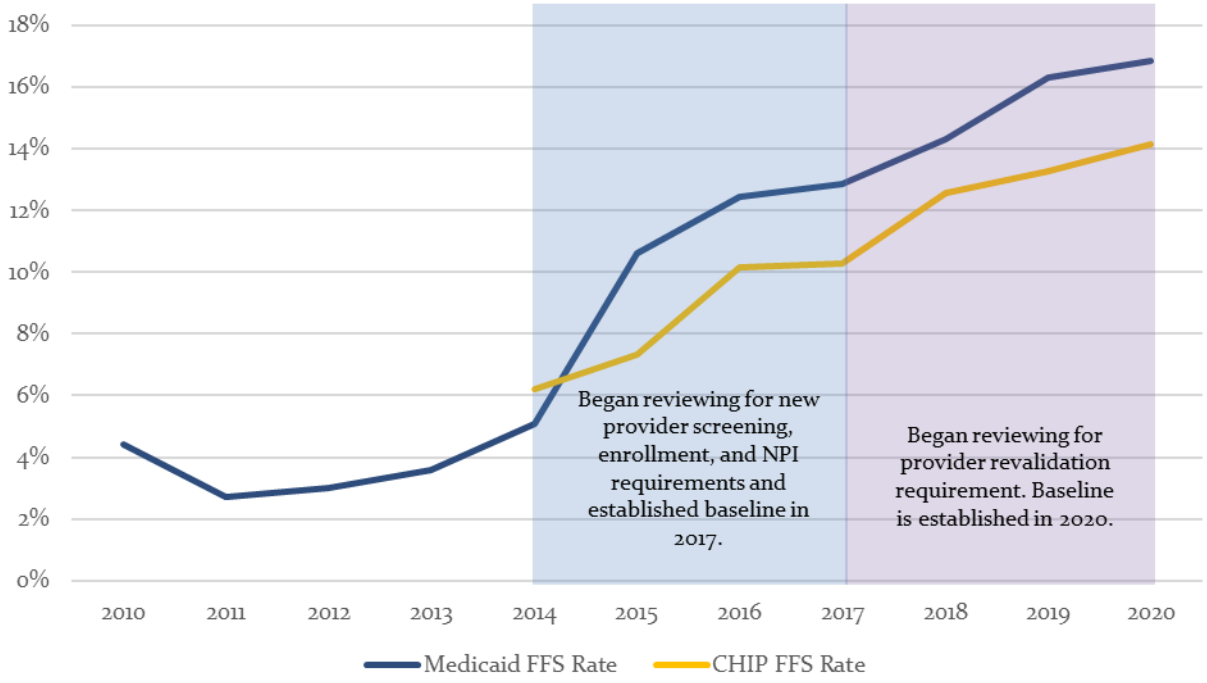


[4] Eligibility reviews were suspended from 2015 to 2017. Therefore, these figures include only two cycles of the eligibility component measured under new requirements (the 34 states measured in 2019 and 2020).

[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.

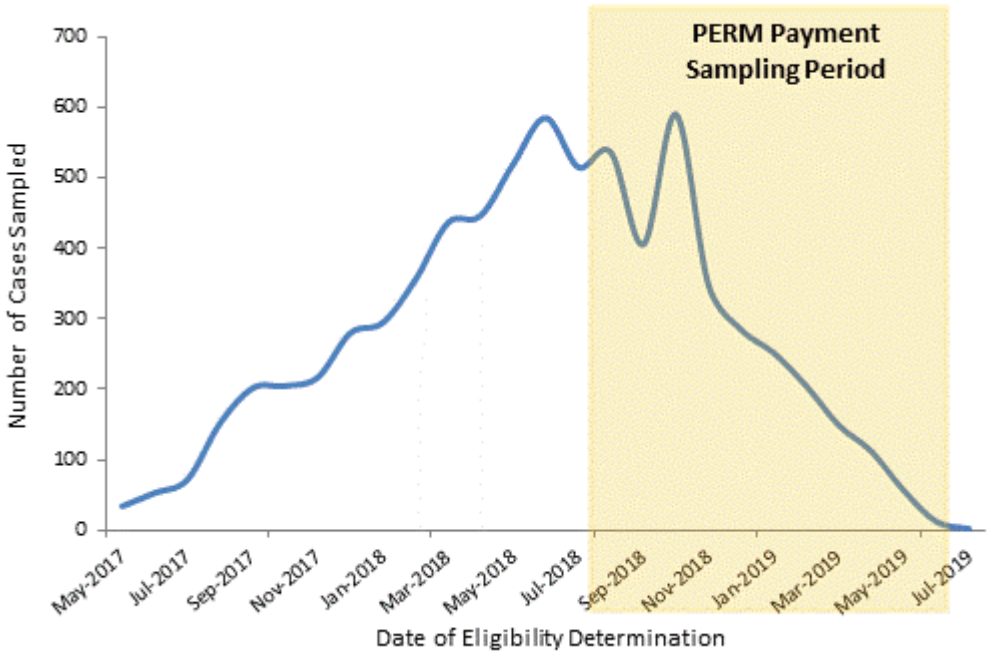
2020 FFS Improper Payment Trends

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



2020 Eligibility Improper Payment Trends

Figure 12. Medicaid and CHIP Eligibility Determination Timeframe for Claims Sampled in the 2020 Review Period



Section 2: 2020 Supplemental Medicaid Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for Medicaid in 2020 based on the 51 states reviewed from 2018-2020.

There was no eligibility component review from 2015-2018. Therefore, the rolling national eligibility estimate is a combination of the eligibility results from the 2020 Cycle 2 measurement, 2019 Cycle 1 measurement, and the most recent cycle prior to 2015 for Cycle 3 (which has not yet been measured under the new eligibility review methodology).

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	6,292	27,977	$22,225,865.22	$111,609,213.08	$30,442.26	$180,814.83	16.84%	16.20% - 17.47%
FFS Medical Review	755	27,977*	$1,455,759.01	$111,609,213.08	$4,010.76	$180,814.83	2.22%	1.97% - 2.47%
FFS Data Processing	5,730	27,977	$21,071,757.17	$111,609,213.08	$27,178.24	$180,814.83	15.03%	14.43% - 15.63%
Managed Care	28	5,146	$6,971.81	$4,971,356.84	$123.68	$224,084.35	0.06%	0.01% - 0.10%
Eligibility	3,579	19,799	$3,968,213.04	$24,054,297.74	$60,487.66	$404,899.18	14.94%	14.25% - 15.63%
Total	**9,899**	**52,922**	**$26,201,050.06**	**$140,634,867.66**	**$86,487.38**	**$404,899.18**	**21.36%**	**20.68% - 22.04%**

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). Of the 27,977 cases sampled, 24,282 were eligible for Medical Reviews.

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	$3.32	3.30%
	Other Monetary Loss	$2.62	2.61%
	Provider Not Enrolled	$2.29	2.28%
Unknown	Insufficient Information to determine eligibility	$42.08	41.83%
	Non-Compliance with Provider Screening and NPI Requirements	$21.08	20.95%
	Other	$1.09	1.08%
	Other Missing Information	$9.59	9.53%
	Redetermination Not Conducted	$13.06	12.98%
Underpayments		$0.16	0.16%
Proxy Eligibility Estimate		$5.30	5.27%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). 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 based on results from FY 2014 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	2,408	2,177	5,444	$3,738,406.69	$8,555,733.82	$9,495.31	$33,672.30	28.20%	26.60% - 29.80%
Personal Support Services	674	572	1,742	$540,545.47	$1,210,883.36	$3,315.24	$12,045.16	27.52%	24.13% - 30.91%
Psychiatric, Mental Health, and Behavioral Health Services	717	589	1,946	$1,432,691.56	$5,875,987.80	$2,888.53	$12,157.83	23.76%	20.62% - 26.90%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	750	645	4,332	$1,997,931.76	$17,437,971.98	$2,758.53	$27,560.79	10.01%	8.96% - 11.06%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	752	593	1,143	$6,804,965.56	$12,320,888.40	$2,741.13	$5,676.40	48.29%	43.82% - 52.76%
Prescribed Drugs	648	556	2,875	$2,201,335.34	$11,869,658.22	$2,383.38	$21,105.61	11.29%	9.46% - 13.13%
Dental and Oral Surgery Services	456	331	539	$69,745.41	$119,957.29	$1,889.72	$3,509.16	53.85%	44.27% - 63.43%
Capitated Care/Fixed Payments	64	46	1,789	$39,526.63	$1,068,858.40	$1,126.06	$18,166.55	6.20%	3.25% - 9.15%
Clinic Services	107	96	773	$26,385.68	$254,943.41	$644.32	$5,220.51	12.34%	7.49% - 17.20%
Inpatient Hospital Services	133	125	2,187	$4,910,276.15	$48,581,923.82	$607.86	$17,079.60	3.56%	1.66% - 5.46%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	122	74	167	$4,531.82	$20,670.92	$482.83	$1,113.75	43.35%	29.89% - 56.81%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	101	93	866	$22,185.57	$533,189.35	$412.35	$5,926.05	6.96%	4.23% - 9.68%
Home Health Services	100	75	315	$69,281.24	$269,427.87	$398.62	$1,748.40	22.80%	15.74% - 29.86%

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
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	93	78	245	$92,613.31	$297,373.00	$337.14	$1,388.65	24.28%	17.09% - 31.46%
Hospice Services	65	48	244	$120,600.69	$759,001.76	$235.07	$1,447.97	16.23%	10.43% - 22.04%
Outpatient Hospital Services	88	76	1,244	$130,878.40	$2,213,719.17	$220.92	$7,358.85	3.00%	1.60% - 4.40%
Transportation and Accommodations	51	48	252	$19,706.77	$175,291.84	$206.73	$1,209.28	17.10%	9.07% - 25.12%
Laboratory, X-ray and Imaging Services	56	42	189	$4,122.72	$22,296.28	$193.99	$915.84	21.18%	12.33% - 30.04%
Crossover Claims	27	27	750	$134.44	$21,046.45	$104.54	$3,452.96	3.03%	(1.66%) - 7.71%
Denied Claims	1	1	935	$0.00	$389.93	$0.00	$59.18	0.00%	0.00% - 0.00%
Total	**7,413**	**6,292**	**27,977**	**$22,225,865.22**	**$111,609,213.08**	**$30,442.26**	**$180,814.83**	**16.84%**	**16.20% - 17.47%**

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)	332	$691,982.09	$2,047.22	$1,658.37	$2,436.08
No Documentation Error (MR1)	229	$493,476.77	$1,009.97	$799.44	$1,220.51
Improperly Completed Documentation (MR9)	114	$210,049.57	$653.87	$472.19	$835.55
Number of Unit(s) Error (MR6)	63	$60,220.19	$310.99	$161.26	$460.72
Medically Unnecessary Service Error (MR7)	2	$515.34	$33.53	-$19.55	$86.61
Policy Violation Error (MR8)	4	$18,223.42	$30.05	-$1.99	$62.10
Administrative/Other Error (MR10)	4	$6,343.59	$15.58	-$0.40	$31.56
Procedure Coding Error (MR3)	5	$4,460.05	$14.71	$0.32	$29.10
Diagnosis Coding Error (MR4)	1	$7,602.63	$8.91	N/A	N/A
Medical Technical Deficiency (MTD)	26	$0.00	$0.00	$0.00	$0.00
Total	**780**	**$1,492,873.64**	**$4,124.84**	**$3,622.32**	**$4,627.36**

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, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 S7, 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.

Table S5. Summary of Medicaid FFS Medical Review Overpayments

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)	332	$691,982.09	$2,047.22	$1,658.37	$2,436.08
No Documentation Error (MR1)	229	$493,476.77	$1,009.97	$799.44	$1,220.51
Improperly Completed Documentation (MR9)	114	$210,049.57	$653.87	$472.19	$835.55
Number of Unit(s) Error (MR6)	61	$57,495.00	$285.50	$140.87	$430.13
Medically Unnecessary Service Error (MR7)	2	$515.34	$33.53	-$19.55	$86.61
Policy Violation Error (MR8)	4	$18,223.42	$30.05	-$1.99	$62.10
Administrative/Other Error (MR10)	4	$6,343.59	$15.58	-$0.40	$31.56
Procedure Coding Error (MR3)	5	$4,460.05	$14.71	$0.32	$29.10
Diagnosis Coding Error (MR4)	1	$7,602.63	$8.91	N/A	N/A
Medical Technical Deficiency (MTD)	26	$0.00	$0.00	$0.00	$0.00
Total	**778**	**$1,490,148.46**	**$4,099.35**	**$3,598.32**	**$4,600.37**

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. However, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 S7, 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.

Table S6. Summary of Medicaid FFS Medical Review Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Number of Unit(s) Error (MR6)	2	$2,725.19	$25.49	-$13.24	$64.23
Total	**2**	**$2,725.19**	**$25.49**	**-$13.24**	**$64.23**

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, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 S7, 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 S7. 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	166	$208,128.29	$1,390.24	$1,034.28	$1,746.20
Provider did not submit required progress notes applicable to the sampled DOS	35	$164,072.35	$144.84	$76.57	$213.11
Provider did not submit the service plan	36	$68,445.12	$131.51	$69.30	$193.72
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	31	$21,705.59	$122.03	$53.61	$190.45
Individual plan (ITP, ISP, IFSP, IEP, or POC) was present, but not applicable to the sampled DOS	24	$45,848.69	$88.44	$32.13	$144.75
Record does not include a physician's order for the sampled service	24	$67,965.43	$85.26	$31.59	$138.93
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	16	$10,865.46	$74.88	$6.61	$143.15
Multiple documents are missing from the record that are required to support payment	11	$31,258.21	$56.89	$10.47	$103.31
Other	7	$25,696.45	$16.05	$3.65	$28.45
Provider did not submit a valid prescription	4	$4,427.03	$12.75	-$1.29	$26.78
Provider did not submit an inpatient admission order	1	$73,428.71	$2.31	N/A	N/A
Provider did not submit proof of delivery	1	$10.70	$0.69	N/A	N/A
Total	**356**	**$721,852.03**	**$2,125.88**	**$1,735.51**	**$2,516.25**

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 S8. Medicaid 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)	103
Progress Notes for All Disciplines/Department (to include physician's 60-day progress notes in effect during sampled date/s of service)	89
Physician Orders (signed and dated, include all orders relevant to sampled claim)	62
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	36
Individual Education Plan (IEP), Individual Program Plan (IPP), Individual Service Plan (ISP), Individual Family Service Plan (IFSP)	30
Member Pharmacy Signature Log/Proof of Delivery	23
Documentation of Daily Patient Presence (e.g., daily census, attendance log, etc.)	12
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)	11
Medication Administration Record (MAR)	11
Member Profile with Refill History for the Sampled Medication	11
Prior Authorization (if required)	11
Documented Proof of Acceptance or Refusal of Counseling	10
Encounter/Clinic Visit Record/Notes (signed and dated)	10
Other	10
Mental Health Progress/Therapy Notes/Daily Attendance Logs (with start and stop times)	7
Plan of Care / Service / Treatment Plan and Goals	6
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)	5
Annual Physical Exam (if required)	4
Case Management Care Plan/Updates and Notes (in effect during sampled date/s of service, including telephonic contact)	4
Physician Orders and Progress Notes (signed and dated)	4
Treatment Administration Record/Notes	4
Initial Intake Assessment/Reassessment (as relevant to dates of service)	3
Total Time Spent for Units Billed (i.e., 15 min., 30 min., 1 hr., 1 visit, etc.)	3
Individual Education Plan (IEP), Individual Program Plan (IPP), Individual Service Plan (ISP), Individual Family Service Plan(IFSP) (in effect during sampled date/s of service, include Physician Orders if required)	2
Orders from Identified Qualified Provider (if required)	2
Dental X-Ray Notes (please do not send x-rays)	1
Dental and Diagnostic Service Records	1
Hospice Nurse Visit and Progress Notes	1

Documentation Type	Total Count
Medical Supplies, Equipment, and Appliances Signature Log/Proof of Delivery	1
PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (RT): Evaluation and Re-evaluation / Notes	1
Patient Education Documentation	1
Physical Therapy: Evaluation/Re-evaluation/Notes (signed and dated with start and stop times, and total time spent for units billed, i.e., 15 min., 30 min., 1hr., 1 visit, etc.)	1
Physician Order Sheet (signed and dated)	1
Procedure Record / Notes	1
Psychiatric Evaluation/Testing	1
Timesheet, Completed and Signed (include description of services approved and provided)	1
Total	**484**

Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.

Table S9. 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)	170
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	90
Psychiatric, Mental Health, and Behavioral Health Services	71
Prescribed Drugs	53
Personal Support Services	47
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	15
Outpatient Hospital Services	11
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	5
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	5
Clinic Services	4
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	4
Dental and Oral Surgery Services	3
Home Health Services	3
Hospice Services	1
Inpatient Hospital Services	1
Laboratory, X-ray and Imaging Services	1
Total	**484**

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 S10. 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	116	$239,023.19	$471.97	$331.35	$612.59
Provider is under fraud investigation or pending litigation	15	$42,456.02	$115.97	$41.40	$190.55
State could not locate the provider	30	$25,299.25	$111.54	$61.76	$161.32
Provider responded that he or she did not have the beneficiary on file or in the system	17	$14,932.13	$82.19	$18.77	$145.61
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	18	$115,548.24	$76.36	-$4.50	$157.21
Provider responded with a statement that the provider had billed in error	15	$28,549.66	$56.42	$14.12	$98.72
Provider responded with a statement that records cannot be located	6	$2,023.59	$53.67	-$5.05	$112.39
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	3	$493.89	$14.07	-$4.40	$32.54
Provider submitted a record for wrong DOS	5	$22,773.15	$14.04	-$2.44	$30.53
Provider did not submit medical records, only the PERM coversheet	1	$4.83	$5.52	N/A	N/A
Provider did not submit medical records, only billing information, which is not enough/sufficient to support the sampled claim	1	$137.46	$3.77	N/A	N/A
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	$3.34	N/A	N/A
Other	1	$964.32	$1.11	N/A	N/A
Total	**229**	**$493,476.77**	**$1,009.97**	**$799.44**	**$1,220.51**

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 S11. 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)	197	183	4,332	$607,397.98	$17,437,971.98	$1,034.23	$27,560.79	3.75%	3.00% - 4.51%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	154	152	5,444	$127,448.84	$8,555,733.82	$921.89	$33,672.30	2.74%	2.02% - 3.46%
Personal Support Services	75	74	1,742	$33,229.95	$1,210,883.36	$514.20	$12,045.16	4.27%	2.06% - 6.48%
Psychiatric, Mental Health, and Behavioral Health Services	135	127	1,946	$77,081.88	$5,875,987.80	$462.58	$12,157.83	3.80%	2.69% - 4.92%
Prescribed Drugs	69	69	2,875	$145,995.20	$11,869,658.22	$356.02	$21,105.61	1.69%	1.04% - 2.34%
Outpatient Hospital Services	20	20	1,244	$42,843.90	$2,213,719.17	$115.08	$7,358.85	1.56%	0.51% - 2.62%
Inpatient Hospital Services	10	10	2,187	$257,178.16	$48,581,923.82	$114.68	$17,079.60	0.67%	0.11% - 1.23%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	31	31	866	$10,942.02	$533,189.35	$100.65	$5,926.05	1.70%	0.69% - 2.71%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	19	19	1,143	$130,642.14	$12,320,888.40	$88.21	$5,676.40	1.55%	0.65% - 2.46%
Laboratory, X-ray and Imaging Services	10	10	189	$645.76	$22,296.28	$76.82	$915.84	8.39%	1.24% - 15.53%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	11	11	167	$548.86	$20,670.92	$47.91	$1,113.75	4.30%	0.77% - 7.83%
Transportation and Accommodations	8	8	252	$469.42	$175,291.84	$42.91	$1,209.28	3.55%	0.37% - 6.73%

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
Clinic Services	17	17	773	$10,458.12	$254,943.41	$38.99	$5,220.51	0.75%	0.23% - 1.27%
Hospice Services	4	4	244	$7,129.89	$759,001.76	$32.10	$1,447.97	2.22%	(0.93%) - 5.36%
Home Health Services	4	4	315	$1,538.52	$269,427.87	$29.03	$1,748.40	1.66%	(0.43%) - 3.75%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	7	7	245	$866.92	$297,373.00	$20.43	$1,388.65	1.47%	(0.05%) - 2.99%
Dental and Oral Surgery Services	9	9	539	$1,341.48	$119,957.29	$15.02	$3,509.16	0.43%	(0.12%) - 0.98%
Capitated Care/Fixed Payments	0	0	1,789	$0.00	$1,068,858.40	$0.00	$18,166.55	0.00%	0.00% - 0.00%
Crossover Claims	0	0	750	$0.00	$21,046.45	$0.00	$3,452.96	0.00%	0.00% - 0.00%
Denied Claims	0	0	935	$0.00	$389.93	$0.00	$59.18	0.00%	0.00% - 0.00%
Total	**780**	**755**	**27,977**	**$1,455,759.01**	**$111,609,213.08**	**$4,010.76**	**$180,814.83**	**2.22%**	**1.97% - 2.47%**

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 S12. 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)	5,780	$22,443,435.25	$27,266.20	$26,171.58	$28,360.81
Non-covered Service/Beneficiary Error (DP2)	87	$358,875.00	$1,413.00	$859.18	$1,966.83
Pricing Error (DP5)	145	$338,270.58	$905.97	$566.56	$1,245.39
Duplicate Claim Error (DP1)	53	$30,214.18	$787.76	$449.86	$1,125.67
Administrative/Other Error (DP12)	30	$86,326.48	$580.37	$188.77	$971.98
Managed Care Payment Error (DP9)	2	$226.95	$108.39	-$56.96	$273.74
Third-Party Liability Error (DP4)	10	$31,300.99	$65.14	$8.58	$121.70
System Logic Edit Error (DP6)	2	$8,144.87	$59.83	-$24.12	$143.79
Claim Filed Untimely Error (DP11)	3	$26,017.74	$8.96	-$4.45	$22.37
Managed Care Rate Cell Error (DP8)	1	$0.33	$0.10	N/A	N/A
Data Processing Technical Deficiency (DTD)	520	$0.00	$0.00	$0.00	$0.00
Total	**6,633**	**$23,322,812.36**	**$31,195.74**	**$29,835.76**	**$32,555.72**

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 S13. Summary of Medicaid FFS Data Processing Overpayments

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)	5,780	$22,443,435.25	$27,266.20	$26,171.58	$28,360.81
Non-covered Service/Beneficiary Error (DP2)	87	$358,875.00	$1,413.00	$859.18	$1,966.83
Pricing Error (DP5)	119	$323,164.52	$878.88	$540.03	$1,217.73
Duplicate Claim Error (DP1)	53	$30,214.18	$787.76	$449.86	$1,125.67
Administrative/Other Error (DP12)	30	$86,326.48	$580.37	$188.77	$971.98
Managed Care Payment Error (DP9)	2	$226.95	$108.39	-$56.96	$273.74
Third-Party Liability Error (DP4)	10	$31,300.99	$65.14	$8.58	$121.70
System Logic Edit Error (DP6)	2	$8,144.87	$59.83	-$24.12	$143.79
Claim Filed Untimely Error (DP11)	3	$26,017.74	$8.96	-$4.45	$22.37
Data Processing Technical Deficiency (DTD)	520	$0.00	$0.00	$0.00	$0.00
Total	**6,606**	**$23,307,705.97**	**$31,168.54**	**$29,808.58**	**$32,528.50**

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 S14. Summary of Medicaid FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	26	$15,106.06	$27.09	$7.32	$46.87
Managed Care Rate Cell Error (DP8)	1	$0.33	$0.10	N/A	N/A
Total	**27**	**$15,106.39**	**$27.20**	**$7.42**	**$46.97**

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.

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

Table S15. 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	3,224	$8,700,756.54	$14,620.57	$13,793.58	$15,447.55
National Provider Identifier (NPI)	Attending or rendering provider NPI required, but not listed on claim	593	$4,088,699.44	$3,695.69	$3,232.65	$4,158.74
	ORP NPI required, but not listed on claim	465	$1,758,552.94	$1,936.13	$1,630.20	$2,242.05
	Billing provider NPI required, but not listed on claim	127	$337,978.47	$824.27	$626.44	$1,022.09
Missing Provider Information	Missing provider risk based screening information	736	$1,992,544.40	$1,946.42	$1,657.74	$2,235.10
	Missing provider enrollment information	123	$279,102.55	$864.59	$705.86	$1,023.33
	Missing information to determine if attending NPI submitted on the claim	64	$578,869.45	$378.21	$286.61	$469.81
	Missing information to determine if billing NPI submitted on the claim	40	$515,539.86	$246.83	$171.78	$321.87
	Other missing provider information	18	$16,772.55	$118.43	$55.06	$181.80
	Missing provider license information	15	$107,146.97	$63.74	$29.56	$97.92
	Missing information to determine if provider NPI was submitted on the claim	5	$617,912.97	$8.71	($2.89)	$20.31
	Missing information to determine if ORP NPI submitted on the claim	1	$57.88	$7.95	N/A	N/A
Provider Enrollment	Provider not enrolled	325	$3,223,203.96	$2,291.16	$1,944.56	$2,637.76
Provider License/Certification	Provider license not current for DOS	44	$226,297.28	$263.51	$97.76	$429.26
	Total	**5,780**	**$22,443,435.25**	**$27,266.20**	**$26,171.58**	**$28,360.81**

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 Data Processing Errors by Service Type

Table S16. 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	2,254	2,090	5,444	$3,691,654.52	$8,555,733.82	$8,895.85	$33,672.30	26.42%	24.90% - 27.94%
Personal Support Services	599	510	1,742	$513,297.94	$1,210,883.36	$2,839.64	$12,045.16	23.57%	20.56% - 26.59%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	733	591	1,143	$6,785,812.64	$12,320,888.40	$2,715.25	$5,676.40	47.83%	43.38% - 52.29%
Psychiatric, Mental Health, and Behavioral Health Services	582	492	1,946	$1,372,742.95	$5,875,987.80	$2,492.97	$12,157.83	20.51%	17.50% - 23.51%
Prescribed Drugs	579	503	2,875	$2,073,678.34	$11,869,658.22	$2,050.30	$21,105.61	9.71%	7.98% - 11.45%
Dental and Oral Surgery Services	447	330	539	$69,130.41	$119,957.29	$1,888.70	$3,509.16	53.82%	44.24% - 63.40%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	553	489	4,332	$1,454,809.18	$17,437,971.98	$1,847.64	$27,560.79	6.70%	5.91% - 7.50%
Capitated Care/Fixed Payments	64	46	1,789	$39,526.63	$1,068,858.40	$1,126.06	$18,166.55	6.20%	3.25% - 9.15%
Clinic Services	90	80	773	$15,927.56	$254,943.41	$605.32	$5,220.51	11.60%	6.75% - 16.44%
Inpatient Hospital Services	123	115	2,187	$4,653,097.99	$48,581,923.82	$493.18	$17,079.60	2.89%	1.07% - 4.71%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	111	69	167	$4,250.91	$20,670.92	$464.58	$1,113.75	41.71%	28.29% - 55.13%
Home Health Services	96	72	315	$68,260.49	$269,427.87	$380.09	$1,748.40	21.74%	14.88% - 28.60%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	86	73	245	$92,118.71	$297,373.00	$323.74	$1,388.65	23.31%	16.25% - 30.37%

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
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	70	64	866	$11,409.50	$533,189.35	$320.59	$5,926.05	5.41%	2.86% - 7.96%
Hospice Services	61	45	244	$113,489.76	$759,001.76	$203.98	$1,447.97	14.09%	9.11% - 19.07%
Transportation and Accommodations	43	42	252	$19,263.05	$175,291.84	$171.37	$1,209.28	14.17%	6.65% - 21.69%
Outpatient Hospital Services	68	58	1,244	$89,595.94	$2,213,719.17	$133.83	$7,358.85	1.82%	0.69% - 2.95%
Laboratory, X-ray and Imaging Services	46	33	189	$3,556.22	$22,296.28	$120.61	$915.84	13.17%	7.50% - 18.84%
Crossover Claims	27	27	750	$134.44	$21,046.45	$104.54	$3,452.96	3.03%	(1.66%) - 7.71%
Denied Claims	1	1	935	$0.00	$389.93	$0.00	$59.18	0.00%	0.00% - 0.00%
Total	**6,633**	**5,730**	**27,977**	**$21,071,757.17**	**$111,609,213.08**	**$27,178.24**	**$180,814.83**	**15.03%**	**14.43% - 15.63%**

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 S17. 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)
Non-covered Service/Beneficiary Error (DP2)	10	$10,563.99	$134.11	$47.78	$220.44
Managed Care Payment Error (DP9)	18	$955.97	$12.73	$8.86	$16.61
Managed Care Rate Cell Error (DP8)	2	$3.12	$1.07	-$0.21	$2.35
Total	**30**	**$11,523.08**	**$147.91**	**$61.49**	**$234.34**

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.

Medicaid Managed Care Data Processing Federal Improper Payments

Table S18. Summary of Medicaid Managed Care Data Processing Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	10	$10,563.99	$134.11	$47.78	$220.44
Managed Care Payment Error (DP9)	13	$735.85	$9.22	$6.29	$12.15
Total	**23**	**$11,299.84**	**$143.33**	**$56.95**	**$229.71**

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 S19. Summary of Medicaid Managed Care Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Managed Care Payment Error (DP9)	5	$220.12	$3.52	$0.80	$6.23
Managed Care Rate Cell Error (DP8)	2	$3.12	$1.07	-$0.21	$2.35
Total	**7**	**$223.24**	**$4.58**	**$1.58**	**$7.58**

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: Non-covered Service/Beneficiary Error (DP2)

Table S20. Medicaid 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	7	$5,660.36	$85.17	$14.50	$155.85
Claim/capitation payment paid for coverage period or DOS after beneficiary's date of death	2	$4,551.27	$26.58	-$8.29	$61.45
Capitation payment made for a beneficiary not enrolled in MCO	1	$352.35	$22.36	N/A	N/A
Total	**10**	**$10,563.99**	**$134.11**	**$47.78**	**$220.44**

Section 3: 2020 Supplemental CHIP Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for CHIP in 2020 based on the 51 states reviewed from 2018-2020.

There was no eligibility component review from 2015-2018. Therefore, the rolling national eligibility estimate is a combination of the eligibility results from the 2020 Cycle 2 measurement, 2019 Cycle 1 measurement, and the most recent cycle prior to 2015 for Cycle 3 (which has not yet been measured under the new eligibility review methodology).

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	5,617	19,496	$8,648,834.10	$59,222,143.44	$742.62	$5,248.31	14.15%	13.31% - 14.99%
FFS Medical Review	683	19,496*	$578,665.38	$59,222,143.44	$81.52	$5,248.31	1.55%	1.29% - 1.82%
FFS Data Processing	5,147	19,496	$8,183,926.07	$59,222,143.44	$679.53	$5,248.31	12.95%	12.13% - 13.77%
Managed Care	19	4,394	$14,733.15	$1,106,228.00	$60.83	$12,443.23	0.49%	0.13% - 0.85%
Eligibility	4,177	16,306	$2,428,449.23	$13,232,800.33	$4,162.87	$17,691.53	23.53%	22.69% - 24.37%
Total	**9,813**	**40,196**	**$11,092,016.47**	**$73,561,171.77**	**$4,777.27**	**$17,691.53**	**27.00%**	**26.15% - 27.85%**

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). Of the 19,496 cases sampled, 18,134 were eligible for Medical Reviews.

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	$0.78	13.98%
	Other Monetary Loss	$0.11	1.91%
	Provider Not Enrolled	$0.03	0.51%
Unknown	Insufficient Information to determine eligibility	$2.55	45.76%
	Non-Compliance with Provider Screening and NPI Requirements	$0.71	12.83%
	Other	$0.04	0.80%
	Other Missing Information	$0.12	2.21%
	Redetermination Not Conducted	$0.78	13.99%
Underpayments		$0.01	0.18%
Proxy Eligibility Estimate		$0.44	7.83%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). 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 based on results from FY 2014 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	2,610	1,766	3,087	$423,952.77	$1,259,688.13	$273.29	$697.31	39.19%	29.31% - 49.07%
Prescribed Drugs	887	778	3,411	$2,884,488.17	$14,803,177.47	$121.61	$1,028.14	11.83%	9.62% - 14.04%
Psychiatric, Mental Health, and Behavioral Health Services	1,371	1,102	3,366	$2,061,628.60	$8,008,281.73	$101.28	$760.00	13.33%	11.71% - 14.94%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,334	932	1,641	$302,906.92	$529,244.44	$80.56	$242.18	33.26%	28.16% - 38.37%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	242	192	1,371	$52,943.94	$504,363.83	$50.44	$523.05	9.64%	6.19% - 13.10%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	319	188	438	$21,317.30	$47,071.93	$44.10	$113.95	38.70%	27.61% - 49.80%
Personal Support Services	218	178	340	$74,099.94	$139,715.75	$19.35	$69.27	27.93%	21.38% - 34.48%
Clinic Services	156	135	1,410	$32,253.87	$372,945.53	$14.30	$382.85	3.74%	2.47% - 5.00%
Inpatient Hospital Services	89	85	1,395	$1,734,238.88	$27,078,095.68	$12.95	$704.02	1.84%	1.15% - 2.53%
Outpatient Hospital Services	114	102	1,473	$230,720.87	$3,537,429.94	$11.18	$423.44	2.64%	1.70% - 3.58%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	53	45	181	$40,226.99	$189,389.53	$7.28	$53.54	13.59%	6.40% - 20.79%
Capitated Care/Fixed Payments	59	26	488	$552,585.46	$2,048,569.59	$2.79	$147.87	1.89%	(0.18%) - 3.96%
Home Health Services	31	27	56	$28,691.44	$50,014.06	$1.39	$10.40	13.32%	3.81% - 22.83%

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	21	18	213	$959.71	$28,208.93	$0.89	$61.31	1.45%	0.31% - 2.59%
Transportation and Accommodations	11	11	99	$6,215.18	$139,377.42	$0.61	$18.36	3.32%	0.58% - 6.06%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	26	20	28	$195,432.31	$268,355.65	$0.53	$1.66	32.01%	10.72% - 53.30%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	3	2	7	$5,753.29	$202,911.90	$0.05	$5.85	0.88%	(0.87%) - 2.62%
Crossover Claims	14	9	69	$418.45	$6,305.04	$0.00	$0.10	3.33%	(1.26%) - 7.92%
Denied Claims	1	1	421	$0.00	$52.67	$0.00	$4.32	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.71	0.00%	0.00% - 0.00%
Total	**7,559**	**5,617**	**19,496**	**$8,648,834.10**	**$59,222,143.44**	**$742.62**	**$5,248.31**	**14.15%**	**13.31% - 14.99%**

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)	227	$162,156.38	$33.20	$25.79	$40.61
No Documentation Error (MR1)	151	$140,331.79	$23.57	$13.87	$33.26
Procedure Coding Error (MR3)	42	$145,701.99	$11.20	$4.27	$18.13
Improperly Completed Documentation (MR9)	191	$42,995.28	$8.53	$5.40	$11.65
Number of Unit(s) Error (MR6)	30	$91,495.63	$4.15	$2.04	$6.26
Administrative/Other Error (MR10)	5	$1,494.81	$0.74	-$0.03	$1.50
Medically Unnecessary Service Error (MR7)	3	$135.07	$0.35	-$0.31	$1.01
Policy Violation Error (MR8)	3	$358.04	$0.33	-$0.13	$0.78
Unbundling Error (MR5)	1	$13.00	$0.03	N/A	N/A
Medical Technical Deficiency (MTD)	46	$0.00	$0.00	$0.00	$0.00
Total	**699**	**$584,681.98**	**$82.08**	**$67.60**	**$96.55**

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, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 T7, 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.

Table T5. Summary of CHIP FFS Medical Review Overpayments

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)	227	$162,156.38	$33.20	$25.79	$40.61
No Documentation Error (MR1)	151	$140,331.79	$23.57	$13.87	$33.26
Improperly Completed Documentation (MR9)	191	$42,995.28	$8.53	$5.40	$11.65
Procedure Coding Error (MR3)	38	$145,336.18	$6.54	$3.43	$9.66
Number of Unit(s) Error (MR6)	29	$91,487.37	$4.11	$2.00	$6.22
Administrative/Other Error (MR10)	5	$1,494.81	$0.74	-$0.03	$1.50
Medically Unnecessary Service Error (MR7)	3	$135.07	$0.35	-$0.31	$1.01
Policy Violation Error (MR8)	3	$358.04	$0.33	-$0.13	$0.78
Unbundling Error (MR5)	1	$13.00	$0.03	N/A	N/A
Medical Technical Deficiency (MTD)	46	$0.00	$0.00	$0.00	$0.00
Total	**694**	**$584,307.91**	**$77.39**	**$64.28**	**$90.49**

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 However, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 T7, 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.

Table T6. Summary of CHIP FFS Medical Review Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Procedure Coding Error (MR3)	4	$365.81	$4.65	-$1.53	$10.84
Number of Unit(s) Error (MR6)	1	$8.26	$0.03	N/A	N/A
Total	**5**	**$374.07**	**$4.69**	**-$1.50**	**$10.88**

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, in FY17 (2018), multiple MR2 errors were included on the same claim if there were multiple documents missing. For RY19 and RY20, multiple documents missing were included in the sub-qualifier for one MR2 error. Therefore, 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 T7, 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 T7. 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)
One or more documents are missing from the record that are required to support payment	60	$72,894.00	$19.80	$13.28	$26.32
Provider did not submit the pharmacy signature log and/or documentation of patient counseling	32	$27,099.15	$5.29	$3.07	$7.52
Provider did not submit the service plan	60	$25,599.66	$3.42	$1.81	$5.02
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	37	$34,178.49	$2.44	$0.54	$4.34
Record does not include a physician's order for the sampled service	5	$13,406.05	$0.90	-$0.07	$1.87
Other	22	$2,610.71	$0.81	-$0.07	$1.69
Multiple documents are missing from the record that are required to support payment	11	$2,536.55	$0.57	$0.12	$1.03
Provider did not submit proof of delivery	2	$787.99	$0.45	-$0.25	$1.16
Provider did not submit required progress notes applicable to the sampled DOS	5	$4,885.02	$0.41	-$0.06	$0.88
Provider did not submit the test result	2	$858.80	$0.17	-$0.10	$0.45
Provider did not submit the face-to-face assessment documentation	1	$299.48	$0.16	N/A	N/A
Individual plan (ITP, ISP, IFSP, IEP, or POC) was present, but not applicable to the sampled DOS	4	$8,702.56	$0.11	-$0.01	$0.24
Total	**241**	**$193,858.46**	**$34.54**	**$27.07**	**$42.01**

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.

Table T8. 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)	81
Member Pharmacy Signature Log/Proof of Delivery	30
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	25
Documented Proof of Acceptance or Refusal of Counseling	23
Encounter/Office Visit/Clinic Record/Notes (signed and dated)	20
Other	18
Daily documentation of specific tasks performed on the sampled date of service.	13
Individual Education Plan (IEP), Individual Program Plan (IPP), Individual Service Plan (ISP), Individual Family Service Plan (IFSP)	11
Mental Health Progress/Therapy Notes/Daily Attendance Logs (with start and stop times)	11
Prior Authorization (if required)	10
Physician Orders and Progress Notes (signed and dated)	9
Procedure Record/Notes (signed and dated)	9
Physician Orders (signed and dated, include all orders relevant to sampled claim)	7
Medication Administration Record (MAR)	6
Laboratory and Diagnostic Tests/Reports	5
PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (RT): Evaluation and Re-evaluation/Notes	5
Dental or Orthodontic Plan of Care (in effect during sampled date/s of service)	4
Member Profile with Refill History for the Sampled Medication	3
Name of Drug, Dose, Route, Number Dispensed, and Number of Refills	3
Case Management Care Plan/Updates and Notes (in effect during sampled date/s of service, including telephonic contact)	2
Documentation of Daily Patient Presence (e.g., daily census, attendance log, etc.)	2
Evaluation and Management (E&M)/Counseling Notes (signed and dated)	2
Ground Mileage/Air Mileage Details	2
Psychological Testing, Mental Health Counseling Notes, Treatment Plan, and Progress Toward Goals	2
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
Dental X-Ray Notes (please do not send x-rays)	1
Dental or Orthodontic Assessment	1
Invoice for Services (dated)	1
Operative and Procedure Reports/Notes	1
Orders (signed and dated, include all physician or authorized relevant practitioner's orders related to sampled claim)	1

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)	1
Treatment plan (in effect during sampled date/s of service)	1
Total	**311**

Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table.

Table T9. CHIP FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Total Count
Psychiatric, Mental Health, and Behavioral Health Services	89
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	78
Prescribed Drugs	57
Dental and Oral Surgery Services	29
Outpatient Hospital Services	20
Clinic Services	16
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	7
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	6
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	2
Personal Support Services	2
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	2
Inpatient Hospital Services	1
Laboratory, X-ray and Imaging Services	1
Transportation and Accommodations	1
Total	**311**

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 T10. 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	87	$60,724.38	$14.66	$5.71	$23.61
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	17	$12,038.73	$3.04	$0.98	$5.10
Provider responded that he or she did not have the beneficiary on file or in the system	12	$31,112.74	$2.31	$0.26	$4.36
Provider responded with a statement that the provider had billed in error	13	$7,822.56	$0.97	$0.14	$1.80
Provider submitted a record for wrong DOS	6	$11,671.20	$0.71	-$0.61	$2.02
Provider responded with a statement that records cannot be located	5	$15,833.53	$0.71	-$0.25	$1.67
Provider responded with a statement that the record is unavailable due to electronic health record issues	1	$107.33	$0.69	N/A	N/A
State could not locate the provider	5	$400.39	$0.40	-$0.22	$1.01
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	3	$408.00	$0.08	-$0.01	$0.17
Provider submitted a record for the wrong beneficiary	1	$48.32	$0.01	N/A	N/A
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	**151**	**$140,331.79**	**$23.57**	**$13.87**	**$33.26**

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 T11. 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	279	277	3,366	$166,612.56	$8,008,281.73	$19.32	$760.00	2.54%	1.92% - 3.16%
Dental and Oral Surgery Services	78	76	3,087	$17,849.57	$1,259,688.13	$18.10	$697.31	2.60%	0.98% - 4.21%
Prescribed Drugs	79	78	3,411	$136,282.37	$14,803,177.47	$13.30	$1,028.14	1.29%	0.84% - 1.74%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	108	98	1,641	$13,672.97	$529,244.44	$8.78	$242.18	3.62%	2.15% - 5.09%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	44	44	1,371	$24,583.30	$504,363.83	$6.86	$523.05	1.31%	0.65% - 1.98%
Outpatient Hospital Services	25	25	1,473	$158,778.94	$3,537,429.94	$5.92	$423.44	1.40%	0.62% - 2.18%
Clinic Services	24	24	1,410	$10,011.24	$372,945.53	$2.87	$382.85	0.75%	0.17% - 1.33%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	36	36	438	$2,269.53	$47,071.93	$1.75	$113.95	1.54%	(0.65%) - 3.72%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	10	10	181	$5,512.76	$189,389.53	$1.52	$53.54	2.85%	(0.20%) - 5.90%
Inpatient Hospital Services	1	1	1,395	$32,676.12	$27,078,095.68	$1.48	$704.02	0.21%	(0.20%) - 0.62%
Personal Support Services	8	8	340	$3,810.36	$139,715.75	$1.26	$69.27	1.83%	0.05% - 3.60%
Laboratory, X-ray and Imaging Services	2	2	213	$665.64	$28,208.93	$0.23	$61.31	0.37%	(0.16%) - 0.91%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	3	2	7	$5,753.29	$202,911.90	$0.05	$5.85	0.88%	(0.87%) - 2.62%

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
Home Health Services	1	1	56	$3.21	$50,014.06	$0.05	$10.40	0.45%	(0.46%) - 1.37%
Transportation and Accommodations	1	1	99	$183.53	$139,377.42	$0.04	$18.36	0.22%	(0.22%) - 0.66%
Capitated Care/Fixed Payments	0	0	488	$0.00	$2,048,569.59	$0.00	$147.87	0.00%	0.00% - 0.00%
Crossover Claims	0	0	69	$0.00	$6,305.04	$0.00	$0.10	0.00%	0.00% - 0.00%
Denied Claims	0	0	421	$0.00	$52.67	$0.00	$4.32	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.71	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	$1.66	0.00%	0.00% - 0.00%
Total	**699**	**683**	**19,496**	**$578,665.38**	**$59,222,143.44**	**$81.52**	**$5,248.31**	**1.55%**	**1.29% - 1.82%**

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.

CHIP FFS Data Processing Federal Improper Payments

Table T12. 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)	6,015	$8,636,561.73	$786.18	$728.33	$844.04
Pricing Error (DP5)	93	$721,926.40	$11.93	$5.07	$18.79
Non-covered Service/Beneficiary Error (DP2)	79	$648,221.90	$7.67	$3.44	$11.91
Duplicate Claim Error (DP1)	26	$559,011.68	$3.31	$0.09	$6.53
Administrative/Other Error (DP12)	17	$10,731.55	$3.08	$0.77	$5.39
Third-Party Liability Error (DP4)	7	$6,564.09	$0.66	-$0.17	$1.48
Claim Filed Untimely Error (DP11)	6	$92,006.00	$0.09	$0.02	$0.15
Data Processing Technical Deficiency (DTD)	617	$0.00	$0.00	$0.00	$0.00
Total	**6,860**	**$10,675,023.35**	**$812.92**	**$754.51**	**$871.32**

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.

Table T13. Summary of CHIP FFS Data Processing Overpayments

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)	6,015	$8,636,561.73	$786.18	$728.33	$844.04
Non-covered Service/ Beneficiary Error (DP2)	79	$648,221.90	$7.67	$3.44	$11.91
Pricing Error (DP5)	62	$698,052.06	$6.50	$2.79	$10.22
Duplicate Claim Error (DP1)	26	$559,011.68	$3.31	$0.09	$6.53
Administrative/Other Error (DP12)	17	$10,731.55	$3.08	$0.77	$5.39
Third-Party Liability Error (DP4)	7	$6,564.09	$0.66	-$0.17	$1.48
Claim Filed Untimely Error (DP11)	6	$92,006.00	$0.09	$0.02	$0.15
Data Processing Technical Deficiency (DTD)	617	$0.00	$0.00	$0.00	$0.00
Total	**6,829**	**$10,651,149.00**	**$807.49**	**$749.32**	**$865.66**

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 T14. Summary of CHIP FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	31	$23,874.34	$5.43	-$0.34	$11.20
Total	**31**	**$23,874.34**	**$5.43**	**-$0.34**	**$11.20**

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 T15. 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	3,373	$4,583,909.86	$634.08	$582.87	$685.30
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	829	$1,378,413.50	$69.19	$56.25	$82.14
	Billing provider NPI required, but not listed on claim	124	$56,780.95	$6.87	$1.20	$12.53
	Attending or rendering provider NPI required, but not listed on claim	40	$57,544.53	$4.65	$1.97	$7.34
Missing Provider Information	Missing provider risk based screening information	1,464	$1,441,014.81	$36.39	$32.01	$40.77
	Missing information to determine if ORP NPI submitted on the claim	50	$2,211.97	$3.03	$1.15	$4.90
	Missing provider enrollment information	4	$602.23	$0.92	($0.07)	$1.92
	Missing provider license information	6	$8,983.60	$0.43	($0.20)	$1.07
	Other missing provider information	2	$895.02	$0.39	($0.17)	$0.96
	Missing information to determine if billing NPI submitted on the claim	2	$364.37	$0.04	($0.02)	$0.10
Provider Enrollment	Provider not enrolled	111	$1,098,366.01	$28.63	$4.95	$ 52.31
Provider License/ Certification	Provider license not current for DOS	10	$7,474.88	$1.56	$0.25	$2.86
	Total	**6,015**	**$8,636,561.73**	**$786.18**	**$728.33**	**$844.04**

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 Data Processing Errors by Service Type

Table T16. 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	2,532	1,733	3,087	$413,907.10	$1,259,688.13	$262.78	$697.31	37.68%	28.14% - 47.23%
Prescribed Drugs	808	723	3,411	$2,772,294.43	$14,803,177.47	$111.09	$1,028.14	10.80%	8.64% - 12.97%
Psychiatric, Mental Health, and Behavioral Health Services	1,092	893	3,366	$1,966,524.71	$8,008,281.73	$86.85	$760.00	11.43%	9.92% - 12.93%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,226	891	1,641	$296,151.50	$529,244.44	$73.14	$242.18	30.20%	25.37% - 35.03%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	198	150	1,371	$28,360.64	$504,363.83	$43.58	$523.05	8.33%	4.97% - 11.70%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	283	158	438	$19,460.81	$47,071.93	$42.55	$113.95	37.34%	26.23% - 48.46%
Personal Support Services	210	175	340	$71,358.58	$139,715.75	$18.45	$69.27	26.63%	20.15% - 33.11%
Clinic Services	132	114	1,410	$22,784.59	$372,945.53	$11.67	$382.85	3.05%	1.94% - 4.16%
Inpatient Hospital Services	88	84	1,395	$1,701,562.76	$27,078,095.68	$11.48	$704.02	1.63%	1.08% - 2.18%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	43	38	181	$35,662.22	$189,389.53	$6.24	$53.54	11.65%	5.31% - 17.99%
Outpatient Hospital Services	89	80	1,473	$72,408.56	$3,537,429.94	$5.82	$423.44	1.38%	0.84% - 1.91%
Capitated Care/Fixed Payments	59	26	488	$552,585.46	$2,048,569.59	$2.79	$147.87	1.89%	(0.18%) - 3.96%
Home Health Services	30	26	56	$28,688.23	$50,014.06	$1.34	$10.40	12.86%	3.54% - 22.19%

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	19	16	213	$294.08	$28,208.93	$0.66	$61.31	1.08%	0.11% - 2.04%
Transportation and Accommodations	10	10	99	$6,031.65	$139,377.42	$0.57	$18.36	3.10%	0.45% - 5.75%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	26	20	28	$195,432.31	$268,355.65	$0.53	$1.66	32.01%	10.72% - 53.30%
Crossover Claims	14	9	69	$418.45	$6,305.04	$0.00	$0.10	3.33%	(1.26%) - 7.92%
Denied Claims	1	1	421	$0.00	$52.67	$0.00	$4.32	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.71	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	7	$0.00	$202,911.90	$0.00	$5.85	0.00%	0.00% - 0.00%
Total	**6,860**	**5,147**	**19,496**	**$8,183,926.07**	**$59,222,143.44**	**$679.53**	**$5,248.31**	**12.95%**	**12.13% - 13.77%**

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 T17. 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)
Non-covered Service/Beneficiary Error (DP2)	16	$14,716.29	$60.56	$6.10	$115.02
Managed Care Payment Error (DP9)	1	$327.95	$26.36	N/A	N/A
Managed Care Rate Cell Error (DP8)	2	$16.84	$0.03	-$0.01	$0.08
Total	**19**	**$15,061.08**	**$86.95**	**$21.37**	**$152.53**

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: 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	16	$14,716.29	$60.56	$6.10	$115.02
Total	**16**	**$14,716.29**	**$60.56**	**$6.10**	**$115.02**

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: Managed Care Payment Error (DP9)

Table T19. CHIP Managed Care Specific Causes of Managed Care Payment Error (DP9)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Rate programming error	1	$327.95	$26.36	N/A	N/A
Total	**1**	**$327.95**	**$26.36**	**N/A**	**N/A**

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.

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 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. Acronym Glossary

Acronym	Definition
CHIP	Children's Health Insurance Program
DOS	Date Of Service
DRG	Diagnosis-Related Group
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
MCO	Managed Care Organization
NPI	National Provider Identifier
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PERM	Payment Error Rate Estimate
POC	Plan Of Care
TD	Technical Deficiency

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2020 HHS AFR.