2023 Medicaid & CHIP Supplemental Improper Payment Data

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 2023 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%	N/A	N/A	**N/A**
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%**
2021 - Cycle 3	13.91%	0.00%	9.27%	**13.68%**
2022 - Cycle 1	3.72%	0.00%	5.36%	**6.64%**
2023 - Cycle 2	5.13%	0.00%	3.90%	**6.26%**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.

**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. 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 PHE impact, the Cycle 2-specific rates may not be comparable to other cycles.

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%**
2021 - Cycle 3	26.07%	0.00%	20.54%	**22.93%**
2022 - Cycle 1	2.44%	0.68%	10.46%	**11.49%**
2023 - Cycle 2	3.82%	1.20%	3.75%	**5.74%**

Note: CHIP improper payment calculations were first implemented in 2012 with Cycle 3 states, and results were not calculated prior to 2012.

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.

**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. From 2007-2013, the cycle-specific rate is calculated using data from the 17 states sampled and projected to the national level. From 2014 onward, the cycle-specific rate represents only the 17 states sampled. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. 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 PHE impact, the Cycle 2-specific rates may not be comparable to other cycles.

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%**
2021 Rolling Rates***	13.90%	0.04%	16.62%	**21.69%**
2022 Rolling Rates***	10.42%	0.03%	11.89%	**15.62%**
2023 Rolling Rates	6.90%	0.00%	5.95%	**8.58%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.

**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. 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.

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%**
2021 Rolling Rates***	13.67%	0.48%	28.71%	**31.84%**
2022 Rolling Rates***	11.23%	0.62%	24.01%	**26.75%**
2023 Rolling Rates	7.09%	0.59%	10.86%	**12.81%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR 31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place.

**The overall estimate is comprised of the weighted sum of the FFS and managed care components, plus the eligibility component, minus a small adjustment to account for the overlap between the claims and eligibility review functions. It is important to note that the 2013 rolling rate for CHIP represents 2 cycles since only 34 states had been sampled at the time. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. 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.

Overall 2023 Improper Payment Findings

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

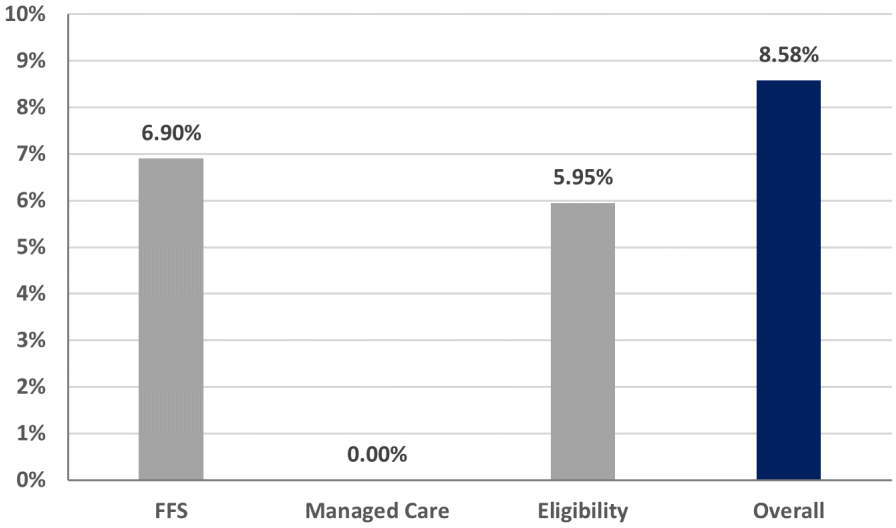


Figure 2. National Rolling CHIP Improper Payment Rate by Claim Type

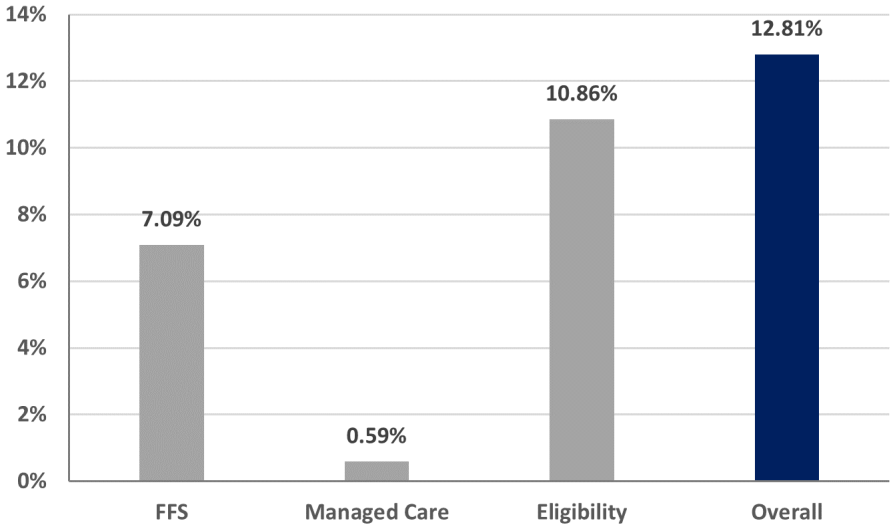


Figure 3. Medicaid Individual Cycle Improper Payments as a Proportion of the National Improper Payments (in Billions)

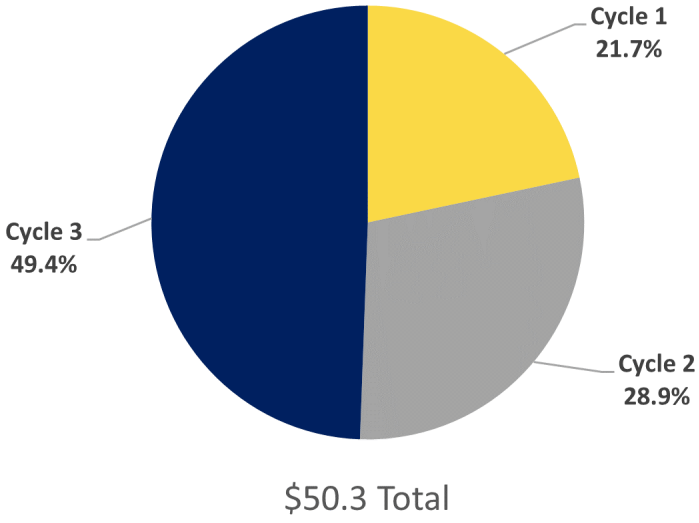


Figure 4. CHIP Individual Cycle Improper Payments as a Proportion of the National Improper Payments (in Billions)

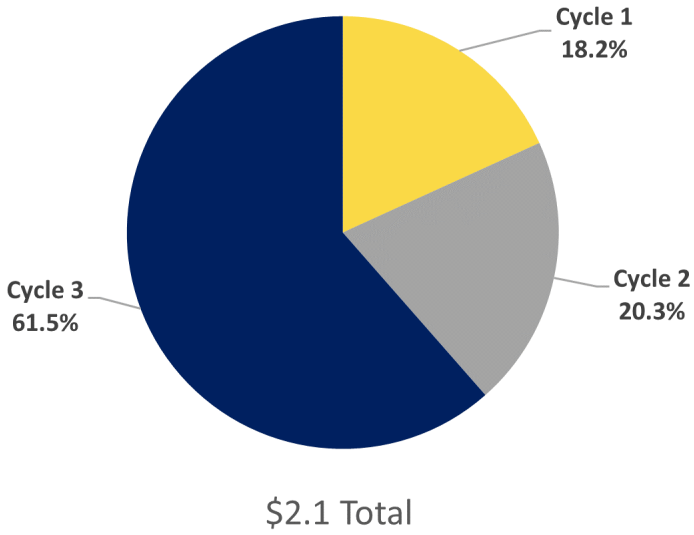


Figure 5. Medicaid Percentage of National Improper Payments by Claim Type (in Millions)[1]

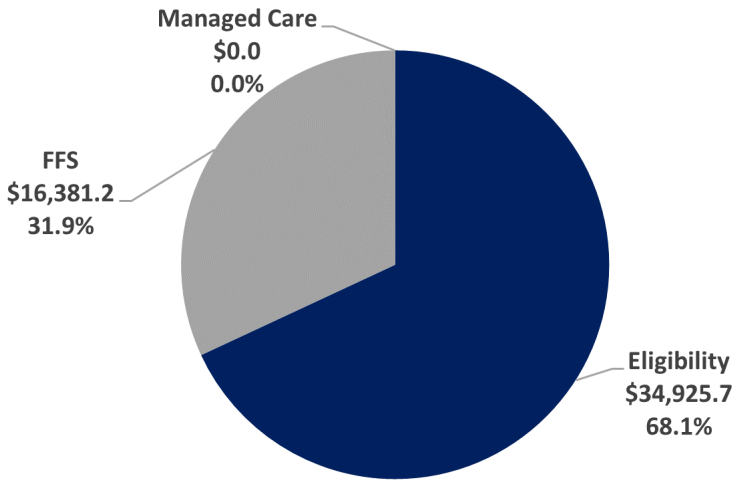
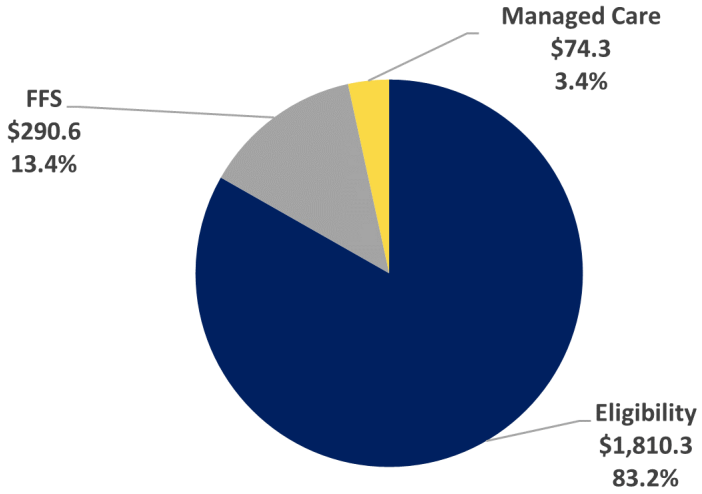


Figure 6. CHIP Percentage of National Improper Payments by Claim Type (in Millions)[1]



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

Common Causes of 2023 Improper Payments

Figure 7. Medicaid Type of Errors by Percentage of National Improper Payments[2]

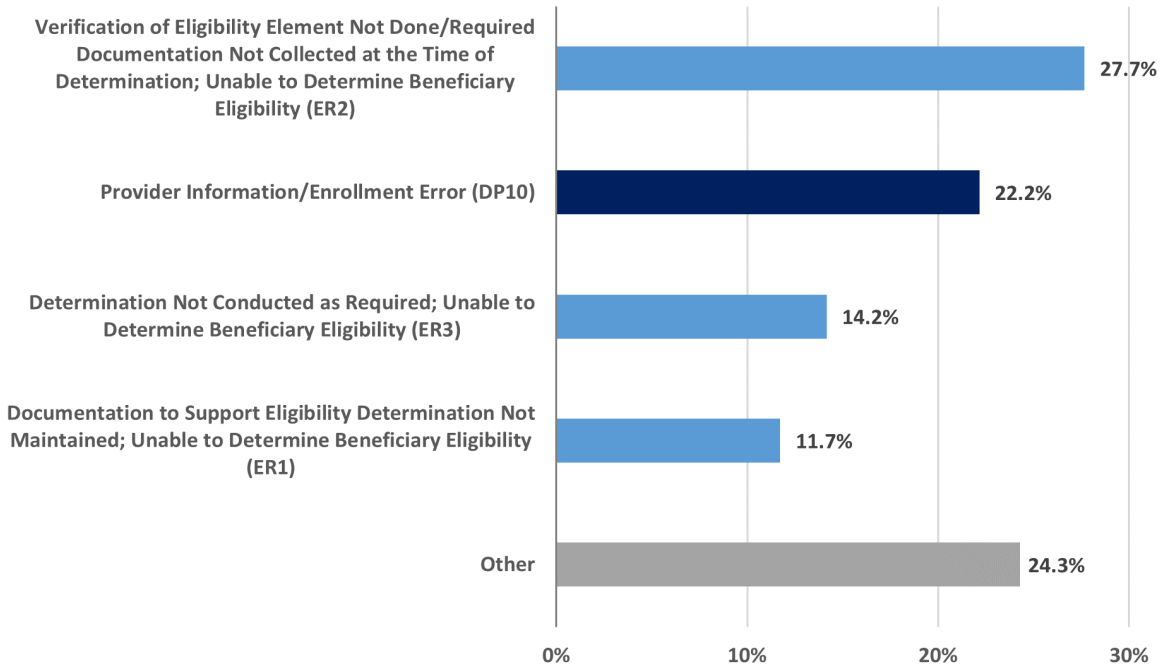
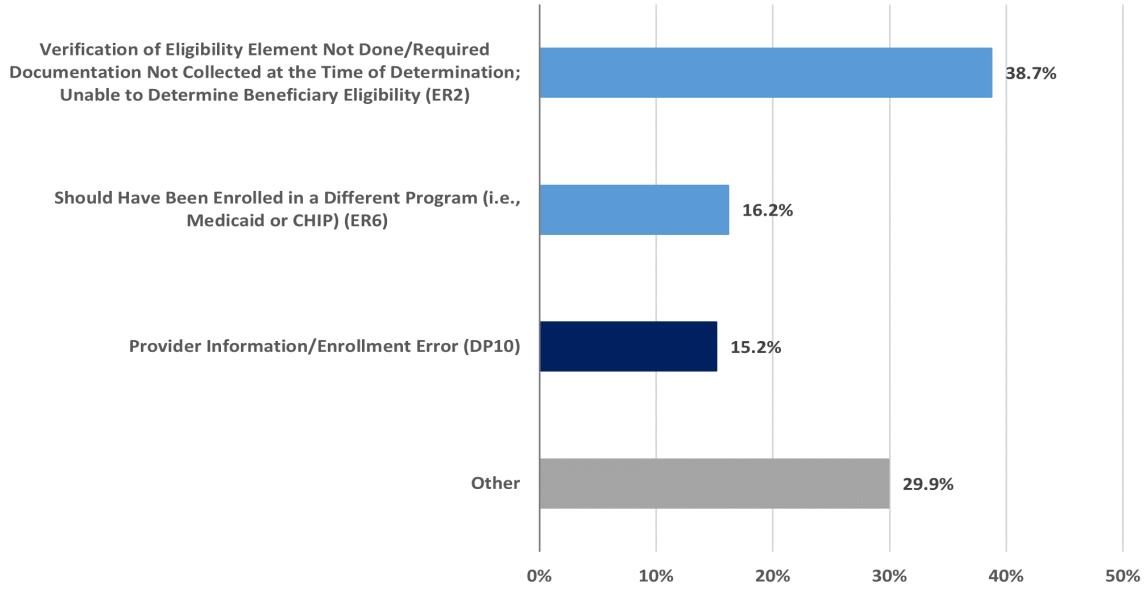


Figure 8. CHIP Type of Errors by Percentage of National Improper Payments[2]



[2] Components in the Other error category include those that did not individually account for more than 10% of the National Improper Payments. Percentages may not sum to 100% due to rounding.

Monetary Loss Findings

Figure 9. Medicaid Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[3]

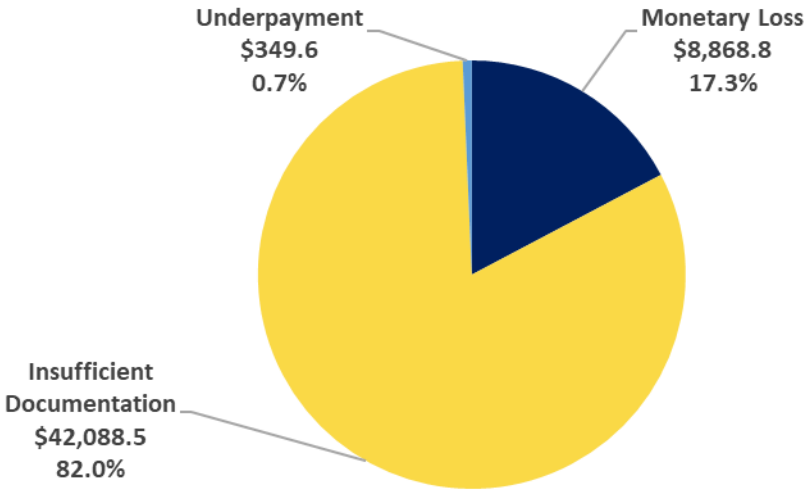
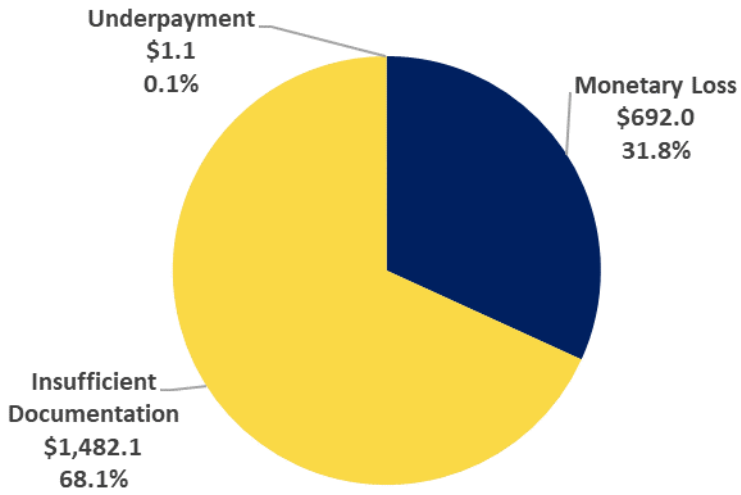


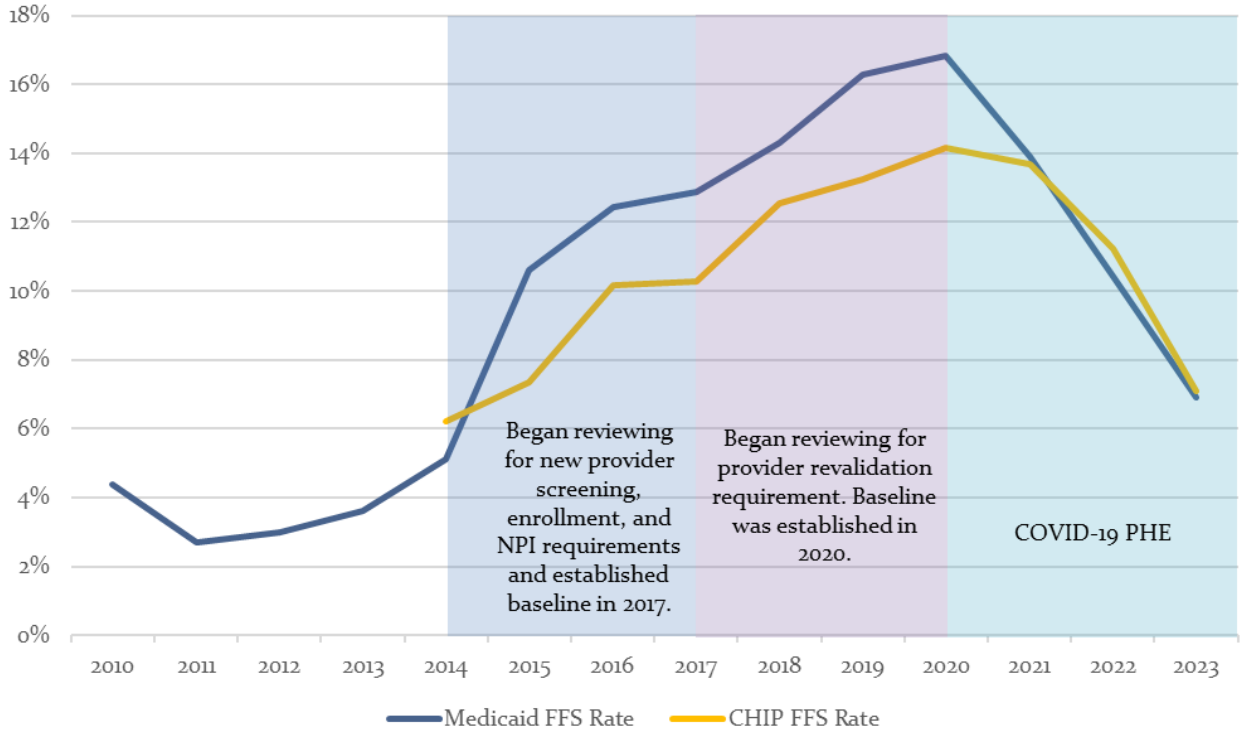
Figure 10. CHIP Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[3]



[3] In the figure, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper. 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.

2023 FFS Improper Payment Trends

Figure 11. Medicaid and CHIP FFS Improper Payments Timeline Highlighting Key Review Events[4]



[4] Results reported in 2023 still reflect the effects of the PHE, which ended on May 11, 2023.

2023 Eligibility Improper Payment Trends

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

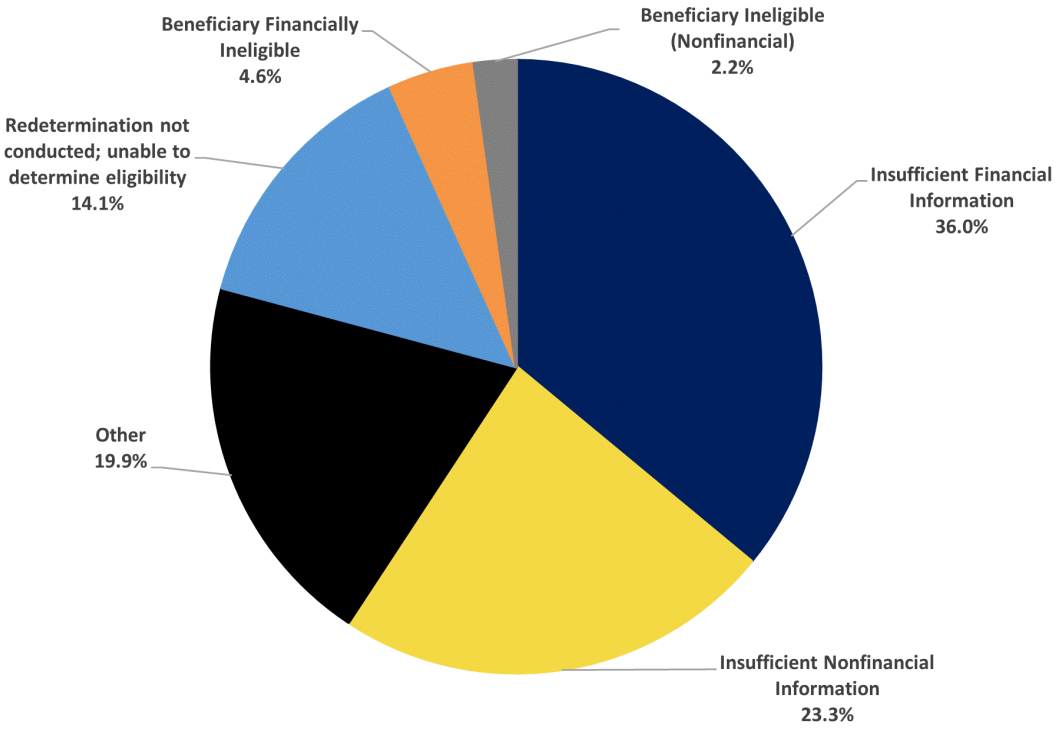


Figure 13. CHIP Type of Errors by Percentage of Eligibility Component Improper Payments

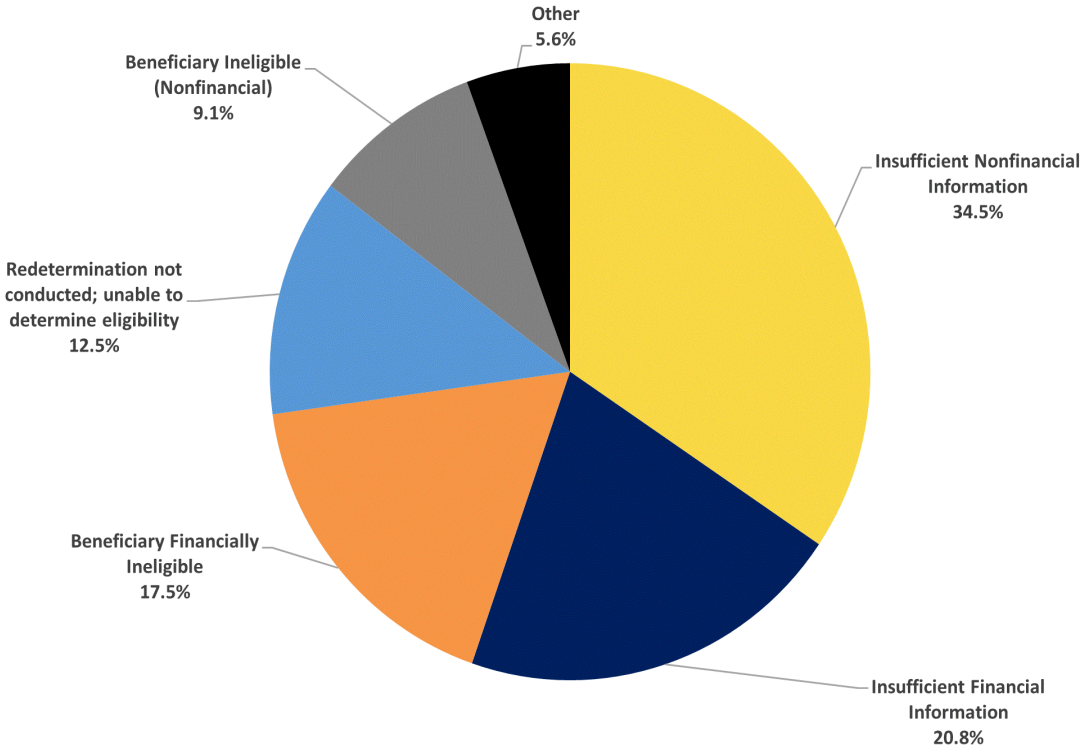


Figure 14. Medicaid Eligibility Monetary Loss Improper Payment Root Causes[5]

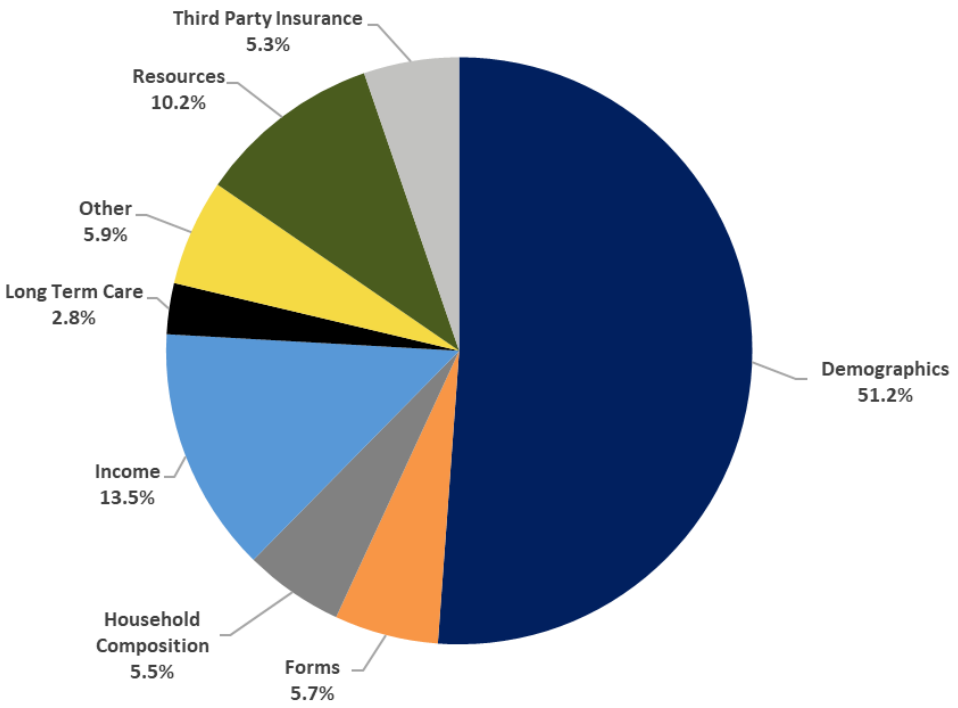
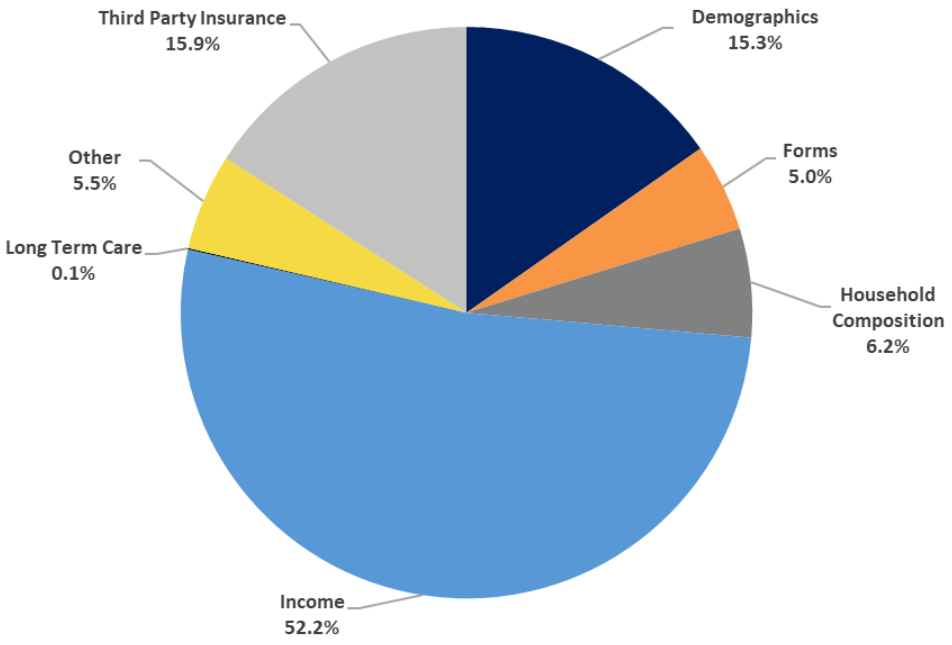
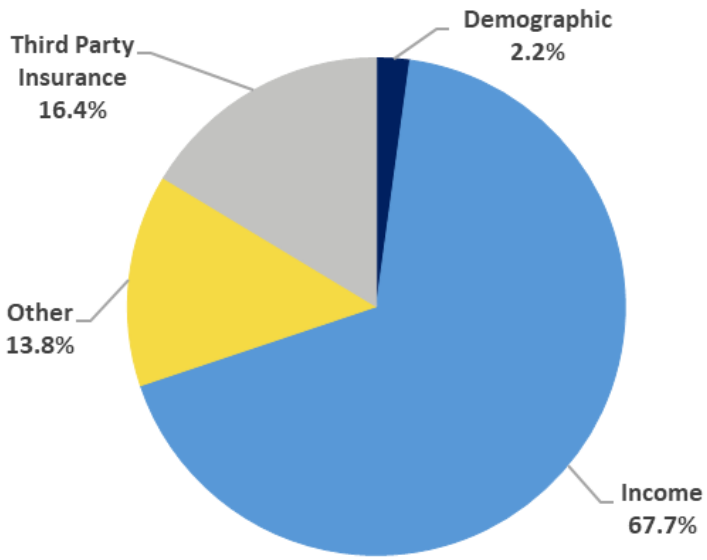


Figure 15. CHIP Eligibility Monetary Loss Improper Payment Root Causes[5]



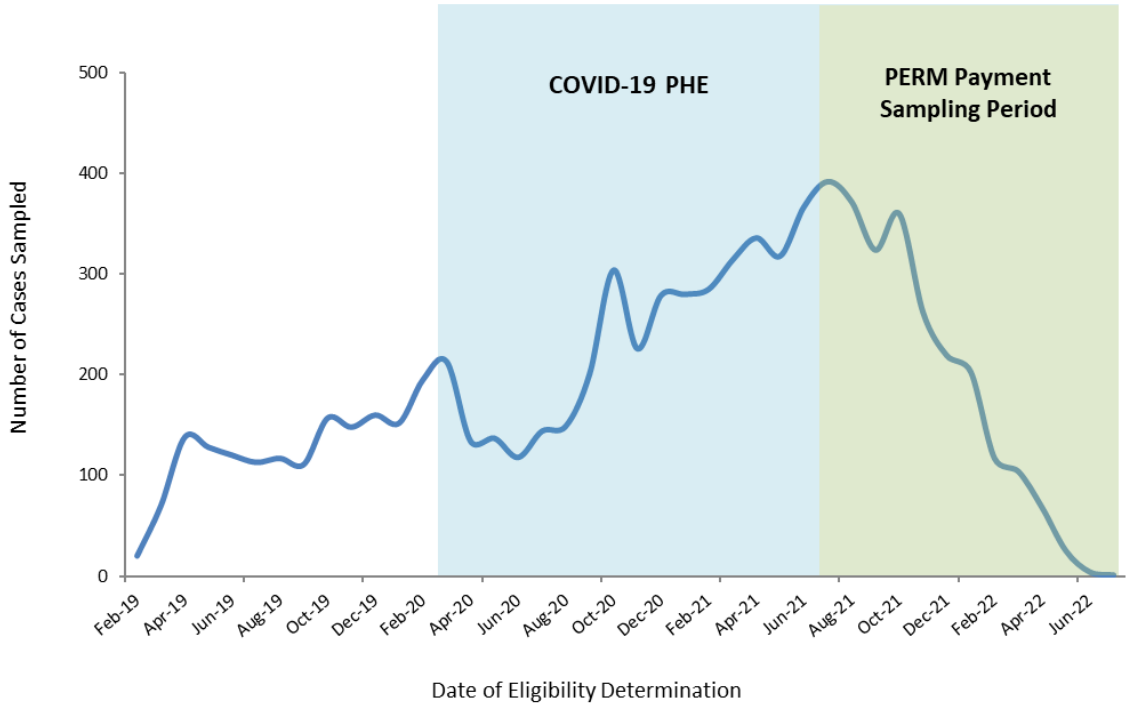
[5] Root causes with small improper payments may appear as 0.0% in this figure due to rounding.

Figure 16. CHIP Eligibility Wrong Program Error Root Causes[6]



[6] "Wrong Program Errors" included in this figure are findings with error code ER6, Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP). The errors included here are also in the "Beneficiary Financially Ineligible" and "Beneficiary Ineligible (Nonfinancial)" eligibility component category in Figure 13.

Figure 17. Medicaid and CHIP Eligibility Determination Timeframe for Claims Sampled in the 2023 Review Period



Section 2: 2023 Supplemental Medicaid Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for Medicaid in 2023 based on the 50 states and the District of Columbia reviewed from 2021-2023. Unless otherwise noted, all tables and figures in Section 2 are based on the rolling rate.

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% Confidence Interval
FFS	1,702	22,393	$4,005,479.34	$73,873,339.92	$16,381.18	$237,518.40	6.90%	6.46% - 7.34%
FFS Medical Review	619	22,393*	$901,425.94	$73,873,339.92	$5,530.00	$237,518.40	2.33%	2.05% - 2.60%
FFS Data Processing	1,140	22,393	$3,198,157.39	$73,873,339.92	$11,431.48	$237,518.40	4.81%	4.45% - 5.18%
Managed Care	5	2,516	$0.00	$2,451,426.17	$0.00	$349,390.43	0.00%	0.00% - 0.00%
Eligibility	1,205	15,607	$3,937,886.19	$38,857,602.27	$34,925.68	$586,908.83	5.95%	5.42% - 6.48%
Total	**2,912**	**40,516**	**$7,943,365.53**	**$115,182,368.37**	**$50,332.06**	**$586,908.83**	**8.58%**	**8.03% - 9.12%**

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 22,393 cases sampled, 18,433 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	$5.76	10.20%
	Other Monetary Loss	$2.17	3.84%
	Provider Not Enrolled	$0.91	1.61%
Insufficient Documentation	Insufficient Information to determine eligibility	$25.03	44.34%
	Non-Compliance with Provider Screening and NPI Requirements	$10.67	18.90%
	Other	$0.35	0.61%
	Other Missing Information	$6.00	10.63%
	Redetermination Not Conducted	$5.21	9.22%
Underpayments	Underpayments	$0.36	0.64%

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, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes.

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% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	611	569	5,213	$411,803.09	$6,704,792.58	$4,512.04	$46,104.20	9.79%	8.65% - 10.93%
Psychiatric, Mental Health, and Behavioral Health Services	236	183	1,173	$350,983.71	$2,171,618.22	$2,632.17	$14,494.64	18.16%	13.94% - 22.38%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	250	243	3,070	$744,589.83	$9,125,409.78	$1,578.57	$26,436.53	5.97%	5.02% - 6.92%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	257	181	585	$1,476,912.70	$5,052,202.98	$1,577.62	$6,498.57	24.28%	19.99% - 28.57%
Personal Support Services	125	113	1,285	$42,404.93	$708,982.65	$1,473.31	$19,953.43	7.38%	5.56% - 9.21%
Prescribed Drugs	157	152	2,979	$367,458.53	$9,264,934.22	$1,258.72	$29,190.94	4.31%	3.02% - 5.60%
Capitated Care/Fixed Payments	18	17	1,704	$4,105.84	$126,225.03	$767.03	$36,531.95	2.10%	0.05% - 4.15%
Clinic Services	44	38	499	$11,167.57	$197,349.34	$437.23	$7,639.55	5.72%	3.05% - 8.40%
Home Health Services	40	25	114	$15,440.77	$71,192.97	$435.15	$1,933.20	22.51%	10.58% - 34.44%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	27	26	583	$9,291.61	$398,730.73	$233.10	$6,446.58	3.62%	1.51% - 5.72%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	17	17	158	$14,526.89	$116,279.13	$201.45	$1,582.34	12.73%	3.85% - 21.62%
Inpatient Hospital Services	26	26	1,690	$500,439.07	$37,638,107.01	$198.27	$20,531.87	0.97%	0.39% - 1.54%
Laboratory, X-ray and Imaging Services	16	16	126	$541.61	$17,185.39	$197.92	$1,326.53	14.92%	3.41% - 26.43%
Transportation and Accommodations	17	11	149	$2,601.39	$65,200.02	$193.62	$1,868.84	10.36%	1.46% - 19.26%

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% Confidence Interval
Outpatient Hospital Services	23	21	862	$21,806.16	$1,680,613.52	$186.69	$8,324.25	2.24%	0.68% - 3.80%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	38	28	122	$1,671.22	$12,647.20	$182.27	$1,091.81	16.69%	8.09% - 25.30%
Hospice Services	15	12	174	$25,729.54	$453,850.29	$163.64	$1,827.78	8.95%	1.65% - 16.25%
Dental and Oral Surgery Services	22	22	335	$3,997.26	$52,355.21	$149.44	$3,017.18	4.95%	2.21% - 7.69%
Crossover Claims	2	2	563	$7.63	$15,529.58	$2.95	$2,592.46	0.11%	(0.11%) - 0.34%
Denied Claims	0	0	1,009	$0.00	$134.07	$0.00	$125.77	0.00%	0.00% - 0.00%
Total	**1,941**	**1,702**	**22,393**	**$4,005,479.34**	**$73,873,339.92**	**$16,381.18**	**$237,518.40**	**6.90%**	**6.46% - 7.34%**

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)
No Documentation Error (MR1)	261	$440,746.75	$2,369.23	$1,939.31	$2,799.16
Document(s) Absent from Record Error (MR2)	249	$371,869.42	$2,268.94	$1,857.54	$2,680.35
Improperly Completed Documentation Error (MR9)	37	$27,545.88	$413.37	$126.61	$700.14
Number of Unit(s) Error (MR6)	56	$37,932.79	$326.51	$191.60	$461.42
Procedure Coding Error (MR3)	9	$1,061.55	$112.09	$8.22	$215.96
Administrative/Other Error (MR10)	5	$5,118.42	$105.56	-$7.66	$218.78
Policy Violation Error (MR8)	13	$14,971.08	$48.69	$16.33	$81.06
Diagnosis Coding/DRG Error (MR4)	2	$9,495.21	$2.65	-$1.23	$6.52
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**633**	**$908,741.10**	**$5,647.05**	**$4,961.47**	**$6,332.63**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of 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)
No Documentation Error (MR1)	261	$440,746.75	$2,369.23	$1,939.31	$2,799.16
Document(s) Absent from Record Error (MR2)	249	$371,869.42	$2,268.94	$1,857.54	$2,680.35
Improperly Completed Documentation Error (MR9)	37	$27,545.88	$413.37	$126.61	$700.14
Number of Unit(s) Error (MR6)	41	$33,768.17	$259.39	$141.51	$377.27
Administrative/Other Error (MR10)	5	$5,118.42	$105.56	-$7.66	$218.78
Procedure Coding Error (MR3)	5	$587.58	$70.65	-$20.37	$161.68
Policy Violation Error (MR8)	12	$14,749.08	$44.15	$13.04	$75.26
Diagnosis Coding/DRG Error (MR4)	2	$9,495.21	$2.65	-$1.23	$6.52
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**613**	**$903,880.50**	**$5,533.95**	**$4,852.59**	**$6,215.31**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of 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)	15	$4,164.62	$67.12	$1.15	$133.10
Procedure Coding Error (MR3)	4	$473.97	$41.43	-$8.60	$91.47
Policy Violation Error (MR8)	1	$222.01	$4.54	N/A	N/A
Total	**20**	**$4,860.60**	**$113.10**	**$29.86**	**$196.34**

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. Further explanation of Medical Review error types can be found in Section 4: Error Codes, Table A1.

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

Table S7. 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)
Documentation was not requested from the provider due to a fraud investigation or pending litigation	110	$153,918.23	$882.68	$634.68	$1,130.69
Provider did not respond to the request for records	87	$111,053.49	$755.85	$502.11	$1,009.59
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	30	$47,378.68	$414.95	$216.88	$613.03
Provider responded that he or she did not have the beneficiary on file or in the system	13	$106,542.83	$105.16	$31.47	$178.86
Provider responded with a statement that they had billed in error	7	$714.10	$46.46	$8.38	$84.54
Provider responded with a statement that the record is lost or destroyed due to an unforeseeable and uncontrollable event such as fire, flood, or earthquake	2	$197.72	$43.82	-$38.24	$125.88
Provider responded with a statement they were unable to locate the records	6	$19,699.92	$35.02	$2.48	$67.56
Provider responded with a statement that he or she billed for the wrong beneficiary	1	$36.00	$31.58	N/A	N/A
Provider responded that he or she is no longer operating business/practice, and the record is unavailable	2	$825.30	$19.73	-$9.36	$48.81
Provider submitted a record for wrong date of service	1	$23.10	$16.47	N/A	N/A
Provider did not submit medical records, only the PERM coversheet	1	$240.09	$9.44	N/A	N/A
Provider responded with a statement that the record is unavailable due to electronic health record issues	1	$117.30	$8.07	N/A	N/A
Total	**261**	**$440,746.75**	**$2,369.23**	**$1,939.31**	**$2,799.16**

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.

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

The tables below include the types of documents and provider types associated with Document(s) Absent from Record Error (MR2). The cause of error is "One or more documents are missing from the record that are required to support payment."

Table S8. Medicaid FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
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)	123
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	94
Regulatory 30/60-day physician visit note	29
Other	19
Physician Orders (signed and dated, include all orders relevant to sampled claim)	18
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)	6
Diagnostic study (laboratory, X-ray, and pathology) results	4
Psychiatric Evaluation/Testing	4
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)	3
PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (RT): Evaluation and Re-evaluation/Notes	3
Timesheet, Completed and Signed (include description of services approved and provided)	2
Annual Physical Exam (if required)	1
Face-to-Face Encounter Record/Notes (if required)	1
Medication Administration Record (MAR)	1
Member Profile with Refill History for the Sampled Medication	1
Optometry and Optical Visit Notes (signed and dated)	1
Procedure Record/Notes	1
Treatment Administration Record/Notes	1
Total	**312**

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	Number of Document(s) Absent from Record	Number of Claims Sampled
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	125	5,213
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	78	3,070
Personal Support Services	33	1,285
Psychiatric, Mental Health, and Behavioral Health Services	28	1,173
Clinic Services	12	499
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	12	585
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	6	583
Laboratory, X-ray and Imaging Services	4	126
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	4	122
Prescribed Drugs	4	2,979
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	3	158
Home Health Services	1	114
Hospice Services	1	174
Outpatient Hospital Services	1	862
Total	**312**	**22,393**

Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table for the Number of Document(s) Absent from Record. Only provider types with at least one MR2 error are included in this table; therefore, the number of claims sampled may not sum to the total.

Medicaid FFS Medical Review Errors by Service Type

Table S10. 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% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	252	246	5,213	$193,226.34	$6,704,792.58	$1,631.24	$46,104.20	3.54%	2.86% - 4.22%
Personal Support Services	74	71	1,285	$29,334.03	$708,982.65	$895.45	$19,953.43	4.49%	3.09% - 5.89%
Psychiatric, Mental Health, and Behavioral Health Services	75	73	1,173	$45,457.14	$2,171,618.22	$890.69	$14,494.64	6.14%	3.77% - 8.52%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	91	91	3,070	$239,606.43	$9,125,409.78	$709.44	$26,436.53	2.68%	1.90% - 3.46%
Prescribed Drugs	24	24	2,979	$105,261.59	$9,264,934.22	$321.75	$29,190.94	1.10%	0.48% - 1.72%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	22	22	583	$7,535.06	$398,730.73	$224.99	$6,446.58	3.49%	1.39% - 5.59%
Clinic Services	18	17	499	$7,388.68	$197,349.34	$160.10	$7,639.55	2.10%	0.78% - 3.41%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	13	13	585	$78,253.35	$5,052,202.98	$143.95	$6,498.57	2.22%	0.70% - 3.73%
Home Health Services	10	8	114	$5,003.64	$71,192.97	$141.70	$1,933.20	7.33%	0.37% - 14.29%
Transportation and Accommodations	7	7	149	$292.48	$65,200.02	$106.46	$1,868.84	5.70%	(2.28%) - 13.68%
Outpatient Hospital Services	7	7	862	$16,330.57	$1,680,613.52	$71.54	$8,324.25	0.86%	0.11% - 1.60%
Inpatient Hospital Services	10	10	1,690	$156,614.34	$37,638,107.01	$59.31	$20,531.87	0.29%	0.04% - 0.54%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	9	9	158	$2,220.31	$116,279.13	$54.69	$1,582.34	3.46%	0.69% - 6.22%

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% Confidence Interval
Dental and Oral Surgery Services	8	8	335	$816.15	$52,355.21	$53.26	$3,017.18	1.77%	0.33% - 3.20%
Laboratory, X-ray and Imaging Services	5	5	126	$57.93	$17,185.39	$24.90	$1,326.53	1.88%	(0.80%) - 4.56%
Hospice Services	4	4	174	$13,808.22	$453,850.29	$22.21	$1,827.78	1.21%	(0.17%) - 2.60%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	4	4	122	$219.68	$12,647.20	$18.34	$1,091.81	1.68%	(0.33%) - 3.69%
Capitated Care/Fixed Payments	0	0	1,704	$0.00	$126,225.03	$0.00	$36,531.95	0.00%	0.00% - 0.00%
Crossover Claims	0	0	563	$0.00	$15,529.58	$0.00	$2,592.46	0.00%	0.00% - 0.00%
Denied Claims	0	0	1,009	$0.00	$134.07	$0.00	$125.77	0.00%	0.00% - 0.00%
Total	**633**	**619**	**22,393**	**$901,425.94**	**$73,873,339.92**	**$5,530.00**	**$237,518.40**	**2.33%**	**2.05% - 2.60%**

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 S11. 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)	1,148	$3,505,589.09	$12,509.30	$11,439.36	$13,579.24
Pricing Error (DP5)	51	$196,614.56	$769.39	-$4.31	$1,543.10
Non-covered Service/Beneficiary Eligibility Error (DP2)	13	$27,404.92	$396.91	-$147.51	$941.33
Administrative/Other Error (DP12)	12	$9,777.30	$76.53	$26.27	$126.79
Claim Filed Untimely Error (DP11)	4	$5,640.37	$74.48	-$17.58	$166.54
Third-Party Liability Error (DP4)	1	$6.98	$10.67	N/A	N/A
Duplicate Claim Error (DP1)	1	$272.73	$4.49	N/A	N/A
Data Processing Technical Deficiency (DTD)	78	$0.00	$0.00	$0.00	$0.00
Total	**1,308**	**$3,745,305.95**	**$13,841.77**	**$12,458.07**	**$15,225.46**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Data Processing error types can be found in Section 4: Error Codes, Table A2.

Table S12. 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)	1,148	$3,505,589.09	$12,509.30	$11,439.36	$13,579.24
Pricing Error (DP5)	28	$195,092.97	$755.98	-$17.58	$1,529.54
Non-covered Service/Beneficiary Eligibility Error (DP2)	13	$27,404.92	$396.91	-$147.51	$941.33
Administrative/Other Error (DP12)	12	$9,777.30	$76.53	$26.27	$126.79
Claim Filed Untimely Error (DP11)	4	$5,640.37	$74.48	-$17.58	$166.54
Third-Party Liability Error (DP4)	1	$6.98	$10.67	N/A	N/A
Duplicate Claim Error (DP1)	1	$272.73	$4.49	N/A	N/A
Data Processing Technical Deficiency (DTD)	78	$0.00	$0.00	$0.00	$0.00
Total	**1,285**	**$3,743,784.36**	**$13,828.36**	**$12,444.73**	**$15,211.98**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Data Processing error types can be found in Section 4: Error Codes, Table A2.

Table S13. 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)	23	$1,521.59	$13.41	-$1.65	$28.47
Total	**23**	**$1,521.59**	**$13.41**	**-$1.65**	**$28.47**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Data Processing error types can be found in Section 4: Error Codes, Table A2.

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

Table S14. 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	515	$813,841.12	$5,555.43	$4,898.94	$6,211.93
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	274	$1,266,315.21	$2,750.36	$2,281.21	$3,219.51
	Attending or rendering provider NPI required, but not listed on claim	118	$485,556.42	$1,397.71	$950.60	$1,844.82
	Billing provider NPI required, but not listed on claim	159	$744,254.08	$965.06	$864.02	$1,066.10
Provider Enrollment	Provider not enrolled	41	$119,355.93	$910.68	$467.35	$1,354.02
Provider License/Certification	Provider license not current for DOS	34	$75,208.50	$809.68	$415.36	$1,204.00
Missing Provider Information	Other missing provider information	7	$1,057.84	$120.37	$29.83	$210.92
Total	**Total**	**1,148**	**$3,505,589.09**	**$12,509.30**	**$11,439.36**	**$13,579.24**

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 S15. DP10 Medicaid FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	63
	Wrong NPI on the claim	52
Billing	No NPI on the claim	159
ORP	No NPI on the claim	186
	Wrong NPI on the claim	88
Rendering	No NPI on the claim	3

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

Table S16. DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Revalidated	284
	Newly Enrolled	231
Provider Risk Level	Limited	503
	High	11
	Moderate	1
Provider Type	Billing	458
	ORP	29
	Rendering	27
	Attending	1
Screening Elements Not Completed	No required databases checked	387
	SAM/EPLS not checked	77
	NPPES not checked	54
	LEIE not checked	46
	FCBC not conducted	11
	On-site not conducted	11
	DMF not checked	7

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

Table S17. DP10 Medicaid FFS Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Number of Errors
ORP	25
Attending	12
Billing	4

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

Medicaid FFS Data Processing Errors by Service Type

Table S18. 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% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	359	342	5,213	$241,969.56	$6,704,792.58	$2,993.51	$46,104.20	6.49%	5.55% - 7.44%
Psychiatric, Mental Health, and Behavioral Health Services	161	114	1,173	$308,185.58	$2,171,618.22	$1,820.54	$14,494.64	12.56%	8.76% - 16.36%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	244	175	585	$1,437,871.94	$5,052,202.98	$1,545.70	$6,498.57	23.79%	19.53% - 28.04%
Prescribed Drugs	133	132	2,979	$262,685.03	$9,264,934.22	$972.23	$29,190.94	3.33%	2.18% - 4.48%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	159	157	3,070	$525,656.05	$9,125,409.78	$908.04	$26,436.53	3.43%	2.88% - 3.99%
Capitated Care/Fixed Payments	18	17	1,704	$4,105.84	$126,225.03	$767.03	$36,531.95	2.10%	0.05% - 4.15%
Personal Support Services	51	45	1,285	$13,364.51	$708,982.65	$623.24	$19,953.43	3.12%	1.84% - 4.41%
Home Health Services	30	21	114	$13,437.03	$71,192.97	$320.23	$1,933.20	16.56%	6.01% - 27.12%
Clinic Services	26	21	499	$3,778.89	$197,349.34	$277.14	$7,639.55	3.63%	1.34% - 5.92%
Transportation and Accommodations	10	9	149	$2,430.76	$65,200.02	$191.21	$1,868.84	10.23%	1.32% - 19.14%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	34	27	122	$1,568.04	$12,647.20	$179.09	$1,091.81	16.40%	7.83% - 24.97%
Laboratory, X-ray and Imaging Services	11	11	126	$483.68	$17,185.39	$173.02	$1,326.53	13.04%	1.79% - 24.29%
Hospice Services	11	10	174	$16,068.32	$453,850.29	$152.40	$1,827.78	8.34%	1.08% - 15.59%

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% Confidence Interval
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	8	8	158	$12,306.57	$116,279.13	$146.76	$1,582.34	9.28%	0.71% - 17.84%
Inpatient Hospital Services	16	16	1,690	$343,824.73	$37,638,107.01	$138.96	$20,531.87	0.68%	0.15% - 1.20%
Outpatient Hospital Services	16	14	862	$5,475.59	$1,680,613.52	$115.16	$8,324.25	1.38%	0.01% - 2.76%
Dental and Oral Surgery Services	14	14	335	$3,181.10	$52,355.21	$96.18	$3,017.18	3.19%	0.85% - 5.53%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	5	5	583	$1,756.55	$398,730.73	$8.10	$6,446.58	0.13%	(0.05%) - 0.30%
Crossover Claims	2	2	563	$7.63	$15,529.58	$2.95	$2,592.46	0.11%	(0.11%) - 0.34%
Denied Claims	0	0	1,009	$0.00	$134.07	$0.00	$125.77	0.00%	0.00% - 0.00%
Total	**1,308**	**1,140**	**22,393**	**$3,198,157.39**	**$73,873,339.92**	**$11,431.48**	**$237,518.40**	**4.81%**	**4.45% - 5.18%**

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 S19. 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)
Data Processing Technical Deficiency (DTD)	5	$0.00	$0.00	$0.00	$0.00
Total	**5**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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.

Medicaid Eligibility Review Errors by Eligibility Category

Table S20. Medicaid Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
MAGI									
MAGI Total	**504**	**486**	**6,290**	**$2,345,959.65**	**$12,932,891.23**	**$19,022.04**	**$271,765.97**	**7.00%**	**5.98% - 8.02%**
MAGI - Medicaid Expansion - Newly Eligible	213	207	2,649	$2,058,364.00	$8,218,446.35	$9,234.55	$137,194.45	6.73%	5.41% - 8.06%
MAGI - Children under Age 19	131	123	1,766	$125,126.55	$1,456,624.23	$3,786.87	$61,034.85	6.20%	4.00% - 8.41%
MAGI - Parent Caretaker	97	94	1,035	$86,161.70	$1,222,617.35	$3,366.04	$36,654.43	9.18%	5.84% - 12.53%
MAGI - Medicaid Expansion - Not Newly Eligible	25	25	327	$26,474.07	$597,828.49	$977.10	$16,753.26	5.83%	1.69% - 9.98%
MAGI - Pregnant Woman	12	11	212	$19,993.01	$361,012.29	$483.25	$8,570.12	5.64%	1.21% - 10.07%
1115 Waiver Programs	6	6	129	$4,073.96	$113,884.06	$413.32	$5,678.72	7.28%	(0.22%) - 14.78%
Emergency Services (Including for Non-Citizens)	8	8	83	$20,692.71	$833,251.60	$257.36	$3,017.67	8.53%	3.66% - 13.40%
Family Planning and Related Services	5	5	17	$976.40	$2,152.19	$183.40	$242.00	75.78%	47.85% - 103.72%
Newborn	2	2	5	$458.32	$7,137.25	$26.57	$197.31	13.46%	(9.70%) - 36.63%
Presumptive Eligibility	2	2	27	$3,565.99	$76,794.56	$7.69	$806.36	0.95%	(0.47%) - 2.37%
LTC/Nursing Home	0	0	2	$0.00	$4,646.88	$0.00	$44.27	0.00%	0.00% - 0.00%
MAGI - CHIP	0	0	1	$0.00	$0.64	$0.00	$0.42	0.00%	0.00% - 0.00%
MAGI - Medicaid CHIP Expansion	0	0	8	$0.00	$1,774.47	$0.00	$164.99	0.00%	0.00% - 0.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Medically Needy	0	0	1	$0.00	$55.26	$0.00	$78.95	0.00%	0.00% - 0.00%
Other Full Benefit Dual Eligible (FBDE)	0	0	2	$0.00	$3,080.16	$0.00	$28.47	0.00%	0.00% - 0.00%
Unborn Child	0	0	4	$0.00	$6,010.11	$0.00	$6.88	0.00%	0.00% - 0.00%
Other (None of the Above)	3	3	22	$72.94	$27,575.34	$285.90	$1,292.82	22.11%	(4.60%) - 48.83%
Non-MAGI									
Non-MAGI Total	**812**	**719**	**9,317**	**$1,591,926.54**	**$25,924,711.04**	**$15,903.64**	**$315,142.86**	**5.05%**	**4.21% - 5.88%**
Aged, Blind, and Disabled - Mandatory Coverage	155	141	980	$205,606.73	$1,983,014.02	$4,239.96	$34,865.30	12.16%	8.95% - 15.37%
LTC/Nursing Home	244	208	1,137	$653,863.54	$3,851,551.43	$3,107.50	$29,023.04	10.71%	8.35% - 13.06%
Home and Community-Based Services	134	120	1,001	$271,263.64	$1,718,806.12	$2,230.31	$31,595.75	7.06%	5.48% - 8.64%
QMB	10	10	158	$474.65	$12,872.90	$1,587.62	$10,711.43	14.82%	(2.73%) - 32.38%
Aged, Blind, and Disabled - Optional Categorically Needy	95	89	522	$132,239.31	$975,692.95	$1,467.19	$12,722.62	11.53%	7.61% - 15.45%
SSI Recipients	37	37	3,680	$68,519.10	$7,926,588.97	$1,086.53	$140,662.97	0.77%	0.45% - 1.09%
Other Full Benefit Dual Eligible (FBDE)	50	43	344	$117,828.50	$682,296.02	$813.75	$8,794.86	9.25%	5.99% - 12.52%
Medically Needy	48	36	317	$47,898.14	$2,088,760.98	$474.84	$8,209.35	5.78%	2.84% - 8.73%
Transitional Medicaid	9	8	172	$2,561.28	$233,990.13	$173.93	$6,288.28	2.77%	1.13% - 4.40%
Qualified Disabled and Working Individuals	3	2	6	$4,529.39	$8,413.38	$171.00	$360.54	47.43%	7.11% - 87.75%
Title IV-E	4	4	185	$1,210.56	$348,441.27	$43.55	$5,511.97	0.79%	(0.16%) - 1.74%

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% Confidence Interval
SLMB	2	2	34	$175.28	$12,993.32	$36.97	$1,441.05	2.57%	(0.57%) - 5.70%
Emergency Services (Including for Non-Citizens)	2	2	26	$16,726.44	$424,461.61	$35.06	$341.98	10.25%	(5.17%) - 25.67%
1115 Waiver Programs	1	1	17	$20,593.92	$59,844.38	$34.43	$501.63	6.86%	(5.92%) - 19.64%
Women with Breast or Cervical Cancer	2	2	17	$3,213.63	$80,772.60	$31.62	$592.34	5.34%	(2.56%) - 13.24%
Community First Choice 1915(k)	0	0	8	$0.00	$3,298.50	$0.00	$747.23	0.00%	0.00% - 0.00%
Newborn	0	0	490	$0.00	$4,867,202.02	$0.00	$15,693.28	0.00%	0.00% - 0.00%
Presumptive Eligibility	0	0	2	$0.00	$798.82	$0.00	$16.71	0.00%	0.00% - 0.00%
Qualified Individuals	0	0	13	$0.00	$2,402.80	$0.00	$850.96	0.00%	0.00% - 0.00%
TEFRA/Katie Beckett	0	0	40	$0.00	$43,098.51	$0.00	$959.74	0.00%	0.00% - 0.00%
Other (None of the Above)	16	14	168	$45,222.43	$599,410.31	$369.38	$5,251.85	7.03%	1.89% - 12.18%

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

Medicaid Eligibility Review Federal Improper Payments

Table S21. Summary of Medicaid Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	484	$2,618,418.97	$15,618.80	$12,720.71	$18,516.89
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	327	$753,209.32	$7,990.76	$6,684.06	$9,297.47
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	219	$506,838.05	$6,623.67	$4,805.92	$8,441.41
Other Errors (ER10)	118	$47,366.21	$3,565.35	$2,127.81	$5,002.88
Not Eligible for Enrolled Program; Financial Issue (ER4)	35	$162,858.45	$1,528.23	$853.83	$2,202.64
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	19	$13,393.44	$777.58	$250.14	$1,305.01
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	23	$6,745.00	$527.37	$118.70	$936.06
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	5	$19,295.86	$195.11	-$68.01	$458.23
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	9	$26,097.41	$134.70	$33.92	$235.48
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	70	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	7	$0.00	$0.00	$0.00	$0.00
Total	**1,316**	**$4,154,222.71**	**$36,961.57**	**$32,945.64**	**$40,977.50**

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. Further explanation of Eligibility Review error types can be found in Section 4: Error Codes, Table A3.

Table S22. Summary of Medicaid Eligibility Review Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	484	$2,618,418.97	$15,618.80	$12,720.71	$18,516.89
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	327	$753,209.32	$7,990.76	$6,684.06	$9,297.47
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	219	$506,838.05	$6,623.67	$4,805.92	$8,441.41
Other Errors (ER10)	99	$44,657.53	$3,540.08	$2,102.87	$4,977.29
Not Eligible for Enrolled Program; Financial Issue (ER4)	35	$162,858.45	$1,528.23	$853.83	$2,202.64
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	19	$13,393.44	$777.58	$250.14	$1,305.01
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	14	$1,895.05	$316.46	-$34.67	$667.59
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	5	$19,295.86	$195.11	-$68.01	$458.23
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	9	$26,097.41	$134.70	$33.92	$235.48
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	70	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	7	$0.00	$0.00	$0.00	$0.00
Total	**1,288**	**$4,146,664.08**	**$36,725.39**	**$32,714.87**	**$40,735.91**

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

Table S23. Summary of Medicaid Eligibility Review Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	9	$4,849.95	$210.91	$1.81	$420.02
Other Errors (ER10)	19	$2,708.68	$25.27	-$6.51	$57.04
Total	**28**	**$7,558.63**	**$236.18**	**$24.68**	**$447.69**

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

Table S24. Summary of Medicaid Eligibility Review – MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	183	$1,862,615.05	$7,529.88	$5,658.66	$9,401.09
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	104	$194,588.02	$3,500.34	$2,135.43	$4,865.25
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	110	$121,349.58	$3,074.40	$2,236.13	$3,912.68
Other Errors (ER10)	30	$8,381.51	$3,045.90	$1,650.68	$4,441.12
Not Eligible for Enrolled Program; Financial Issue (ER4)	17	$119,359.85	$927.34	$385.17	$1,469.50
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	12	$10,016.70	$625.82	$115.24	$1,136.39
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	20	$3,912.69	$457.22	$63.36	$851.08
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	5	$19,295.86	$195.11	-$68.01	$458.23
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	3	$16,300.72	$47.53	-$10.30	$105.36
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	19	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	1	$0.00	$0.00	N/A	N/A
Total	**504**	**$2,355,819.98**	**$19,403.53**	**$16,461.58**	**$22,345.48**

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

Table S25. Summary of Medicaid Eligibility Review – Non-MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	301	$755,803.92	$8,088.92	$5,874.99	$10,302.86
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	217	$631,859.74	$4,916.36	$3,911.02	$5,921.70
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	115	$312,250.03	$3,123.32	$1,922.70	$4,323.94
Not Eligible for Enrolled Program; Financial Issue (ER4)	18	$43,498.60	$600.90	$199.80	$1,001.99
Other Errors (ER10)	88	$38,984.70	$519.44	$154.65	$884.24
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	7	$3,376.74	$151.76	$19.48	$284.04
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	6	$9,796.69	$87.17	$4.64	$169.71
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	3	$2,832.31	$70.16	-$38.92	$179.23
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	51	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	6	$0.00	$0.00	$0.00	$0.00
Total	**812**	**$1,798,402.73**	**$17,558.04**	**$14,810.68**	**$20,305.40**

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

Table S26. Summary of Medicaid Eligibility Review – Root Cause

Root Cause	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Caseworker	811	$3,560,752.11	$18,577.29	$16,319.77	$20,834.81
System	275	$333,495.13	$9,582.70	$6,744.94	$12,420.46
Policy	164	$159,597.15	$7,371.95	$5,603.98	$9,139.92
Multiple	50	$66,673.29	$938.95	$605.96	$1,271.95
Unable to Determine	14	$29,722.00	$438.76	-$17.79	$895.31
Other	2	$3,983.03	$51.92	-$47.90	$151.73
Total	**1,316**	**$4,154,222.71**	**$36,961.57**	**$32,945.64**	**$40,977.50**

Note: Details do not always sum to the total due to rounding. For root 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. Further explanation of root causes can be found in Section 4: Root Cause Glossary, Table A4.

Table S27. Summary of Medicaid Eligibility Case Action

Case Action	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Federal Improper Payment Rate	95% Confidence Interval
Redetermination	734	689	5,554	$1,184,389.76	$18,720.36	8.67%	7.33% - 10.00%
Application	302	262	2,096	$2,241,646.26	$7,658.87	10.08%	7.69% - 12.47%
Change	210	185	1,876	$432,363.25	$4,890.61	7.79%	5.71% - 9.86%
Not Applicable	58	57	6,069	$67,196.64	$3,134.89	1.35%	0.79% - 1.92%
Unknown	12	12	12	$12,290.28	$520.95	100.00%	100.00% - 100.00%
Total	**1,316**	**1,205**	**15,607**	**$3,937,886.19**	**$34,925.68**	**5.95%**	**5.42% - 6.48%**

Note: Details do not always sum to the total due to rounding. For case action categories with fewer than two claims per sample stratum, a confidence interval is not calculated. 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. Further explanation of case actions can be found in Section 4: Case Action Glossary, Table A5.

Table S28. Summary of Medicaid Eligibility Claim Type

Claim Type	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Federal Improper Payment Rate	95% Confidence Interval
MC	540	515	7,619	$486,421.48	$19,569.33	5.83%	5.02% - 6.64%
FFS	776	690	7,988	$3,451,464.71	$15,356.35	6.12%	4.98% - 7.25%
Total	**1,316**	**1,205**	**15,607**	**$3,937,886.19**	**$34,925.68**	**5.95%**	**5.42% - 6.48%**

Note: Details do not always sum to the total due to rounding. For claim types with fewer than two claims per sample stratum, a confidence interval is not calculated. 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.

Eligibility Review Federal Improper Payments: Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Table S29. Specific Causes of Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	152	$156,010.67	$5,109.42	$3,512.89	$6,705.96
Resources verification not on file/incomplete	121	$344,788.95	$4,950.48	$2,794.32	$7,106.63
Signature not obtained	75	$1,835,665.33	$3,054.64	$2,149.01	$3,960.27
LTC verification not on file/incomplete	45	$101,739.53	$707.23	$431.38	$983.07
Eligibility process(es) not followed	54	$77,748.60	$634.58	$313.93	$955.22
Discrepant information not acted upon	22	$82,029.50	$576.87	$92.53	$1,061.21
Other verification/other required forms not on file/incomplete	7	$14,896.63	$299.54	-$41.66	$640.75
Demographic verification not on file/incomplete	7	$5,520.73	$272.48	$16.03	$528.94
TPL verification not on file/incomplete	1	$19.03	$13.56	N/A	N/A
Total	**484**	**$2,618,418.97**	**$15,618.80**	**$12,720.71**	**$18,516.89**

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

Eligibility Review Federal Improper Payments: Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Table S30. Specific Causes of Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Redetermination not conducted within 12 months before date of payment for services	263	$670,787.17	$5,205.90	$4,251.36	$6,160.45
Initial determination not conducted	36	$31,960.17	$1,665.16	$953.94	$2,376.38
Determination not conducted after underlying eligibility was terminated	28	$50,461.98	$1,119.70	$574.96	$1,664.44
Total	**327**	**$753,209.32**	**$7,990.76**	**$6,684.06**	**$9,297.47**

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

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

Table S31. Specific Causes of Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility Error (ER1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Signature not on file	65	$128,113.63	$2,253.30	$959.31	$3,547.29
Income verification not on file/incomplete	37	$73,070.96	$1,729.00	$655.44	$2,802.57
Application/Renewal form not on file	63	$143,853.47	$1,405.66	$858.59	$1,952.73
Resources verification not on file/incomplete	23	$72,451.29	$506.19	$189.52	$822.86
LTC verification not on file/incomplete	14	$53,521.93	$238.44	$98.85	$378.03
Other verification/other required forms not on file/incomplete	8	$28,021.93	$233.37	$26.87	$439.86
Application form not on file	5	$1,058.43	$159.98	$8.39	$311.58
TPL verification not on file/incomplete	1	$5,921.97	$75.16	N/A	N/A
Demographic verification not on file/incomplete	3	$824.44	$22.55	-$8.42	$53.53
Total	**219**	**$506,838.05**	**$6,623.67**	**$4,805.92**	**$8,441.41**

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

State-Specific Improper Payment Rates for the States Measured in 2023 Cycle 2

Considerations for viewing state-specific PERM rates:

- What is included in PERM rates and represented in this table
    - **Three components** – PERM measures Fee-For-Service (FFS) payments made to providers, managed care capitation payments made to Managed Care Organizations (MCOs), and beneficiary eligibility determinations made by state agencies and combines them to form the overall rate per state. The overall improper payment rate is computed by proportionally combining the FFS and managed care components based on expenditures for each component (the claims rate), then adding the eligibility component and subtracting out the overlap between the claims and eligibility component. Because of this, you cannot simply average the three components to reach the overall rate.
    - **Three cycles** – PERM measures on a three-year, 17 state rotation cycle, meaning that each state is measured once every three years and each PERM cycle measurement includes one third of all states. The most recent three cycles combine to form each year's overall national rate.
    - **Sample vs projection** –
        - *Sample improper payments* – The improper payments associated with the actual reviewed sample of claims. These are then extrapolated out to represent the entire universe of claims (the projected improper payments). The federal share of the sampled overpayments is the only portion that CMS has the authority to recover from the FFS and managed care universes.
        - *Projected improper payments* – The estimated improper payments used for national reporting to represent the entire Medicaid program (derived by projecting out the actual sampled improper payments to represent all Medicaid improper payments).
    - **Insufficient Documentation vs Monetary Loss Errors** –
        - *Insufficient Documentation Errors* – Improper payments also include instances where there is insufficient or no documentation to support the payment as proper or improper. A majority of Medicaid improper payments were due to instances where information required for payment or eligibility determination was missing from the claim or state systems (e.g., not properly saving documentation after verification) and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to incorrect providers or beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable.
        - *Monetary Loss Errors* – Instances of monetary loss errors occur when CMS has sufficient information to determine that the Medicaid payment should not have occurred or should have been made in a different amount. Monetary loss errors represent a smaller proportion of Medicaid improper payments.
- **State-specific Improper Payment Rates Are Not Comparable**
  States have flexibility to design their policies and operate their programs to meet the individual needs of the state, such as establishing a managed care delivery system rather than relying on FFS. Variation between states and the resulting methodological differences between states' PERM rates makes it impossible to accurately compare state-specific PERM rates between states. Additional reasons include:
    - *Eligibility Measurement* – CMS established a baseline measurement of all 50 states and the District of Columbia in 2021, which allows CMS to measure the progress made by states since they were last reviewed, and target areas for additional oversight. Due to the PHE, Cycle 2 states did not receive state-specific rates or reports in RY20. Therefore, states in Cycle 2 have not yet had the opportunity to be measured a second time and show improved compliance with the new requirements, as has Cycle 1. Additionally, states in Cycle 3 have not yet had this opportunity to be measured a second time and show improved compliance with the new requirements.

- *COVID-19 Flexibilities Afforded to States* – Given the timing of the COVID-19 pandemic, each cycle of states was impacted differently by the associated requirements, conditions, and flexibilities afforded to states, such as postponed disenrollments from coverage and modified requirements around provider enrollment or revalidations. Depending on when these flexibilities were lifted, they could also impact future cycle rates differently, potentially leading to higher rates in Cycle 1 and Cycle 3 when those cycles are measured, as the flexibilities may no longer be in place. Please note that the 2023 cycle data does not capture any effects of the PHE unwinding, as it will be included in future report periods.
- *State-level precision/confidence interval* – The national PERM rate is established by capturing a statistically valid random sample representative of all Medicaid payments matched with federal funds. The national PERM improper payment rate meets a national precision requirement where CMS is 95 percent confident that the Medicaid improper payment rate is within +/- 3 percentage points. The PERM program was not designed to produce that level of precision at the state level. Therefore, state-level precision can vary, leading to wider confidence intervals in some states.
- *Program structure* – PERM has historically seen a lower instance of improper payments in managed care than FFS, based on differences in the review standards that apply to claims from the two service delivery models. Due to the differing review methodology, states' rates are often not comparable due to the varying distribution between FFS and managed care expenditures.
    - The definition of a FFS delivery system used below includes states' direct payment to providers for each service rendered to individual beneficiaries. Managed care is a delivery system in which a state makes a risk-based monthly capitated payment to a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan, which is responsible for managing beneficiary care. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to a data processing review.
- *State Policies* – Policies vary by state, which leads to differences in the states' specific Medicaid rates. These varying policies may include medical documentation and coverage requirements, integration and coordination of payment and eligibility systems, and prioritization of resources based on budget limitation.

- **Other Considerations**
    - Some states rely solely on FFS and do not have a managed care program at all (those states are marked with "--" in the managed care columns).
    - 82% of Medicaid estimated improper payments in 2023 were those with insufficient documentation. These include improper payments with no documentation and insufficient documentation (such as failing to submit or maintain the appropriate documentation for someone who *may* be eligible for care). To provide more meaningful improper payment data about the no documentation and insufficient documentation errors, CMS is implementing PERM independent review verifications to verify, for example, if the beneficiary was truly eligible, even if the state did not document or perform the required eligibility or provider enrollment verification.

State-Specific Improper Payment Rates for the States Measured in 2023 Cycle 2

State	Overall					Fee-For-Service						
	Projected IP Rate	Projected Monetary Loss IP Rate	Projected Confidence Interval	Projected IP ($ mil)	Sampled IP	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	% of Total Projected Expenditures	Sampled Expenditures
Alabama	0.2%	0.0%	(-0.2%) - 0.5%	$6.9	$3,678.6	0.2%	0.0%	$6.9	$3,678.6	$4,319.1	100.0%	$1,080,815.2
California	8.1%	4.0%	6.3% - 9.9%	$6,097.5	$162,150.4	4.5%	1.3%	$1,741.7	$116,931.5	$38,672.4	51.2%	$4,167,721.5
Colorado	5.4%	0.2%	2.6% - 8.3%	$380.5	$39,084.1	4.0%	0.2%	$232.8	$27,295.5	$5,853.5	83.7%	$1,241,622.8
Georgia	1.8%	0.2%	0.4% - 3.1%	$168.5	$11,830.6	3.2%	0.4%	$168.5	$11,830.6	$5,328.2	56.6%	$1,009,502.1
Kentucky	2.9%	0.0%	1.5% - 4.3%	$364.5	$26,826.9	9.1%	0.0%	$267.9	$26,388.8	$2,930.8	23.4%	$333,238.4
Maryland	4.5%	0.2%	2.6% - 6.5%	$432.7	$20,492.0	2.4%	0.0%	$109.5	$2,883.4	$4,606.9	48.3%	$1,004,554.0
Massachusetts	7.1%	1.3%	5.1% - 9.0%	$918.0	$74,998.5	4.0%	1.6%	$270.6	$29,417.4	$6,792.8	52.2%	$1,743,323.7
Nebraska	1.2%	0.0%	0.1% - 2.2%	$27.8	$22,678.6	2.5%	0.0%	$18.5	$22,490.9	$750.6	31.9%	$737,692.7
New Hampshire	3.9%	0.9%	2.0% - 5.8%	$60.8	$58,748.9	7.3%	0.0%	$43.5	$55,334.4	$599.5	38.9%	$495,967.6
New Jersey	5.7%	0.3%	3.8% - 7.6%	$780.2	$59,052.7	6.4%	0.0%	$229.4	$42,170.9	$3,610.0	26.5%	$726,484.1
North Carolina	3.0%	0.1%	1.9% - 4.0%	$398.3	$23,775.8	6.0%	0.2%	$337.6	$22,140.7	$5,644.3	42.0%	$2,019,955.7
Rhode Island	8.8%	0.3%	5.5% - 12.2%	$191.5	$150,916.7	3.1%	0.2%	$22.7	$26,827.5	$723.8	33.4%	$1,008,905.6
South Carolina	20.5%	0.9%	17.8% - 23.3%	$1,098.1	$560,246.1	27.8%	1.4%	$692.0	$528,872.9	$2,491.3	46.6%	$2,024,254.7
Tennessee	5.6%	0.1%	3.7% - 7.5%	$514.4	$448,322.7	8.7%	0.5%	$208.3	$425,225.8	$2,401.9	26.2%	$1,790,796.2
Utah	1.9%	1.8%	1.1% - 2.8%	$59.0	$4,434.6	4.0%	3.7%	$59.0	$4,434.6	$1,468.4	48.0%	$1,496,718.7
Vermont	5.6%	0.6%	2.8% - 8.4%	$75.9	$43,013.2	5.6%	0.6%	$75.9	$43,013.2	$1,353.9	100.0%	$892,790.4
West Virginia	3.5%	0.0%	2.0% - 4.9%	$155.4	$80,850.3	5.4%	0.0%	$129.1	$74,419.7	$2,384.2	52.9%	$901,643.2

State	Managed Care			Eligibility					
	Projected IP Rate	Projected IP ($ mil)	Projected Expenditures ($ mil)	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	Sampled Expenditures
Alabama	--	--	--	0.0%	0.0%	$0.0	$0.0	$4,319.1	$379,728.6
California	0.0%	$0.0	$36,802.7	5.9%	3.5%	$4,458.7	$45,218.9	$75,475.1	$1,371,039.4
Colorado	0.0%	$0.0	$1,143.2	2.2%	0.0%	$152.8	$11,788.7	$6,996.7	$317,320.1
Georgia	0.0%	$0.0	$4,080.2	0.0%	0.0%	$0.0	$0.0	$9,408.3	$461,062.3
Kentucky	0.0%	$0.0	$9,579.9	0.8%	0.0%	$98.7	$438.1	$12,510.8	$237,688.1
Maryland	0.0%	$0.0	$4,936.7	3.4%	0.2%	$326.9	$17,608.6	$9,543.6	$736,680.3
Massachusetts	0.0%	$0.0	$6,216.9	5.1%	0.5%	$661.2	$45,581.2	$13,009.7	$1,420,222.9
Nebraska	0.0%	$0.0	$1,599.5	0.4%	0.0%	$9.4	$187.8	$2,350.1	$366,747.1
New Hampshire	0.0%	$0.0	$941.9	1.2%	0.9%	$17.8	$3,414.5	$1,541.4	$188,546.6
New Jersey	0.0%	$0.0	$10,019.2	4.1%	0.3%	$560.2	$16,881.8	$13,629.1	$766,925.3
North Carolina	0.0%	$0.0	$7,805.7	0.5%	0.0%	$62.3	$1,635.1	$13,450.0	$632,930.1
Rhode Island	0.0%	$0.0	$1,443.4	7.9%	0.3%	$170.6	$124,089.2	$2,167.2	$552,917.4
South Carolina	0.0%	$0.0	$2,856.6	8.7%	0.3%	$466.5	$31,373.2	$5,347.9	$808,832.5
Tennessee	0.0%	$0.0	$6,765.1	3.4%	0.0%	$313.2	$23,096.9	$9,167.0	$744,685.3
Utah	0.0%	$0.0	$1,591.9	0.0%	0.0%	$0.0	$0.0	$3,060.3	$536,640.7
Vermont	--	--	--	0.0%	0.0%	$0.0	$0.0	$1,353.9	$639,011.1
West Virginia	0.0%	$0.0	$2,120.9	0.6%	0.0%	$27.1	$6,430.7	$4,505.2	$456,566.5

Note: IP is the abbreviation for improper payment.

Section 3: 2023 Supplemental CHIP Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for CHIP in 2023 based on the 50 states and the District of Columbia reviewed from 2021-2023. Unless otherwise noted, all tables and figures in Section 3 are based on the rolling rate.

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% Confidence Interval
FFS	1,028	13,505	$2,174,247.24	$51,346,918.94	$290.60	$4,096.95	7.09%	6.47% - 7.71%
FFS Medical Review	280	13,505*	$194,275.52	$51,346,918.94	$81.47	$4,096.95	1.99%	1.54% - 2.43%
FFS Data Processing	766	13,505	$1,993,918.89	$51,346,918.94	$216.79	$4,096.95	5.29%	4.83% - 5.76%
Managed Care	4	1,671	$441.46	$378,637.97	$74.28	$12,573.32	0.59%	(0.12%) - 1.30%
Eligibility	1,151	10,509	$3,128,077.28	$24,074,006.83	$1,810.32	$16,670.27	10.86%	9.15% - 12.57%
Total	**2,183**	**25,685**	**$5,302,765.98**	**$75,799,563.75**	**$2,135.58**	**$16,670.27**	**12.81%**	**11.06% - 14.56%**

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 13,505 cases sampled, 11,715 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	$0.60	23.58%
	Other Monetary Loss	$0.10	3.95%
	Provider Not Enrolled	$0.02	0.59%
Insufficient Documentation	Insufficient Information to determine eligibility	$1.10	43.52%
	Non-Compliance with Provider Screening and NPI Requirements	$0.34	13.29%
	Other	$0.03	1.37%
	Other Missing Information	$0.10	3.88%
	Redetermination Not Conducted	$0.25	9.76%
Underpayments	Underpayments	$0.00	0.06%

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, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes.

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% Confidence Interval
Psychiatric, Mental Health, and Behavioral Health Services	645	289	1,473	$139,799.02	$2,258,814.47	$109.86	$590.31	18.61%	16.38% - 20.84%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	302	245	1,092	$30,423.71	$421,130.21	$35.39	$264.86	13.36%	10.19% - 16.54%
Prescribed Drugs	140	124	2,886	$895,541.66	$17,156,785.24	$32.07	$902.42	3.55%	2.01% - 5.10%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	47	45	918	$18,869.68	$252,192.64	$21.46	$295.92	7.25%	3.23% - 11.27%
Clinic Services	71	66	826	$19,447.51	$235,459.17	$20.30	$355.17	5.72%	3.58% - 7.86%
Dental and Oral Surgery Services	96	85	2,310	$26,023.00	$480,045.35	$14.03	$468.07	3.00%	1.94% - 4.05%
Inpatient Hospital Services	22	22	944	$842,328.60	$25,398,392.30	$13.81	$381.53	3.62%	0.65% - 6.59%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	40	34	264	$2,648.36	$17,858.99	$10.77	$74.71	14.42%	7.75% - 21.09%
Home Health Services	29	20	66	$25,369.93	$40,184.18	$10.54	$25.45	41.41%	25.70% - 57.12%
Outpatient Hospital Services	35	34	1,046	$29,682.33	$2,240,888.92	$10.19	$310.44	3.28%	0.52% - 6.04%
Laboratory, X-ray and Imaging Services	11	11	148	$10,263.74	$25,575.70	$4.66	$51.28	9.08%	(1.46%) - 19.62%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	9	9	144	$16,021.80	$169,063.31	$3.84	$48.38	7.94%	0.76% - 15.11%
Personal Support Services	18	15	175	$4,539.73	$60,685.46	$1.90	$28.33	6.70%	2.10% - 11.30%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Capitated Care/Fixed Payments	18	18	605	$54,071.05	$2,143,700.75	$0.83	$274.98	0.30%	0.20% - 0.40%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	7	5	14	$54,981.19	$224,111.77	$0.50	$1.44	34.85%	7.10% - 62.61%
Transportation and Accommodations	5	5	66	$4,221.83	$106,527.95	$0.45	$15.85	2.85%	(0.16%) - 5.86%
Crossover Claims	1	1	38	$14.10	$3,046.06	$0.00	$1.59	0.00%	(0.00%) - 0.00%
Denied Claims	0	0	478	$0.00	$180.04	$0.00	$1.19	0.00%	0.00% - 0.00%
Hospice Services	0	0	5	$0.00	$11,387.40	$0.00	$3.02	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	7	$0.00	$100,889.03	$0.00	$2.02	0.00%	0.00% - 0.00%
Total	**1,496**	**1,028**	**13,505**	**$2,174,247.24**	**$51,346,918.94**	**$290.60**	**$4,096.95**	**7.09%**	**6.47% - 7.71%**

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)
No Documentation Error (MR1)	140	$115,371.66	$40.88	$28.02	$53.75
Document(s) Absent from Record Error (MR2)	89	$62,893.64	$17.81	$12.49	$23.14
Number of Unit(s) Error (MR6)	19	$4,558.50	$8.66	$1.48	$15.84
Improperly Completed Documentation Error (MR9)	26	$12,429.40	$6.29	$2.18	$10.40
Policy Violation Error (MR8)	7	$261.00	$6.12	-$2.97	$15.22
Procedure Coding Error (MR3)	6	$287.87	$3.21	-$0.88	$7.30
Unbundling Error (MR5)	2	$9.07	$0.23	-$0.22	$0.69
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**290**	**$195,811.13**	**$83.21**	**$64.27**	**$102.15**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of 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)
No Documentation Error (MR1)	140	$115,371.66	$40.88	$28.02	$53.75
Document(s) Absent from Record Error (MR2)	89	$62,893.64	$17.81	$12.49	$23.14
Number of Unit(s) Error (MR6)	18	$4,545.34	$8.65	$1.47	$15.83
Improperly Completed Documentation Error (MR9)	26	$12,429.40	$6.29	$2.18	$10.40
Policy Violation Error (MR8)	7	$261.00	$6.12	-$2.97	$15.22
Procedure Coding Error (MR3)	5	$203.73	$2.88	-$1.16	$6.92
Unbundling Error (MR5)	2	$9.07	$0.23	-$0.22	$0.69
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**288**	**$195,713.83**	**$82.88**	**$63.95**	**$101.81**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of 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)	1	$84.14	$0.32	N/A	N/A
Number of Unit(s) Error (MR6)	1	$13.16	$0.01	N/A	N/A
Total	**2**	**$97.29**	**$0.33**	**-$0.30**	**$0.97**

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. Further explanation of Medical Review error types can be found in Section 4: Error Codes, Table A1.

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

Table T7. 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)
Documentation was not requested from the provider due to a fraud investigation or pending litigation	45	$34,317.35	$10.81	$3.70	$17.91
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	24	$12,135.55	$10.53	$3.42	$17.63
Provider did not respond to the request for records	40	$58,848.62	$10.41	$3.80	$17.02
Provider responded that he or she did not have the beneficiary on file or in the system	8	$1,805.76	$3.10	$0.16	$6.04
Provider responded with a statement that they had billed in error	12	$4,500.81	$2.19	$0.18	$4.21
Provider responded with a statement they were unable to locate the records	6	$2,699.49	$1.49	-$0.25	$3.24
Provider did not submit medical records, only billing information, which is insufficient to support the sampled claim	1	$136.81	$1.35	N/A	N/A
Provider submitted a record for wrong date of service	2	$475.16	$0.65	-$0.33	$1.63
State could not locate the provider	1	$20.54	$0.29	N/A	N/A
Provider responded with a statement that there was no documentation for the encounter/billed service	1	$431.57	$0.07	N/A	N/A
Total	**140**	**$115,371.66**	**$40.88**	**$28.02**	**$53.75**

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.

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

The tables below include the types of documents and provider types associated with Document(s) Absent from Record Error (MR2). The cause of error is "One or more documents are missing from the record that are required to support payment."

Table T8. CHIP FFS Specific Types of Document(s) Absent from Record

Documentation Type	Total Count
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)	44
Daily Progress Notes, Attendance Logs, Flowsheets, Worksheets, and Records (signed and dated, with amount, type, start/stop times, and duration)	27
Physician Orders (signed and dated, include all relevant orders for the sampled claim)	7
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)	6
PT, OT, SLP, Audiology, Vision, and Respiratory Therapy (RT): Evaluation and Re-evaluation/Notes	5
Dental or Orthodontic Clinical Notes (signed and dated)	4
Other	4
Operative and Procedure Reports/Notes	2
Dental and Diagnostic Service Records	1
Discharge Summary	1
Invoice for Services (dated)	1
Member Profile with Refill History for the Sampled Medication	1
Related Laboratory/Diagnostic Reports	1
Treatment Administration Record/Notes	1
Total	**105**

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	Number of Document(s) Absent from Record	Number of Claims Sampled
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	35	1,092
Psychiatric, Mental Health, and Behavioral Health Services	27	1,473
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	12	918
Prescribed Drugs	7	2,886
Clinic Services	6	826
Dental and Oral Surgery Services	4	2,310
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	4	264
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	3	144
Home Health Services	2	66
Laboratory, X-ray and Imaging Services	2	148
Inpatient Hospital Services	1	944
Outpatient Hospital Services	1	1,046
Personal Support Services	1	175
Total	**105**	**13,505**

Note: It is possible for a claim to have multiple documents absent, so one claim may be counted multiple times in this table for the Number of Document(s) Absent from Record. Only provider types with at least one MR2 error are included in this table; therefore, the number of claims sampled may not sum to the total.

CHIP FFS Medical Review Errors by Service Type

Table T10. 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% Confidence Interval
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	28	28	918	$15,374.10	$252,192.64	$16.75	$295.92	5.66%	1.76% - 9.55%
Psychiatric, Mental Health, and Behavioral Health Services	73	70	1,473	$57,108.93	$2,258,814.47	$14.83	$590.31	2.51%	1.61% - 3.41%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	59	55	1,092	$14,567.38	$421,130.21	$13.69	$264.86	5.17%	2.37% - 7.97%
Clinic Services	33	33	826	$12,900.45	$235,459.17	$13.16	$355.17	3.71%	1.96% - 5.45%
Dental and Oral Surgery Services	35	34	2,310	$4,162.15	$480,045.35	$4.65	$468.07	0.99%	0.40% - 1.58%
Laboratory, X-ray and Imaging Services	5	5	148	$961.50	$25,575.70	$4.05	$51.28	7.89%	(2.66%) - 18.44%
Outpatient Hospital Services	15	15	1,046	$23,150.37	$2,240,888.92	$3.85	$310.44	1.24%	(0.40%) - 2.88%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	9	9	264	$1,432.62	$17,858.99	$2.51	$74.71	3.36%	(0.03%) - 6.76%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	3	3	144	$1,040.47	$169,063.31	$2.31	$48.38	4.77%	(1.40%) - 10.94%
Home Health Services	6	5	66	$1,919.70	$40,184.18	$2.11	$25.45	8.28%	(0.00%) - 16.57%
Prescribed Drugs	9	9	2,886	$34,143.49	$17,156,785.24	$2.00	$902.42	0.22%	0.03% - 0.42%
Personal Support Services	8	7	175	$3,212.59	$60,685.46	$0.94	$28.33	3.32%	(0.59%) - 7.24%

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% Confidence Interval
Inpatient Hospital Services	5	5	944	$20,979.86	$25,398,392.30	$0.47	$381.53	0.12%	(0.00%) - 0.25%
Transportation and Accommodations	2	2	66	$3,321.90	$106,527.95	$0.16	$15.85	1.02%	(0.57%) - 2.61%
Capitated Care/Fixed Payments	0	0	605	$0.00	$2,143,700.75	$0.00	$274.98	0.00%	0.00% - 0.00%
Crossover Claims	0	0	38	$0.00	$3,046.06	$0.00	$1.59	0.00%	0.00% - 0.00%
Denied Claims	0	0	478	$0.00	$180.04	$0.00	$1.19	0.00%	0.00% - 0.00%
Hospice Services	0	0	5	$0.00	$11,387.40	$0.00	$3.02	0.00%	0.00% - 0.00%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	0	0	14	$0.00	$224,111.77	$0.00	$1.44	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	7	$0.00	$100,889.03	$0.00	$2.02	0.00%	0.00% - 0.00%
Total	**290**	**280**	**13,505**	**$194,275.52**	**$51,346,918.94**	**$81.47**	**$4,096.95**	**1.99%**	**1.54% - 2.43%**

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

Table T11. 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)	1,082	$2,125,129.78	$383.70	$359.24	$408.17
Non-covered Service/Beneficiary Eligibility Error (DP2)	41	$104,329.98	$12.23	$0.27	$24.19
Pricing Error (DP5)	39	$59,012.22	$2.77	$0.54	$5.00
Administrative/Other Error (DP12)	2	$416.07	$0.73	-$0.48	$1.93
Third-Party Liability Error (DP4)	2	$78.06	$0.38	-$0.15	$0.92
Data Processing Technical Deficiency (DTD)	40	$0.00	$0.00	$0.00	$0.00
Total	**1,206**	**$2,288,966.10**	**$399.81**	**$372.49**	**$427.13**

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 T12. 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)	1,082	$2,125,129.78	$383.70	$359.24	$408.17
Non-covered Service/Beneficiary Eligibility Error (DP2)	41	$104,329.98	$12.23	$0.27	$24.19
Pricing Error (DP5)	21	$58,919.23	$1.66	-$0.28	$3.60
Administrative/Other Error (DP12)	2	$416.07	$0.73	-$0.48	$1.93
Third-Party Liability Error (DP4)	2	$78.06	$0.38	-$0.15	$0.92
Data Processing Technical Deficiency (DTD)	40	$0.00	$0.00	$0.00	$0.00
Total	**1,188**	**$2,288,873.12**	**$398.71**	**$371.40**	**$426.01**

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 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)	18	$92.99	$1.11	$0.01	$2.20
Total	**18**	**$92.99**	**$1.11**	**$0.01**	**$2.20**

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 T14. 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	653	$1,204,722.16	$249.05	$227.50	$270.61
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	281	$831,576.05	$62.62	$50.41	$74.82
	Billing provider NPI required, but not listed on claim	42	$8,612.83	$16.94	$10.92	$22.95
	Attending or rendering provider NPI required, but not listed on claim	27	$7,798.18	$7.85	$3.12	$12.58
Missing Provider Information	Other missing provider information	58	$23,405.05	$32.28	$20.24	$44.32
Provider Enrollment	Provider not enrolled	21	$49,015.51	$14.97	$4.51	$25.44
Total	**Total**	**1,082**	**$2,125,129.78**	**$383.70**	**$359.24**	**$408.17**

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 T15. DP10 CHIP FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	8
	Wrong NPI on the claim	4
Billing	No NPI on the claim	37
	Wrong NPI on the claim	5
ORP	No NPI on the claim	262
	Wrong NPI on the claim	19
Rendering	No NPI on the claim	13
	Wrong NPI on the claim	2

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

Table T16. DP10 CHIP Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Newly Enrolled	453
	Revalidated	200
Provider Risk Level	Limited	605
	High	43
	Moderate	5
Provider Type	Billing	339
	Rendering	206
	ORP	106
	Attending	2
Screening Elements Not Completed	No required databases checked	558
	NPPES not checked	53
	On-site not conducted	47
	FCBC not conducted	42
	SAM/EPLS not checked	41
	DMF not checked	19
	LEIE not checked	17

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

Table T17. DP10 CHIP Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Number of Errors
ORP	11
Attending	5
Billing	5

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

CHIP FFS Data Processing Errors by Service Type

Table T18. 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% Confidence Interval
Psychiatric, Mental Health, and Behavioral Health Services	572	223	1,473	$92,536.59	$2,258,814.47	$96.52	$590.31	16.35%	14.29% - 18.42%
Prescribed Drugs	131	116	2,886	$861,700.96	$17,156,785.24	$30.15	$902.42	3.34%	1.81% - 4.87%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	243	196	1,092	$17,161.25	$421,130.21	$22.55	$264.86	8.51%	6.71% - 10.32%
Inpatient Hospital Services	17	17	944	$821,348.74	$25,398,392.30	$13.34	$381.53	3.50%	0.52% - 6.47%
Home Health Services	23	18	66	$24,506.26	$40,184.18	$9.83	$25.45	38.62%	23.13% - 54.12%
Dental and Oral Surgery Services	61	52	2,310	$22,367.72	$480,045.35	$9.56	$468.07	2.04%	1.17% - 2.92%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	31	26	264	$1,272.99	$17,858.99	$8.48	$74.71	11.35%	5.34% - 17.36%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	19	18	918	$4,214.41	$252,192.64	$7.56	$295.92	2.55%	0.37% - 4.73%
Clinic Services	38	33	826	$6,547.06	$235,459.17	$7.14	$355.17	2.01%	0.73% - 3.29%
Outpatient Hospital Services	20	20	1,046	$6,685.92	$2,240,888.92	$6.94	$310.44	2.24%	(0.06%) - 4.53%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	6	6	144	$14,981.34	$169,063.31	$1.53	$48.38	3.17%	(0.40%) - 6.73%
Personal Support Services	10	8	175	$1,327.14	$60,685.46	$0.96	$28.33	3.38%	0.88% - 5.87%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Capitated Care/Fixed Payments	18	18	605	$54,071.05	$2,143,700.75	$0.83	$274.98	0.30%	0.20% - 0.40%
Laboratory, X-ray and Imaging Services	6	6	148	$9,302.25	$25,575.70	$0.61	$51.28	1.19%	0.09% - 2.29%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	7	5	14	$54,981.19	$224,111.77	$0.50	$1.44	34.85%	7.10% - 62.61%
Transportation and Accommodations	3	3	66	$899.93	$106,527.95	$0.29	$15.85	1.83%	(0.62%) - 4.27%
Crossover Claims	1	1	38	$14.10	$3,046.06	$0.00	$1.59	0.00%	(0.00%) - 0.00%
Denied Claims	0	0	478	$0.00	$180.04	$0.00	$1.19	0.00%	0.00% - 0.00%
Hospice Services	0	0	5	$0.00	$11,387.40	$0.00	$3.02	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	7	$0.00	$100,889.03	$0.00	$2.02	0.00%	0.00% - 0.00%
Total	**1,206**	**766**	**13,505**	**$1,993,918.89**	**$51,346,918.94**	**$216.79**	**$4,096.95**	**5.29%**	**4.83% - 5.76%**

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 T19. 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 Eligibility Error (DP2)	3	$440.77	$74.24	-$45.03	$193.50
Pricing Error (DP5)	1	$0.69	$0.04	N/A	N/A
Total	**4**	**$441.46**	**$74.28**	**-$44.98**	**$193.55**

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. There were no underpayments cited, so only overpayments are reported in this table.

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

Table T20. CHIP Managed Care Specific Causes of Non-covered Service/Beneficiary Eligibility 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	3	$440.77	$74.24	-$45.03	$193.50
Total	**3**	**$440.77**	**$74.24**	**-$45.03**	**$193.50**

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: Pricing Error (DP5)

Table T21. CHIP Managed Care Specific Causes of Pricing Error (DP5)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Incorrect system calculation	1	$0.69	$0.04	N/A	N/A
Total	**1**	**$0.69**	**$0.04**	**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.

CHIP Eligibility Review Errors by Eligibility Category

Table T22. CHIP ELG Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
MAGI - CHIP	446	418	3,613	$1,194,567.18	$10,927,021.69	$947.72	$6,737.68	14.07%	10.21% - 17.93%
MAGI - Medicaid CHIP Expansion	756	679	6,134	$1,848,505.11	$11,856,278.22	$822.46	$9,112.10	9.03%	7.64% - 10.41%
Unborn Child	56	53	643	$84,828.24	$1,176,895.54	$39.47	$632.27	6.24%	3.15% - 9.34%
MAGI - Children under Age 19	1	1	57	$176.75	$16,936.87	$0.68	$134.46	0.50%	(0.49%) - 1.50%
1115 Waiver Programs	0	0	19	$0.00	$14,022.35	$0.00	$22.93	0.00%	0.00% - 0.00%
Emergency Services (Including for Non-Citizens)	0	0	7	$0.00	$2,983.88	$0.00	$6.89	0.00%	0.00% - 0.00%
MAGI - Medicaid Expansion - Newly Eligible	0	0	3	$0.00	$2,269.24	$0.00	$0.42	0.00%	0.00% - 0.00%
MAGI - Parent Caretaker	0	0	1	$0.00	$64.72	$0.00	$0.06	0.00%	0.00% - 0.00%
MAGI - Pregnant Woman	0	0	1	$0.00	$26.18	$0.00	$0.41	0.00%	0.00% - 0.00%
Medically Needy	0	0	1	$0.00	$15.67	$0.00	$0.46	0.00%	0.00% - 0.00%
Other	0	0	11	$0.00	$23,927.26	$0.00	$8.57	0.00%	0.00% - 0.00%
Presumptive Eligibility	0	0	12	$0.00	$9,347.95	$0.00	$9.51	0.00%	0.00% - 0.00%
SSI Recipients	0	0	7	$0.00	$44,217.26	$0.00	$4.51	0.00%	0.00% - 0.00%
Total	**1,259**	**1,151**	**10,509**	**$3,128,077.28**	**$24,074,006.83**	**$1,810.32**	**$16,670.27**	**10.86%**	**9.15% - 12.57%**

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 Eligibility Review Federal Improper Payments

Table T23. Summary of CHIP Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	430	$581,822.06	$980.59	$719.45	$1,241.72
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	262	$1,596,083.43	$409.30	$303.56	$515.04
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	237	$690,870.93	$252.91	$196.58	$309.24
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	174	$299,701.79	$114.89	$89.81	$139.97
Other Errors (ER10)	25	$4,034.30	$86.61	$34.56	$138.67
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	53	$30,555.53	$79.73	$31.81	$127.64
Not Eligible for Enrolled Program; Financial Issue (ER4)	32	$79,435.24	$36.35	$14.81	$57.88
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	2	$3,029.31	$13.41	-$5.40	$32.22
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	38	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	6	$0.00	$0.00	$0.00	$0.00
Total	**1,259**	**$3,285,532.59**	**$1,973.79**	**$1,683.73**	**$2,263.84**

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

Table T24. Summary of CHIP Eligibility Review – Root Cause

Root Cause	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Caseworker	765	$2,757,506.51	$938.80	$800.98	$1,076.62
Policy	134	$132,615.39	$615.29	$364.64	$865.95
System	282	$356,505.42	$331.50	$227.05	$435.94
Multiple	70	$36,123.06	$77.58	$46.90	$108.25
Unable to Determine	8	$2,782.21	$10.62	$1.26	$19.98
Total	**1,259**	**$3,285,532.59**	**$1,973.79**	**$1,683.73**	**$2,263.84**

Note: Details do not always sum to the total due to rounding. For root 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. Further explanation of root causes can be found in Section 4: Root Cause Glossary, Table A4.

Table T25. Summary of CHIP Eligibility Case Action

Case Action	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Federal Improper Payment Rate	95% Confidence Interval
Redetermination	774	715	5,048	$1,176,669.64	$1,231.20	14.45%	11.45% - 17.46%
Application	302	275	1,463	$1,819,287.85	$326.52	15.86%	11.66% - 20.05%
Change	156	134	1,451	$102,403.92	$201.79	9.51%	5.90% - 13.12%
Not Applicable	23	23	2,543	$28,445.21	$44.83	1.13%	0.46% - 1.80%
Unknown	4	4	4	$1,270.66	$5.99	100.00%	100.00% - 100.00%
Total	**1,259**	**1,151**	**10,509**	**$3,128,077.28**	**$1,810.32**	**10.86%**	**9.15% - 12.57%**

Note: Details do not always sum to the total due to rounding. For case action categories with fewer than two claims per sample stratum, a confidence interval is not calculated. 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. Further explanation of case actions can be found in Section 4: Case Action Glossary, Table A5.

Table T26. Summary of CHIP Eligibility Claim Type

Claim Type	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Federal Improper Payment Rate	95% Confidence Interval
MC	667	613	5,679	$163,482.46	$1,481.72	11.79%	9.54% - 14.04%
FFS	592	538	4,830	$2,964,594.82	$328.60	8.01%	6.57% - 9.44%
Total	**1,259**	**1,151**	**10,509**	**$3,128,077.28**	**$1,810.32**	**10.86%**	**9.15% - 12.57%**

Note: Details do not always sum to the total due to rounding. For claim types with fewer than two claims per sample stratum, a confidence interval is not calculated. 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.

Eligibility Review Federal Improper Payments: Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Table T27. Specific Causes of Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Signature not obtained	43	$75,900.37	$420.27	$182.72	$657.82
Income verification not on file/incomplete	283	$413,959.30	$334.83	$222.11	$447.56
Discrepant information not acted upon	73	$38,885.67	$141.92	$80.94	$202.89
TPL verification not on file/incomplete	19	$49,311.00	$74.32	$11.54	$137.10
Demographic verification not on file/incomplete	9	$1,967.69	$6.40	$1.08	$11.72
Eligibility process(es) not followed	3	$1,798.03	$2.86	-$1.02	$6.73
Total	**430**	**$581,822.06**	**$980.59**	**$719.45**	**$1,241.72**

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.

Eligibility Review Federal Improper Payments: Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) Error (ER6)

Table T28. Specific Causes of Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) Error (ER6)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income correctly calculated; below income limit	58	$355,044.77	$100.77	$29.19	$172.34
Pre-tax deduction incorrectly excluded	25	$637,982.12	$67.65	$6.76	$128.53
Beneficiary had credible health insurance (CHIP only)	44	$26,497.44	$66.93	$27.32	$106.55
Information provided, not acted on as required	18	$18,184.14	$59.67	$48.81	$70.54
MAGI Tax filer/tax dependent status incorrect	19	$17,725.99	$21.33	$9.20	$33.46
Other non-financial error	17	$63,417.59	$18.52	$5.52	$31.52
Income incorrectly calculated	17	$1,778.79	$15.91	$6.16	$25.67
Income incorrectly included	20	$5,200.96	$11.54	$5.15	$17.93
Data entry error	8	$52,508.85	$11.22	-$0.20	$22.65
MAGI Non-filer/non-dependent status incorrect	8	$331,023.59	$8.02	$0.12	$15.92
MAGI tax deduction incorrectly excluded	3	$444.78	$6.88	-$1.04	$14.79
Requirement not met	5	$62,848.09	$6.64	$1.25	$12.04
Income conversion factor incorrect	4	$423.30	$5.36	-$0.85	$11.58
Other financial error	6	$557.55	$4.25	-$1.40	$9.91
Beneficiary was 19 years or older in CHIP	3	$485.30	$1.81	-$0.79	$4.41
Exempt income incorrectly included	4	$908.75	$1.35	-$0.42	$3.13
MAGI Tax dependent exception incorrect	2	$7,288.18	$0.90	-$0.71	$2.52
Income correctly calculated; above income limit	1	$13,763.24	$0.53	N/A	N/A
Total	**262**	**$1,596,083.43**	**$409.30**	**$303.56**	**$515.04**

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

Eligibility Review Federal Improper Payments: Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Table T29. Specific Causes of Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Redetermination not conducted within 12 months before date of payment for services	233	$689,600.27	$246.92	$190.98	$302.87
Initial determination not conducted	4	$1,270.66	$5.99	-$0.57	$12.55
Total	**237**	**$690,870.93**	**$252.91**	**$196.58**	**$309.24**

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

Section 4: Error Codes

Table A1. Medical Review Error Codes

Error Code	Error	Definition
MR1	No Documentation Error	The provider failed to respond to requests for the medical records or the provider responded that he or she did not have the requested documentation. The provider did not send any documentation related to the sampled payment.
MR2	Document(s) Absent from Record Error	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/DRG 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 Error	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.

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 date of service (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 or CHIP programs and/or the beneficiary is ineligible for the coverage category for the service.
DP3	FFS Payment for a Managed Care Service Error	The beneficiary is enrolled in a managed care organization 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 date of service 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	The sampled claim was missing documentation needed to complete the review.
DTD	Data Processing Technical Deficiency	A deficiency was found during data processing review that did not result in a payment error.

*Note: Error codes are retired and no longer in use.

Table A3. Eligibility Error Codes

Error Code	Error	Definition
ER1	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicated that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.
ER2	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.
ER3	Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility	The state could not provide evidence that the state conducted an eligibility determination or completed a timely redetermination.
ER4	Not Eligible for Enrolled Program; Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the financial elements of the eligibility determination.
ER5	Not Eligible for Enrolled Program; Non-Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the non-financial elements of the eligibility determination.
ER6	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP)	The beneficiary is not eligible for the enrolled program (i.e., Medicaid or CHIP), but is eligible for the other program.
ER7	Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.
ER8	Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category, which results in the individual receiving services for which they were not eligible.
ER9	Federally-Facilitated Exchange-Determination (FFE-D) Error	Not applicable to states; used for errors when the FFE incorrectly determined eligibility for the beneficiary.
ER10	Other Errors	The beneficiary is improperly denied or terminated, or the contribution to care calculation is incorrectly calculated, or the beneficiary is eligible for emergency services only.
ERTD1	Incorrect Case Determination, But There was No Payment on Claim	The beneficiary is ineligible for any of the reasons cited in the ER1 – ER10, but no payment was made for the claim.

Error Code	Error	Definition
ERTD2	Finding Noted With Case, But Did Not Affect Case Determination or Payment	The state completed an eligibility determination that was not in accordance with timeliness standards, but was completed before the claim date of payment, or an "other" finding was noted that does not impact claims payment.

Table A4. Eligibility Root Cause Glossary

Root Cause	Definition
Caseworker	The determination under review had some elements that were completed by a caseworker. The finding is related to the caseworker's actions and could have been prevented with caseworker training, provision of desk aids, smaller caseloads, or other caseworker-related actions.
System	The determination under review had some elements that were completed by a system. The finding is related to a system action or indicator, and a system edit could prevent a similar occurrence in the future.
Multiple	The determination under review had elements that were completed, used, or significantly affected by some combination of the caseworker, system, and/or state policy. The finding is related to something that was directly affected by more than one cause in the combination, and a fix in any of the contributing causes would each do something to prevent similar errors in the future.
Policy	The state policy around the finding was not in compliance with Federal Regulation or other regulatory guidance; however, in the determination under review, the system actions were completed as expected and/or the caseworker followed all state policies correctly.
Other	In the determination action under review, the system functioned as expected, the caseworker correctly applied all applicable policies and took all relevant actions, and state policy was in compliance with federal policy. Something unrelated to these areas led to this finding.
Unable to Determine	The ERC is unable to identify the root cause of what led to this error, but the determination was incorrect.

Table A5. Eligibility Case Action Glossary

Case Action	Definition
Application	Last action was a result of processing an application submitted to the state.
Redetermination	Last action was a result of processing a redetermination submitted to the state or when a redetermination was not completed timely.
Change	Last action was a result of processing a change (change in income, household, etc.) communicated to the state.
Not Applicable	No specific case action to review. This classification applies to cases like SSI and Title IV-E cases, or other case types that are not determined eligible by the Medicaid agency. Cases with a termination action are also coded with a Not Applicable case action.
Unknown	Case actions could not be identified. This classification applies to cases in which it is unclear what type of case action was made to grant eligibility for the date of service.

Table A6. Acronym Glossary

Acronym	Definition
APN	Advanced Practice Nurse
ASC	Accredited Standards Committee
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CI	Confidence Interval
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
DFO	Division of Financial Operations
DME	Durable Medical Equipment
DMF	Social Security Death Master File
DOS	Date Of Service
DP	Data Processing
DR	Difference Resolution
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
ER	Eligibility Review
ERC	Eligibility Review Contractor
FBDE	Full Benefit Dual Eligible
FCBC	Fingerprint-based Criminal Background Check
FEFR	Final Errors for Recovery
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Reviews
H&P	History and Physical
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICF	Intermediate Care Facility
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IID	Individuals With Intellectual Disabilities
IPP	Individual Program Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MAR	Medication Administration Record

Acronym	Definition
MBES	Medicaid Budget and Expenditure System
MC	Managed Care
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MR	Medical Review
NADAC	National Average Drug Acquisition Cost
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
OT	Occupational Therapy
PA	Physician Assistant
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Measurement
PHE	Public Health Emergency
POC	Plan Of Care
PT	Physical Therapy
QMB	Qualified Medicare Beneficiary
RBS	Risk-Based Screening
RC	Review Contractor
RT	Respiratory Therapy
RY	Reporting Year
SAM/EPLS	System for Award Management/Excluded Parties List System
SC	Statistical Contractor
SLMB	Specified Low - Income Medicare Beneficiary
SLP	Speech Language Pathology
SMERF	State Medicaid Error Rate Findings
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TD	Technical Deficiency
TEFRA	Tax Equity and Fiscal Responsibility Act
TPL	Third-Party Liability

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2023 HHS AFR.