2021 Medicaid & CHIP Supplemental Improper Payment Data

November 2021

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 2021 improper payment rate (i.e., Cycle 3) are in **bold**.

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

Year	FFS	Managed Care	Eligibility*	Overall**
2007 - Cycle 1	4.7%			
2008 - Cycle 2	8.9%	3.1%	2.9%	**10.5%**
2009 - Cycle 3	2.6%	0.1%	6.7%	**8.7%**
2010 - Cycle 1	1.9%	0.1%	7.6%	**9.0%**
2011 - Cycle 2	3.6%	0.5%	4.0%	**6.7%**
2012 - Cycle 3	3.3%	0.3%	3.3%	**5.8%**
2013 - Cycle 1	3.4%	0.2%	3.3%	**5.7%**
2014 - Cycle 2	8.8%	0.1%	2.3%	**8.2%**
2015 - Cycle 3	18.63%	0.08%	N/A	**N/A**
2016 - Cycle 1	9.78%	0.49%	N/A	**N/A**
2017 - Cycle 2	10.55%	0.38%	N/A	**N/A**
2018 - Cycle 3	23.91%	0.02%	N/A	**N/A**
2019 - Cycle 1*	15.12%	0.00%	20.60%	**26.18%**
2020 - Cycle 2***	12.67%	0.16%	22.32%	**27.47%**
2021 - Cycle 3	13.91%	0.00%	9.27%	**13.68%**

Year	FFS	Managed Care	Eligibility*	Overall**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place. In relation to 2021 eligibility rates, the PERM program is unable to access data containing Federal Tax Information (FTI) as part of the eligibility reviews. For income verification, states have the option to use the Federal Data Services Hub (Hub) or other data sources for income verification. However, IRS statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including CMS improper payment measurement programs. Since requesting FTI from states is statutorily prohibited, PERM did not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source for Medicaid income eligibility.

**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 Public Health Emergency, 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 public health emergency 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%**

*For the 2015-2018 measurements, eligibility reviews were suspended. Therefore, eligibility component improper payment rates have been removed from these rates. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158). Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place. In relation to 2021 eligibility rates, the PERM program is unable to access data containing Federal Tax Information (FTI) as part of the eligibility reviews. For income verification, states have the option to use the Federal Data Services Hub (Hub) or other data sources for income verification. However, IRS statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including

Year	FFS	Managed Care	Eligibility*	Overall**

CMS improper payment measurement programs. Since requesting FTI from states is statutorily prohibited, PERM did not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source for CHIP income eligibility.

**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 Public Health Emergency, 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 public health emergency 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%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place. In relation to 2021 eligibility rates, the PERM program is unable to access data containing Federal Tax Information (FTI) as part of the eligibility reviews. For income verification, states have the option to use the Federal Data Services Hub (Hub) or other data sources for income verification. However, IRS statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including CMS improper payment measurement programs. Since requesting FTI from states is statutorily prohibited, PERM did not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source for Medicaid income eligibility.

**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.

Year	FFS	Managed Care	Eligibility*	Overall**

***Due to the COVID-19 Public Health Emergency, 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%**

*Rolling eligibility component statistics for 2015-2018 reflect the latest eligibility results from the most recent cycles prior to the eligibility freeze. 2019 represents the first cycle measured under the new PERM regulation (82 FR31158) and the rolling calculation methodology is described in the following section. Cycles prior to 2015 were measured under the previous PERM eligibility methodology. Additionally, CMS began reporting the official rates to two decimal places in 2015. Cycles prior to 2015 had rates reported to one decimal place. In relation to 2021 eligibility rates, the PERM program is unable to access data containing Federal Tax Information (FTI) as part of the eligibility reviews. For income verification, states have the option to use the Federal Data Services Hub (Hub) or other data sources for income verification. However, IRS statute 6103 of the Internal Revenue Code prohibits states from disclosing FTI to any outside source, including CMS improper payment measurement programs. Since requesting FTI from states is statutorily prohibited, PERM did not review for an indicator to confirm state income verification against the Hub where FTI was the sole verification source for CHIP income eligibility.

**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 Public Health Emergency, 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 2021 Improper Payment Findings

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

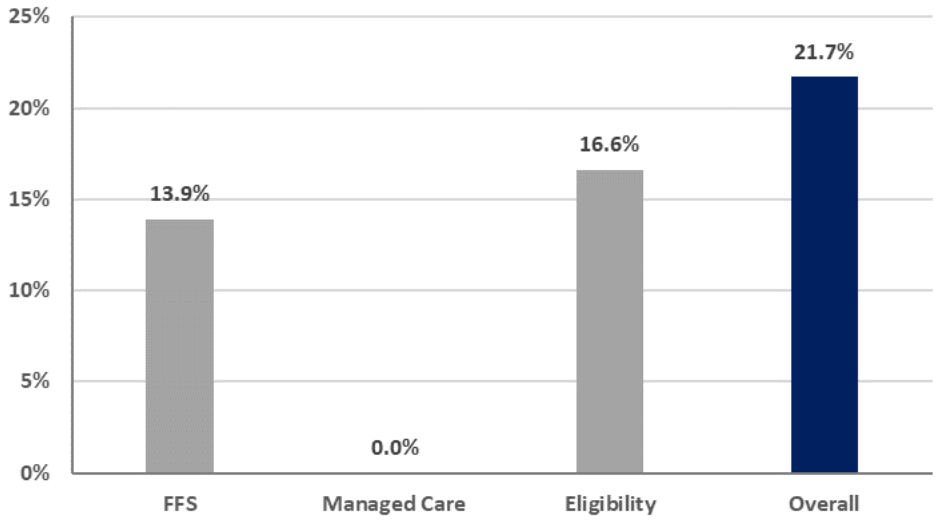


Figure 2. National Rolling CHIP Improper Payment Rate by Claim Type

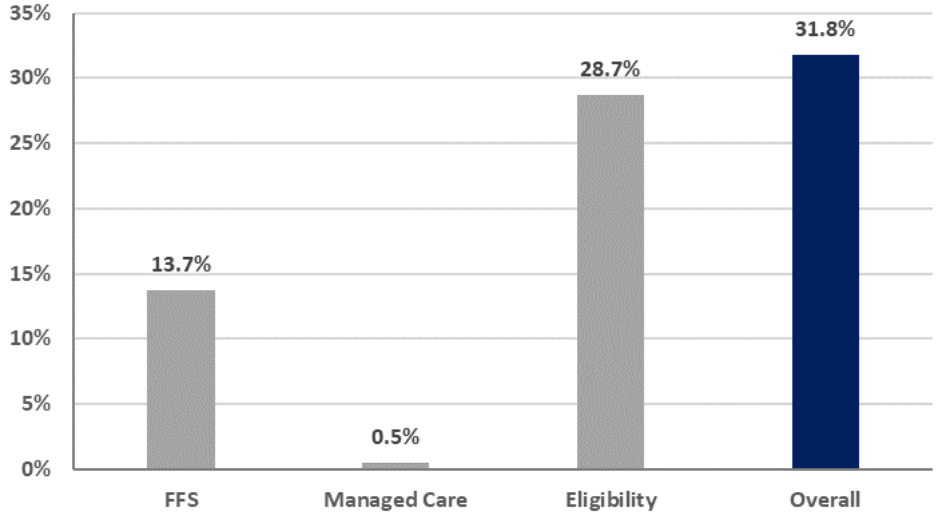


Figure 3. Medicaid Individual Cycle Improper Payments (in Billions)

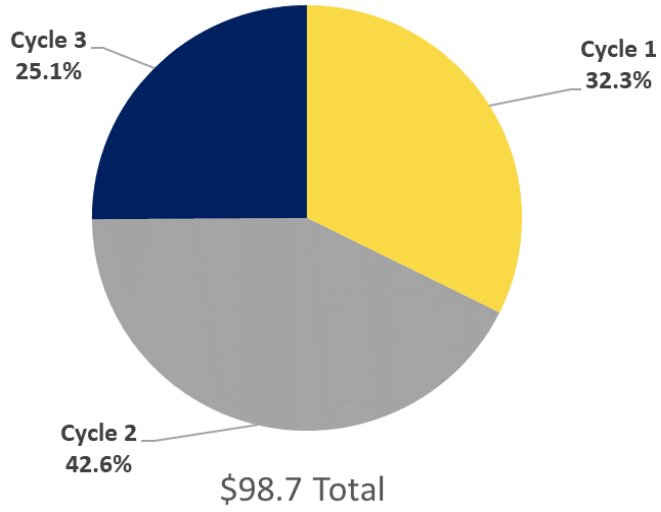


Figure 4. CHIP Individual Cycle Improper Payments (in Billions)

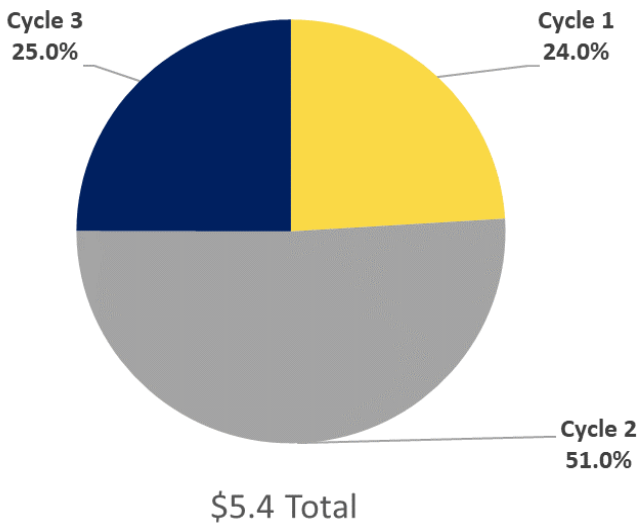


Figure 5. Medicaid Percentage of National Improper Payments by Claim Type (in Millions)[1]

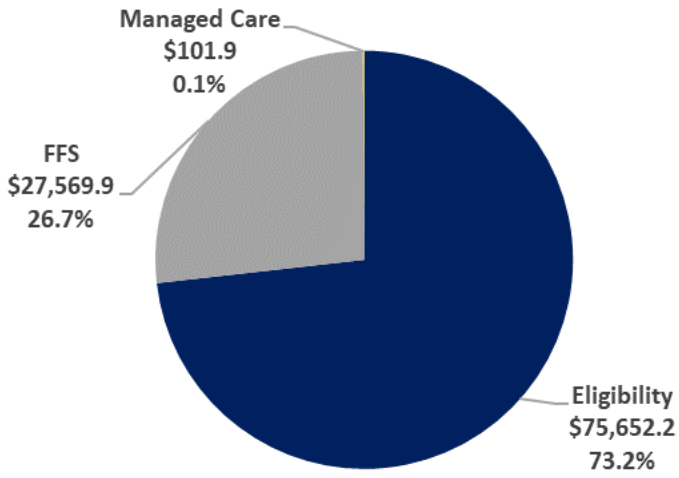
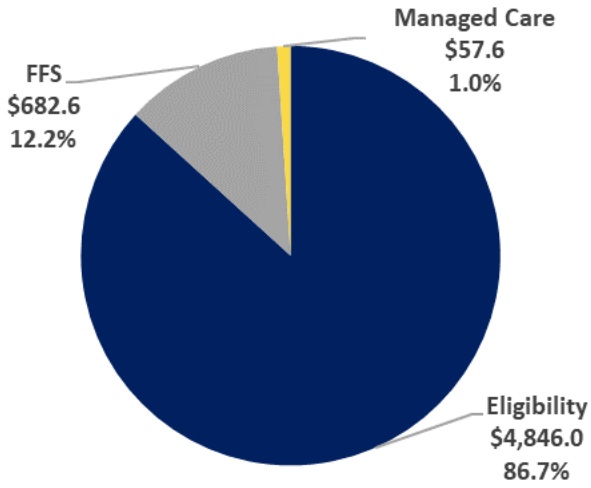


Figure 6. CHIP Percentage of National Improper Payments by Claim Type (in Millions)[1]



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

Common Causes of 2021 Improper Payments

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

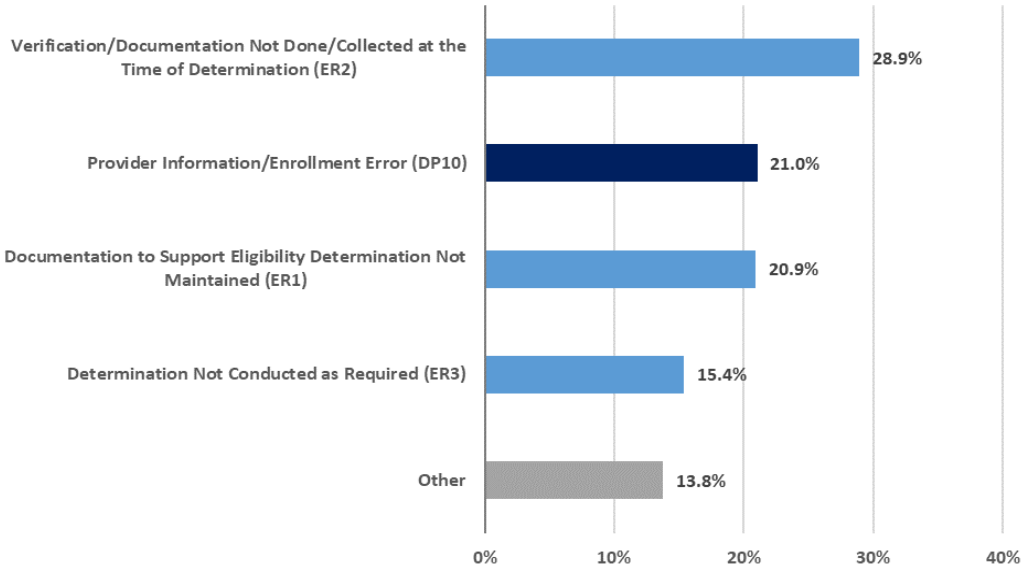
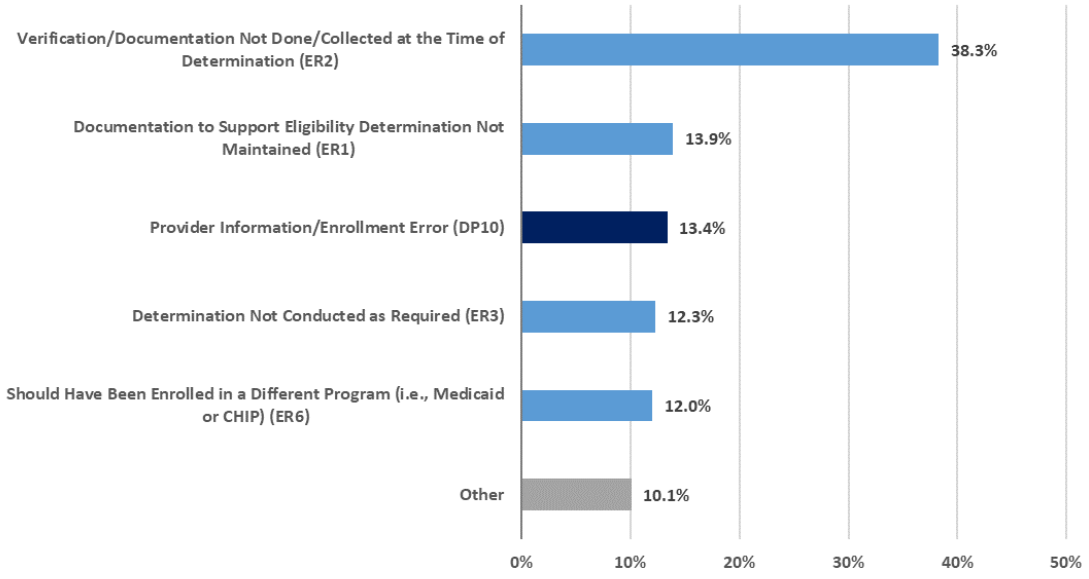


Figure 8. CHIP Type of Errors by Percentage of National Improper Payments[2]



[2] 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]

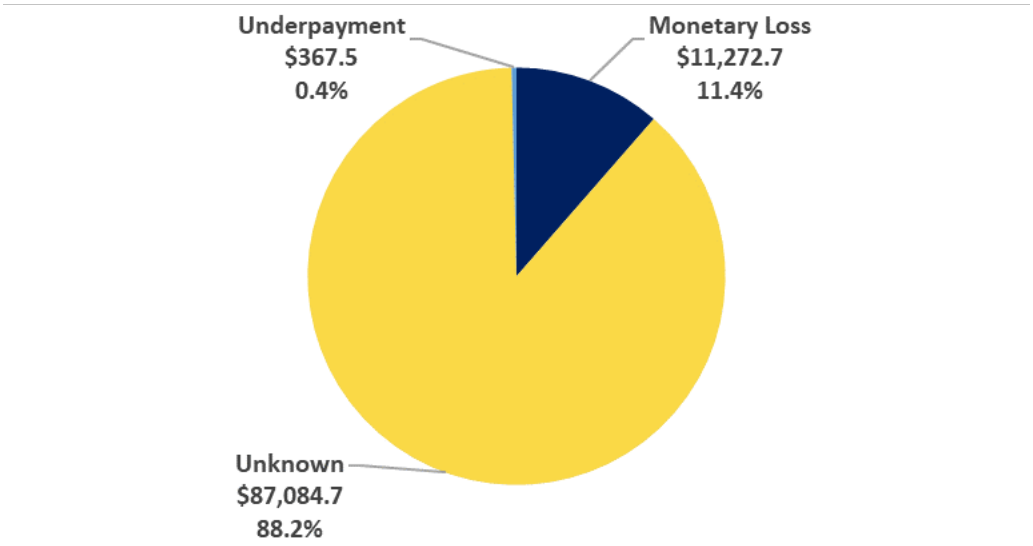
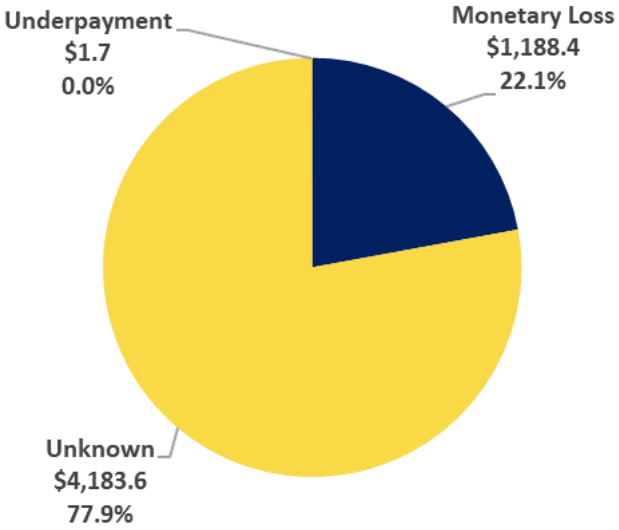


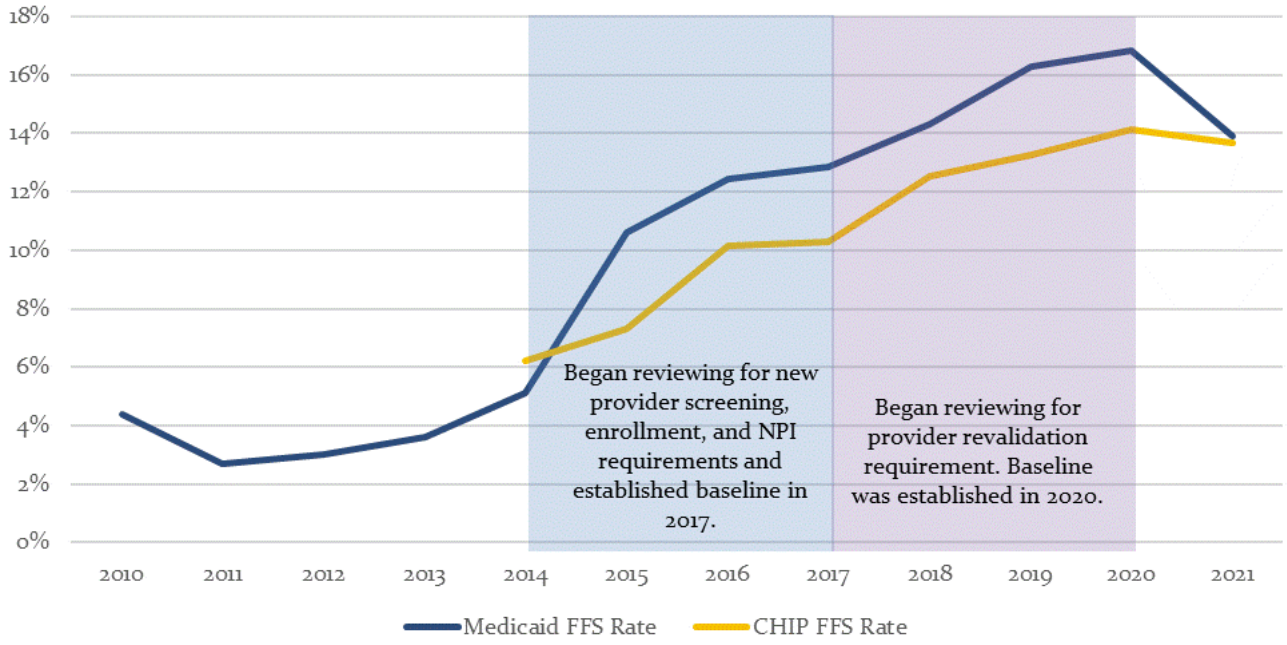
Figure 10. CHIP Improper Payments and Percentage of Improper Payments by Monetary Loss Category (in Millions)[3]



[3] 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.

2021 FFS Improper Payment Trends

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



2021 Eligibility Improper Payment Trends

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

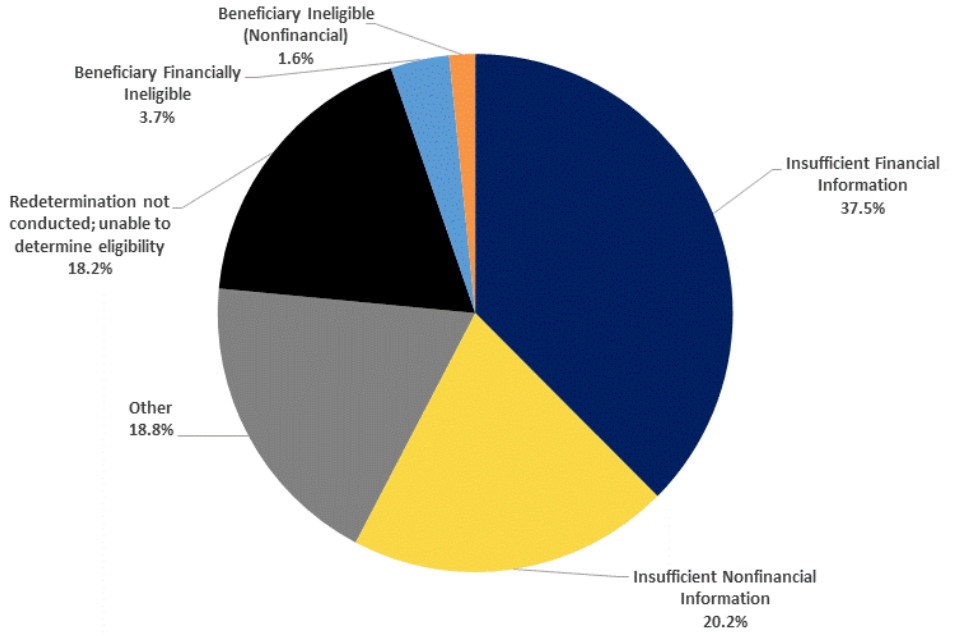


Figure 13. CHIP Type of Errors by Percentage of Eligibility Component Improper Payments

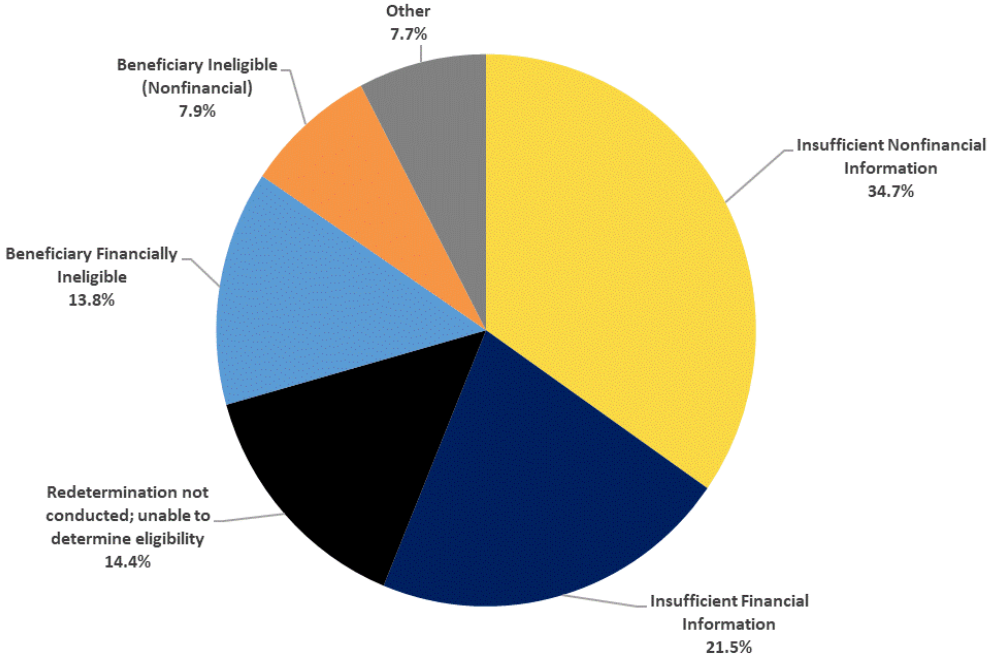


Figure 14. Medicaid Eligibility Monetary Loss Improper Payment Root Causes[4]

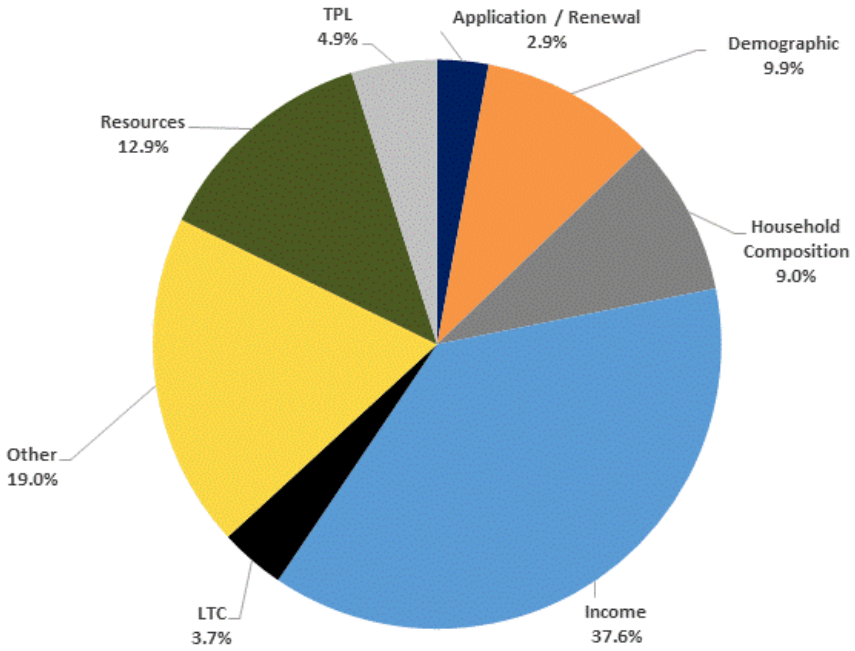
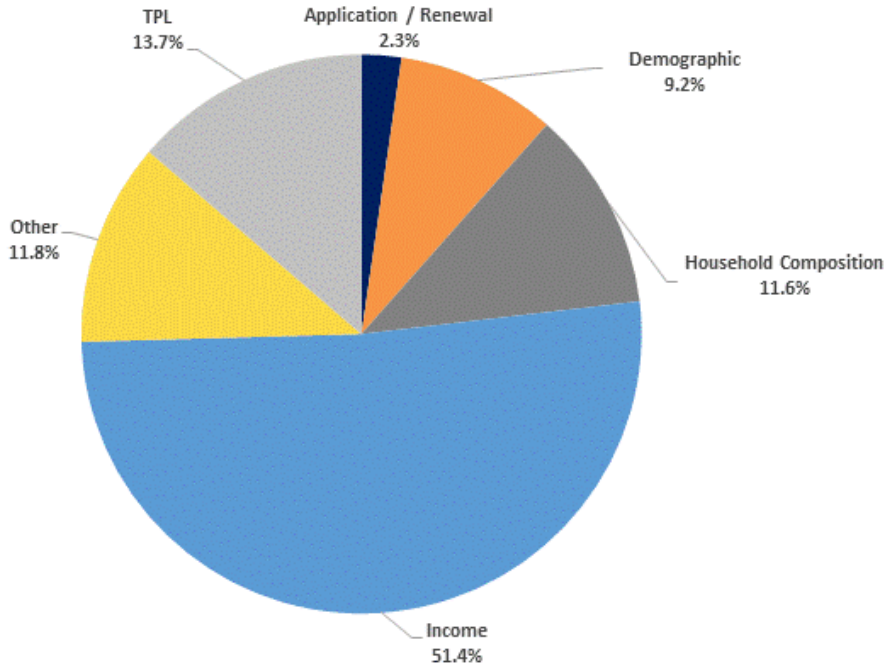
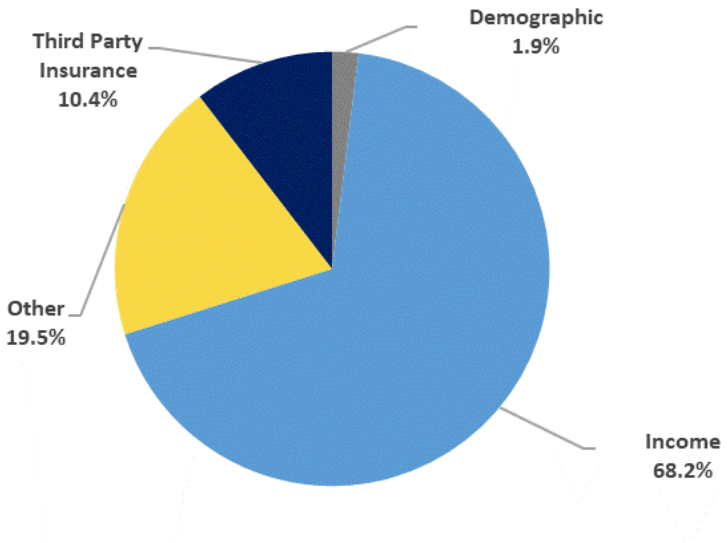


Figure 15. CHIP Eligibility Monetary Loss Improper Payment Root Causes[4]



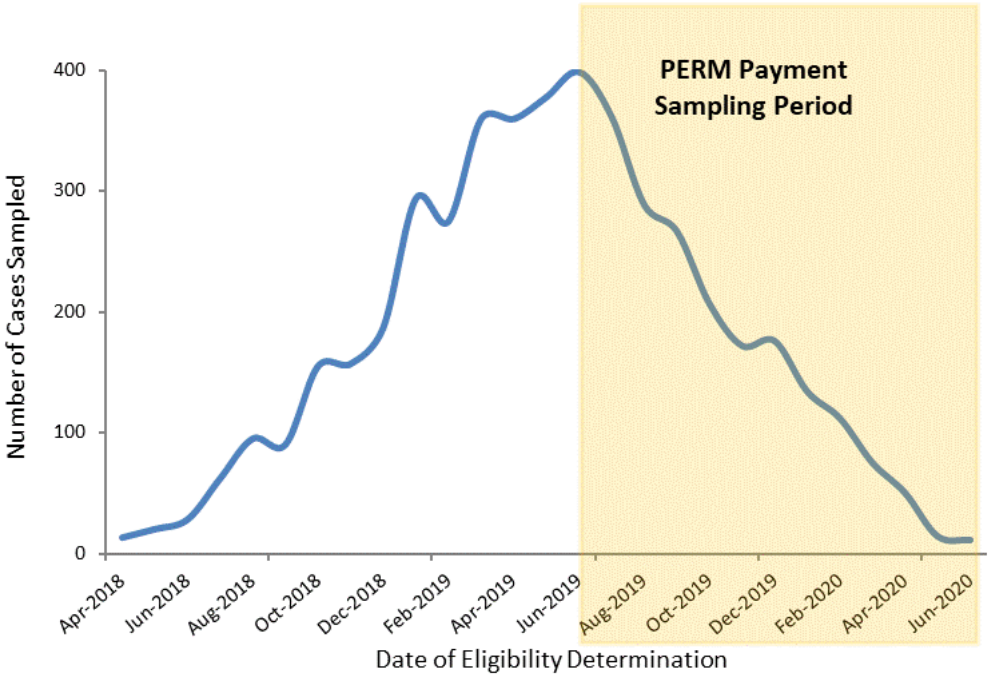
[4] Root causes with small improper payments may appear as 0.0% in this figure due to rounding.

Figure 16. CHIP Eligibility Wrong Program Error Root Causes[5]



[5] "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).

Figure 17. Medicaid and CHIP Eligibility Determination Timeframe for Claims Sampled in the 2021 Review Period



Section 2: 2021 Supplemental Medicaid Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for Medicaid in 2021 based on the 50 states and the District of Columbia reviewed from 2019-2021. 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% CI
FFS	3,117	18,878	$5,402,863.89	$47,834,443.58	$27,569.92	$198,307.19	13.90%	13.26% - 14.54%
FFS Medical Review	496	18,878*	$733,447.50	$47,834,443.58	$4,236.31	$198,307.19	2.14%	1.88% - 2.39%
FFS Data Processing	2,722	18,878	$4,787,536.85	$47,834,443.58	$24,114.15	$198,307.19	12.16%	11.56% - 12.76%
Managed Care	8	2,549	$5,325.62	$1,922,317.12	$101.89	$256,868.43	0.04%	0.00% - 0.08%
Eligibility	3,775	15,491	$4,679,012.14	$25,532,575.20	$75,652.24	$455,175.62	16.62%	15.90% - 17.34%
Total	**6,900**	**36,918**	**$10,087,201.65**	**$75,289,335.89**	**$98,724.88**	**$455,175.62**	**21.69%**	**20.97% - 22.41%**

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 18,878 cases sampled, 15,925 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	$5.11	4.50%
	Other Monetary Loss	$3.94	3.47%
	Provider Not Enrolled	$2.25	1.98%
Unknown	Insufficient Information to determine eligibility	$58.99	51.95%
	Non-Compliance with Provider Screening and NPI Requirements	$20.16	17.75%
	Other Unknown	$1.60	1.41%
	Other Missing Information	$6.04	5.32%
	Redetermination Not Conducted	$15.05	13.25%
Underpayments		$0.42	0.37%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Unknown" represents payments where there was no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

Medicaid FFS Component Federal Improper Payment Rate

Table S3. Medicaid FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,181	1,113	3,693	$1,277,211.05	$4,285,191.03	$8,230.66	$34,953.49	23.55%	21.71% - 25.39%
Psychiatric, Mental Health, and Behavioral Health Services	351	294	1,253	$440,385.24	$2,449,833.26	$3,652.30	$13,878.91	26.32%	22.12% - 30.52%
Personal Support Services	349	282	1,140	$78,492.14	$459,861.10	$3,122.74	$14,313.53	21.82%	18.43% - 25.21%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	509	450	3,168	$1,129,120.36	$10,497,531.49	$2,374.27	$26,872.45	8.84%	7.77% - 9.90%
Prescribed Drugs	312	287	2,097	$599,438.89	$5,193,200.34	$2,219.16	$22,661.09	9.79%	7.98% - 11.61%
Dental and Oral Surgery Services	176	152	311	$23,177.31	$39,389.75	$1,891.70	$3,490.07	54.20%	44.09% - 64.32%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	295	212	722	$1,302,391.80	$5,725,389.81	$1,596.19	$6,017.09	26.53%	21.73% - 31.33%
Capitated Care/Fixed Payments	42	38	1,237	$28,923.74	$957,704.94	$1,332.42	$25,945.55	5.14%	1.91% - 8.36%
Clinic Services	52	45	450	$14,480.26	$127,468.08	$749.08	$6,357.04	11.78%	6.68% - 16.88%
Inpatient Hospital Services	36	35	1,308	$394,783.64	$15,971,901.93	$505.56	$18,667.81	2.71%	1.00% - 4.41%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	49	48	512	$14,075.77	$311,226.10	$413.48	$6,326.88	6.54%	3.46% - 9.61%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	69	39	93	$1,648.47	$10,259.05	$283.71	$929.36	30.53%	17.21% - 43.84%
Outpatient Hospital Services	30	28	737	$44,768.78	$1,147,677.06	$270.41	$7,851.25	3.44%	1.57% - 5.32%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	28	23	134	$15,236.54	$114,123.27	$231.02	$1,461.26	15.81%	6.09% - 25.53%
Transportation and Accommodations	23	16	125	$3,096.95	$35,702.02	$218.46	$1,402.43	15.58%	4.39% - 26.77%
Home Health Services	28	20	80	$13,854.58	$39,599.42	$212.16	$1,398.45	15.17%	5.83% - 24.52%
Crossover Claims	8	8	510	$64.53	$13,470.44	$104.10	$3,489.78	2.98%	(1.65%) - 7.62%
Laboratory, X-ray and Imaging Services	17	17	119	$587.62	$14,404.77	$102.20	$891.25	11.47%	3.25% - 19.69%
Hospice Services	12	10	161	$21,126.20	$440,119.79	$60.30	$1,340.80	4.50%	(0.65%) - 9.65%
Denied Claims	0	0	1,028	$0.00	$389.93	$0.00	$58.68	0.00%	0.00% - 0.00%
Total	**3,567**	**3,117**	**18,878**	**$5,402,863.89**	**$47,834,443.58**	**$27,569.92**	**$198,307.19**	**13.90%**	**13.26% - 14.54%**

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

Medicaid FFS Medical Review Federal Improper Payments

Table S4. Summary of Medicaid FFS Medical Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	221	$318,133.19	$1,948.26	$1,545.51	$2,351.00
No Documentation Error (MR1)	162	$259,660.67	$1,520.74	$1,196.76	$1,844.71
Improperly Completed Documentation (MR9)	44	$79,968.33	$375.96	$205.32	$546.61
Number of Unit(s) Error (MR6)	41	$40,240.57	$299.75	$144.91	$454.60
Policy Violation Error (MR8)	8	$23,266.82	$47.84	$9.16	$86.52
Procedure Coding Error (MR3)	6	$4,571.81	$33.75	-$6.44	$73.95
Medically Unnecessary Service Error (MR7)	2	$515.34	$33.24	-$19.39	$85.87
Administrative/Other Error (MR10)	5	$6,894.46	$24.05	$0.92	$47.17
Diagnosis Coding Error (MR4)	2	$7,742.91	$14.39	-$12.21	$40.99
Medical Technical Deficiency (MTD)	15	$0.00	$0.00	$0.00	$0.00
Total	**506**	**$740,994.09**	**$4,297.99**	**$3,730.11**	**$4,865.87**

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)
Document(s) Absent from Record (MR2)	221	$318,133.19	$1,948.26	$1,545.51	$2,351.00
No Documentation Error (MR1)	162	$259,660.67	$1,520.74	$1,196.76	$1,844.71
Improperly Completed Documentation (MR9)	44	$79,968.33	$375.96	$205.32	$546.61
Number of Unit(s) Error (MR6)	37	$36,375.93	$265.71	$116.69	$414.72
Policy Violation Error (MR8)	8	$23,266.82	$47.84	$9.16	$86.52
Medically Unnecessary Service Error (MR7)	2	$515.34	$33.24	-$19.39	$85.87

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Administrative/Other Error (MR10)	5	$6,894.46	$24.05	$0.92	$47.17
Procedure Coding Error (MR3)	5	$4,460.05	$14.58	$0.31	$28.85
Diagnosis Coding Error (MR4)	2	$7,742.91	$14.39	-$12.21	$40.99
Medical Technical Deficiency (MTD)	15	$0.00	$0.00	$0.00	$0.00
Total	**501**	**$737,017.70**	**$4,244.77**	**$3,679.59**	**$4,809.95**

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)	4	$3,864.64	$34.05	-$8.05	$76.15
Procedure Coding Error (MR3)	1	$111.76	$19.17	N/A	N/A
Total	**5**	**$3,976.40**	**$53.22**	**-$3.21**	**$109.65**

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: Document(s) Absent from Record Error (MR2)

Table S7. Medicaid FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
One or more documents are missing from the record that are required to support payment	221	$318,133.19	$1,948.26	$1,545.51	$2,351.00
Total	**221**	**$318,133.19**	**$1,948.26**	**$1,545.51**	**$2,351.00**

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

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

Documentation Type	Total Count
Provider did not submit required progress notes applicable to the DOS	95
Provider did not submit the individual plan (ITP, ISP, IFSP, IEP, or POC)	90
Record does not include a physician's order for the sampled service	37
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	22
Other	14
Provider did not submit the pharmacy signature log	12
Provider did not submit the face-to-face assessment documentation	11
Medication Administration Record (MAR)	8
Provider did not submit the required physician certification/recertification of services	6
Provider did not submit prior authorization	6
Provider did not submit a valid prescription	2
Provider did not submit diagnostic study (laboratory, x-ray or pathology)	1
Provider did not submit documentation of patient counseling (or refusal)	1
Provider did not submit proof of delivery	1
Total	**306**

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
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	121	3,168
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	75	3,693
Personal Support Services	41	1,140
Psychiatric, Mental Health, and Behavioral Health Services	26	1,253
Prescribed Drugs	15	2,097
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	7	722
Clinic Services	5	450
Home Health Services	3	80
Laboratory, X-ray and Imaging Services	3	119
Outpatient Hospital Services	3	737
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	3	512
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	2	134
Hospice Services	1	161
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	1	93
Total	**306**	**18,878**

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.

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

Table S10. Medicaid FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	79	$126,823.25	$726.29	$478.59	$973.99
Documentation was not requested from the provider due to a fraud investigation or pending litigation	35	$83,249.88	$371.11	$226.67	$515.55
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	12	$21,087.95	$128.93	$46.36	$211.51

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider responded that he or she did not have the beneficiary on file or in the system	9	$12,963.58	$93.54	$21.88	$165.19
State could not locate the provider	11	$11,216.66	$52.26	$15.39	$89.12
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	$1,318.74	$43.56	-$35.60	$122.72
Provider responded with a statement that records cannot be located	6	$1,850.50	$42.47	$5.49	$79.45
Provider responded with a statement that the provider had billed in error	3	$248.59	$24.72	-$9.01	$58.45
Provider submitted a record for wrong DOS	2	$519.15	$19.57	-$12.34	$51.48
Provider did not submit medical records, only the PERM coversheet	2	$244.92	$14.56	-$6.23	$35.34
Provider did not submit medical records, only billing information, which is not enough/sufficient to support the sampled claim	1	$137.46	$3.74	N/A	N/A
Total	**162**	**$259,660.67**	**$1,520.74**	**$1,196.76**	**$1,844.71**

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

Medicaid FFS Medical Review Errors by Service Type

Table S11. Medicaid FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	108	107	3,693	$78,599.35	$4,285,191.03	$925.65	$34,953.49	2.65%	1.93% - 3.37%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	134	129	3,168	$321,328.74	$10,497,531.49	$888.05	$26,872.45	3.30%	2.58% - 4.03%
Personal Support Services	61	60	1,140	$26,529.80	$459,861.10	$572.12	$14,313.53	4.00%	2.01% - 5.99%
Psychiatric, Mental Health, and Behavioral Health Services	49	48	1,253	$42,749.17	$2,449,833.26	$561.48	$13,878.91	4.05%	2.48% - 5.61%
Prescribed Drugs	50	50	2,097	$107,110.04	$5,193,200.34	$354.67	$22,661.09	1.57%	0.93% - 2.20%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	22	22	512	$7,452.68	$311,226.10	$130.50	$6,326.88	2.06%	0.93% - 3.19%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	10	10	722	$49,009.13	$5,725,389.81	$122.57	$6,017.09	2.04%	0.52% - 3.56%
Transportation and Accommodations	9	9	125	$536.20	$35,702.02	$119.89	$1,402.43	8.55%	(1.58%) - 18.68%
Outpatient Hospital Services	9	9	737	$17,529.76	$1,147,677.06	$118.91	$7,851.25	1.51%	0.40% - 2.62%
Inpatient Hospital Services	10	10	1,308	$61,087.52	$15,971,901.93	$115.19	$18,667.81	0.62%	0.17% - 1.06%
Clinic Services	12	11	450	$7,830.43	$127,468.08	$107.49	$6,357.04	1.69%	0.54% - 2.84%
Laboratory, X-ray and Imaging Services	10	10	119	$570.61	$14,404.77	$86.24	$891.25	9.68%	1.77% - 17.58%
Hospice Services	3	3	161	$6,952.43	$440,119.79	$42.09	$1,340.80	3.14%	(1.88%) - 8.16%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	5	5	93	$188.10	$10,259.05	$28.38	$929.36	3.05%	(0.59%) - 6.70%
Dental and Oral Surgery Services	5	5	311	$1,138.95	$39,389.75	$25.47	$3,490.07	0.73%	(0.05%) - 1.51%
Home Health Services	5	4	80	$4,684.60	$39,599.42	$20.27	$1,398.45	1.45%	(0.77%) - 3.67%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	4	4	134	$149.99	$114,123.27	$17.36	$1,461.26	1.19%	(0.23%) - 2.60%
Capitated Care/Fixed Payments	0	0	1,237	$0.00	$957,704.94	$0.00	$25,945.55	0.00%	0.00% - 0.00%
Crossover Claims	0	0	510	$0.00	$13,470.44	$0.00	$3,489.78	0.00%	0.00% - 0.00%
Denied Claims	0	0	1,028	$0.00	$389.93	$0.00	$58.68	0.00%	0.00% - 0.00%
Total	**506**	**496**	**18,878**	**$733,447.50**	**$47,834,443.58**	**$4,236.31**	**$198,307.19**	**2.14%**	**1.88% - 2.39%**

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

Medicaid FFS Data Processing Federal Improper Payments

Table S12. Summary of Medicaid FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	2,720	$5,039,106.97	$23,881.11	$22,524.02	$25,238.20
Non-covered Service/Beneficiary Error (DP2)	51	$125,980.50	$1,700.37	$942.66	$2,458.08
Pricing Error (DP5)	67	$73,075.29	$823.19	$71.18	$1,575.20
Administrative/Other Error (DP12)	27	$9,989.54	$591.33	$201.78	$980.89
Duplicate Claim Error (DP1)	29	$4,369.01	$225.03	$119.96	$330.11
Managed Care Payment Error (DP9)	2	$226.95	$107.47	-$56.47	$271.41
Third-Party Liability Error (DP4)	5	$5,761.69	$65.24	$6.25	$124.23
Claim Filed Untimely Error (DP11)	2	$4,277.85	$22.62	-$20.32	$65.57
Managed Care Rate Cell Error (DP8)	1	$0.33	$0.10	N/A	N/A
Data Processing Technical Deficiency (DTD)	157	$0.00	$0.00	$0.00	$0.00
Total	**3,061**	**$5,262,788.12**	**$27,416.48**	**$25,675.78**	**$29,157.18**

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 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)	2,720	$5,039,106.97	$23,881.11	$22,524.02	$25,238.20
Non-covered Service/Beneficiary Error (DP2)	51	$125,980.50	$1,700.37	$942.66	$2,458.08

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)	49	$67,206.39	$793.10	$41.50	$1,544.71
Administrative/Other Error (DP12)	27	$9,989.54	$591.33	$201.78	$980.89
Duplicate Claim Error (DP1)	29	$4,369.01	$225.03	$119.96	$330.11
Managed Care Payment Error (DP9)	2	$226.95	$107.47	-$56.47	$271.41
Third-Party Liability Error (DP4)	5	$5,761.69	$65.24	$6.25	$124.23
Claim Filed Untimely Error (DP11)	2	$4,277.85	$22.62	-$20.32	$65.57
Data Processing Technical Deficiency (DTD)	157	$0.00	$0.00	$0.00	$0.00
Total	**3,042**	**$5,256,918.89**	**$27,386.29**	**$25,645.67**	**$29,126.91**

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 Data Processing error types can be found in Section 4: Error Codes, Table A2.

Table S14. Summary of Medicaid FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	18	$5,868.90	$30.09	$5.34	$54.84
Managed Care Rate Cell Error (DP8)	1	$0.33	$0.10	N/A	N/A
Total	**19**	**$5,869.23**	**$30.19**	**$5.44**	**$54.94**

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 S15. Medicaid FFS Specific Causes of Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Screening	Provider not appropriately screened using risk based criteria	1,554	$2,187,108.59	$14,177.12	$13,122.52	$15,231.72
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	339	$939,909.09	$3,121.29	$2,636.53	$3,606.05
	Attending or rendering provider NPI required, but not listed on claim	330	$823,687.18	$2,003.77	$1,563.71	$2,443.82
	Billing provider NPI required, but not listed on claim	118	$251,044.93	$858.58	$656.01	$1,061.14
Provider Enrollment	Provider not enrolled	181	$359,362.61	$2,247.81	$1,800.87	$2,694.76
Provider License/Certification	Provider license not current for DOS	43	$131,395.36	$813.08	$431.20	$1,194.96
Missing Provider Information	Missing provider risk based screening information	139	$259,043.84	$405.89	$287.48	$524.30
	Other missing provider information	11	$3,520.17	$183.95	$71.34	$296.56
	Missing provider enrollment information	3	$83,743.71	$59.22	-$22.42	$140.86
	Missing provider license information	2	$291.49	$10.41	-$4.18	$24.99
Total		**2,720**	**$5,039,106.97**	**$23,881.11**	**$22,524.02**	**$25,238.20**

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 S16. 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	277
	Wrong NPI on the claim	52

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Billing	No NPI on the claim	117
	Wrong NPI on the claim	1
ORP	No NPI on the claim	275
	Wrong NPI on the claim	64
Rendering	No NPI on the claim	1

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

Table S17. DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Revalidated	1,247
	Newly Enrolled	446
Provider Risk Level	Limited	1,572
	Moderate	67
	High	54
Provider Type	Billing	1,537
	Rendering	103
	ORP	53
Screening Elements Not Completed	No required databases checked	1,223
	SAM/EPLS not checked	248
	LEIE not checked	227
	NPPES not checked	146
	On-site not conducted	91
	DMF not checked	77

Breakdown	Additional Detail	Number of Errors
	FCBC not checked	11

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 S18. DP10 Medicaid FFS Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Number of Errors
Billing	143
ORP	25
Attending	15
Rendering	1

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

Medicaid FFS Data Processing Errors by Service Type

Table S19. Medicaid FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	1,073	1,042	3,693	$1,233,433.71	$4,285,191.03	$7,581.31	$34,953.49	21.69%	19.93% - 23.45%
Psychiatric, Mental Health, and Behavioral Health Services	302	253	1,253	$410,846.20	$2,449,833.26	$3,190.61	$13,878.91	22.99%	18.90% - 27.08%
Personal Support Services	288	231	1,140	$53,720.78	$459,861.10	$2,613.65	$14,313.53	18.26%	15.22% - 21.30%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Prescribed Drugs	262	244	2,097	$494,105.08	$5,193,200.34	$1,886.33	$22,661.09	8.32%	6.60% - 10.04%
Dental and Oral Surgery Services	171	148	311	$22,596.88	$39,389.75	$1,868.01	$3,490.07	53.52%	43.39% - 63.65%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	375	341	3,168	$849,412.94	$10,497,531.49	$1,569.33	$26,872.45	5.84%	5.02% - 6.66%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	285	207	722	$1,274,627.38	$5,725,389.81	$1,564.36	$6,017.09	26.00%	21.23% - 30.76%
Capitated Care/Fixed Payments	42	38	1,237	$28,923.74	$957,704.94	$1,332.42	$25,945.55	5.14%	1.91% - 8.36%
Clinic Services	40	34	450	$6,649.83	$127,468.08	$641.59	$6,357.04	10.09%	5.10% - 15.09%
Inpatient Hospital Services	26	25	1,308	$333,696.12	$15,971,901.93	$390.36	$18,667.81	2.09%	0.44% - 3.74%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	64	39	93	$1,648.47	$10,259.05	$283.71	$929.36	30.53%	17.21% - 43.84%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	27	26	512	$6,623.09	$311,226.10	$282.98	$6,326.88	4.47%	1.60% - 7.35%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	24	20	134	$15,104.34	$114,123.27	$218.66	$1,461.26	14.96%	5.33% - 24.59%
Transportation and Accommodations	14	13	125	$2,688.29	$35,702.02	$203.48	$1,402.43	14.51%	3.34% - 25.68%
Home Health Services	23	19	80	$11,946.72	$39,599.42	$196.57	$1,398.45	14.06%	5.03% - 23.08%
Outpatient Hospital Services	21	19	737	$27,239.03	$1,147,677.06	$151.50	$7,851.25	1.93%	0.42% - 3.44%
Crossover Claims	8	8	510	$64.53	$13,470.44	$104.10	$3,489.78	2.98%	(1.65%) - 7.62%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Hospice Services	9	8	161	$14,192.73	$440,119.79	$19.20	$1,340.80	1.43%	0.17% - 2.70%
Laboratory, X-ray and Imaging Services	7	7	119	$17.01	$14,404.77	$15.97	$891.25	1.79%	(0.58%) - 4.17%
Denied Claims	0	0	1,028	$0.00	$389.93	$0.00	$58.68	0.00%	0.00% - 0.00%
Total	**3,061**	**2,722**	**18,878**	**$4,787,536.85**	**$47,834,443.58**	**$24,114.15**	**$198,307.19**	**12.16%**	**11.56% - 12.76%**

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.

Medicaid Managed Care Errors by Type of Error

Table S20. Summary of Medicaid Managed Care Data Processing Projected Federal Dollars by Type of Error

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	8	$9,873.77	$124.86	$40.01	$209.71
Managed Care Rate Cell Error (DP8)	2	$3.12	$1.06	-$0.21	$2.33
Total	**10**	**$9,876.89**	**$125.92**	**$41.06**	**$210.78**

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

Medicaid Managed Care Data Processing Federal Improper Payments

Table S21. Summary of Medicaid Managed Care Data Processing Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	8	$9,873.77	$124.86	$40.01	$209.71
Total	**8**	**$9,873.77**	**$124.86**	**$40.01**	**$209.71**

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

Table S22. Summary of Medicaid Managed Care Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Managed Care Rate Cell Error (DP8)	2	$3.12	$1.06	-$0.21	$2.33
Total	**2**	**$3.12**	**$1.06**	**-$0.21**	**$2.33**

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

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

Table S23. Medicaid Managed Care Specific Causes of Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Beneficiary was ineligible for the applicable program on the DOS	5	$4,970.14	$76.34	$7.17	$145.50
Claim/capitation payment paid for coverage period or DOS after beneficiary's date of death	2	$4,551.27	$26.35	-$8.22	$60.92
Capitation payment made for a beneficiary not enrolled in MCO	1	$352.35	$22.17	N/A	N/A
Total	**8**	**$9,873.77**	**$124.86**	**$40.01**	**$209.71**

Medicaid Eligibility Review Errors by Eligibility Category

Table S24. Medicaid Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
MAGI									
MAGI Total	**1,923**	**1,763**	**5,890**	**$1,521,811.13**	**$6,900,675.17**	**$42,319.55**	**$194,601.74**	**21.75%**	**20.25% - 23.24%**
MAGI - Medicaid Expansion - Newly Eligible	610	555	2,077	$827,957.30	$3,196,996.33	$18,070.57	$87,622.60	20.62%	18.33% - 22.91%
MAGI - Children under Age 19	650	594	1,884	$209,125.73	$1,302,222.63	$10,234.43	$46,367.29	22.07%	18.96% - 25.19%
MAGI - Parent Caretaker	367	351	1,109	$231,702.29	$1,177,852.01	$7,920.53	$29,800.52	26.58%	22.82% - 30.34%
MAGI - Medicaid Expansion - Not Newly Eligible	108	102	224	$90,674.40	$317,084.98	$3,118.89	$13,518.80	23.07%	16.13% - 30.01%
1115 Waiver Programs	44	40	141	$16,818.58	$147,206.80	$1,050.28	$5,180.36	20.27%	11.41% - 29.14%
MAGI - Pregnant Woman	98	82	272	$90,485.58	$466,987.88	$980.61	$7,662.64	12.80%	7.52% - 18.08%
Emergency Services (Including for Non-Citizens)	16	13	57	$40,936.63	$185,363.49	$500.42	$2,182.69	22.93%	9.13% - 36.73%
Presumptive Eligibility	4	4	24	$1,580.58	$32,376.44	$228.53	$971.85	23.51%	(3.72%) - 50.75%
MAGI - CHIP	5	3	8	$8,062.26	$16,722.62	$58.34	$224.58	25.98%	(8.73%) - 60.69%
Newborn	2	2	4	$458.32	$6,559.71	$25.57	$180.59	14.16%	(10.71%) - 39.03%
Other Full Benefit Dual Eligible (FBDE)	3	2	2	$299.63	$299.63	$19.69	$19.69	100.00%	100.00% - 100.00%
Family Planning and Related Services	3	3	26	$2.52	$1,333.81	$6.78	$498.12	1.36%	(1.55%) - 4.27%
MAGI - Medicaid CHIP Expansion	9	8	42	$51.37	$1,886.90	$1.96	$68.84	2.85%	0.06% - 5.64%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
SSI Recipients	0	0	4	$0.00	$3,808.00	$0.00	$113.17	0.00%	0.00% - 0.00%
Unborn Child	0	0	4	$0.00	$6,010.11	$0.00	$6.62	0.00%	0.00% - 0.00%
Other (None of the Above)	4	4	12	$3,655.94	$37,963.83	$102.96	$183.37	56.15%	21.46% - 90.84%
Non-MAGI									
Non-MAGI Total	**2,373**	**2,012**	**9,601**	**$3,157,201.01**	**$18,631,900.03**	**$33,332.69**	**$260,573.88**	**12.79%**	**11.77% - 13.82%**
Aged, Blind, and Disabled - Mandatory Coverage	460	379	1,088	$482,230.39	$2,030,972.01	$6,872.79	$26,963.06	25.49%	21.41% - 29.57%
LTC/Nursing Home	521	436	1,059	$1,097,903.65	$3,376,007.46	$5,978.14	$25,061.58	23.85%	20.40% - 27.31%
Aged, Blind, and Disabled - Optional Categorically Needy	398	344	668	$530,183.11	$1,388,088.31	$5,756.40	$13,923.52	41.34%	36.58% - 46.11%
Home and Community-Based Services	384	318	1,009	$362,200.68	$1,449,579.85	$4,107.71	$23,515.61	17.47%	14.60% - 20.34%
Other Full Benefit Dual Eligible (FBDE)	185	151	340	$228,470.35	$605,227.53	$3,007.70	$7,091.47	42.41%	35.72% - 49.11%
SSI Recipients	100	97	3,739	$148,797.90	$6,440,380.30	$1,909.45	$116,240.64	1.64%	1.21% - 2.08%
QMB	38	35	158	$829.75	$31,216.47	$1,404.05	$8,365.20	16.78%	(1.83%) - 35.40%
Transitional Medicaid	65	54	177	$6,875.83	$396,601.83	$1,042.17	$3,420.72	30.47%	21.02% - 39.91%
Medically Needy	118	100	345	$124,432.47	$546,073.40	$973.16	$6,550.08	14.86%	10.10% - 19.61%
TEFRA/Katie Beckett	21	21	47	$46,153.22	$86,342.03	$365.24	$853.64	42.79%	25.04% - 60.53%
Qualified Disabled and Working Individuals	6	4	5	$5,509.39	$5,509.47	$318.21	$318.37	99.95%	99.84% - 100.06%
Qualified Individuals	8	6	14	$268.00	$18,381.68	$214.22	$1,062.90	20.15%	(10.00%) - 50.31%
Newborn	13	13	462	$3,843.87	$1,151,206.99	$212.91	$13,806.55	1.54%	0.62% - 2.47%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Emergency Services (Including for Non-Citizens)	6	6	25	$21,068.44	$121,045.15	$145.30	$603.29	24.08%	4.86% - 43.31%
Presumptive Eligibility	1	1	3	$1,804.77	$11,038.17	$75.12	$137.59	54.60%	(5.05%) - 114.25%
SLMB	3	3	26	$162.92	$13,600.65	$73.42	$808.07	9.09%	(3.84%) - 22.02%
Title IV-E	9	9	168	$954.31	$290,590.86	$73.00	$3,524.91	2.07%	0.22% - 3.92%
1115 Waiver Programs	3	3	37	$20,599.06	$64,707.27	$64.34	$988.34	6.51%	(2.16%) - 15.18%
Women with Breast or Cervical Cancer	1	1	19	$7,423.64	$46,541.54	$12.72	$370.17	3.44%	(3.31%) - 10.18%
Community First Choice 1915(k)	0	0	8	$0.00	$3,298.50	$0.00	$719.25	0.00%	0.00% - 0.00%
Other (None of the Above)	33	31	204	$67,489.26	$555,490.56	$726.66	$6,248.91	11.63%	6.35% - 16.90%

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 S25. 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/Documentation Not Done/Collected at the Time of Determination (ER2)	1,188	$1,971,890.45	$32,823.25	$29,443.05	$36,203.44
Documentation to Support Eligibility Determination Not Maintained (ER1)	842	$1,530,355.43	$23,762.68	$21,583.36	$25,942.00
Determination Not Conducted as Required (ER3)	725	$1,351,310.14	$17,455.62	$15,724.58	$19,186.66
Not Eligible for Enrolled Program - Financial Issue (ER4)	82	$112,741.06	$2,328.70	$1,626.66	$3,030.74
Other Errors (ER10)	179	$41,637.66	$1,690.11	$1,093.52	$2,286.70
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	38	$31,015.27	$1,171.17	$591.65	$1,750.69
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	49	$32,665.54	$1,099.85	$511.46	$1,688.23
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	45	$11,952.86	$780.80	$408.01	$1,153.58
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	14	$32,936.15	$612.24	$200.46	$1,024.02
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	183	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	951	$0.00	$0.00	$0.00	$0.00
Total	**4,296**	**$5,116,504.56**	**$81,724.41**	**$77,345.59**	**$86,103.22**

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 Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the	1,188	$1,971,890.45	$32,823.25	$29,443.05	$36,203.44

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Time of Determination (ER2)					
Documentation to Support Eligibility Determination Not Maintained (ER1)	842	$1,530,355.43	$23,762.68	$21,583.36	$25,942.00
Determination Not Conducted as Required (ER3)	725	$1,351,310.14	$17,455.62	$15,724.58	$19,186.66
Not Eligible for Enrolled Program - Financial Issue (ER4)	82	$112,741.06	$2,328.70	$1,626.66	$3,030.74
Other Errors (ER10)	160	$39,498.51	$1,656.91	$1,061.15	$2,252.66
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	38	$31,015.27	$1,171.17	$591.65	$1,750.69
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	34	$21,401.23	$796.91	$253.76	$1,340.06
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	45	$11,952.86	$780.80	$408.01	$1,153.58
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	14	$32,936.15	$612.24	$200.46	$1,024.02
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	183	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	945	$0.00	$0.00	$0.00	$0.00
Total	**4,256**	**$5,103,101.10**	**$81,388.26**	**$77,014.42**	**$85,762.11**

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

Table S27. 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 - Incorrect FMAP Assignment (ER7)	15	$11,264.31	$302.94	$76.70	$529.17
Other Errors (ER10)	19	$2,139.15	$33.20	$0.38	$66.03
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	6	$0.00	$0.00	$0.00	$0.00
Total	**40**	**$13,403.46**	**$336.14**	**$107.54**	**$564.75**

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 S28. 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/Documentation Not Done/Collected at the Time of Determination (ER2)	624	$775,917.19	$17,947.70	$15,890.76	$20,004.64
Documentation to Support Eligibility Determination Not Maintained (ER1)	370	$545,379.74	$12,074.19	$10,329.16	$13,819.22
Determination Not Conducted as Required (ER3)	303	$178,761.16	$8,302.70	$7,127.56	$9,477.85
Not Eligible for Enrolled Program - Financial Issue (ER4)	46	$41,185.49	$1,476.01	$969.78	$1,982.24
Other Errors (ER10)	25	$7,101.90	$1,213.16	$663.87	$1,762.45
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	44	$28,908.55	$993.90	$417.62	$1,570.17
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	21	$16,663.69	$812.29	$265.92	$1,358.66

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	44	$11,924.34	$779.81	$430.63	$1,128.99
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	8	$26,488.03	$479.65	$87.43	$871.87
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	68	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	370	$0.00	$0.00	$0.00	$0.00
Total	**1,923**	**$1,632,330.09**	**$44,079.41**	**$41,111.59**	**$47,047.23**

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

Table S29. 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/Documentation Not Done/Collected at the Time of Determination (ER2)	564	$1,195,973.26	$14,875.55	$12,489.06	$17,262.04
Documentation to Support Eligibility Determination Not Maintained (ER1)	472	$984,975.69	$11,688.49	$10,488.88	$12,888.09
Determination Not Conducted as Required (ER3)	422	$1,172,548.98	$9,152.92	$7,985.53	$10,320.31
Not Eligible for Enrolled Program - Financial Issue (ER4)	36	$71,555.57	$852.69	$416.96	$1,288.41
Other Errors (ER10)	154	$34,535.76	$476.95	$240.60	$713.29
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	17	$14,351.58	$358.88	$176.72	$541.04
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	6	$6,448.12	$132.59	$7.19	$257.99
Not Eligible for Enrolled Eligibility Category -	5	$3,756.99	$105.95	-$12.37	$224.26

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Incorrect FMAP Assignment (ER7)					
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	1	$28.52	$0.99	N/A	N/A
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	115	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	581	$0.00	$0.00	$0.00	$0.00
Total	**2,373**	**$3,484,174.47**	**$37,644.99**	**$34,787.34**	**$40,502.64**

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 S30. 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	2,472	$2,840,118.27	$38,223.12	$35,456.99	$40,989.24
Unable to Determine	911	$1,200,191.03	$21,831.04	$19,952.98	$23,709.10
System	828	$958,246.79	$19,146.81	$16,130.51	$22,163.12
Policy	74	$101,134.39	$2,285.35	$1,509.98	$3,060.71
Multiple	9	$12,831.05	$188.12	$5.85	$370.38
Other	2	$3,983.03	$49.97	-$46.11	$146.05
Total	**4,296**	**$5,116,504.56**	**$81,724.41**	**$77,345.59**	**$86,103.22**

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 S31. 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	2,722	2,390	7,098	$2,599,280.65	$48,263.91	23.52%	21.88% - 25.16%
Application	635	554	2,379	$996,439.87	$11,547.81	15.66%	13.28% - 18.04%
Change	685	581	2,016	$764,785.54	$9,506.20	19.96%	17.47% - 22.45%
Unknown	130	130	131	$176,208.66	$3,563.11	99.54%	98.63% - 100.45%
Not Applicable	124	120	3,867	$142,297.42	$2,771.21	2.22%	1.67% - 2.76%
Total	**4,296**	**3,775**	**15,491**	**$4,679,012.14**	**$75,652.24**	**16.62%**	**15.71% - 17.53%**

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. A case action of "Not Applicable" applies to cases where eligibility happens automatically. Examples include Title IV-E cases and SSI cases in 1634 states. A case action of "Unknown" applies to cases where the type of action is not able to be determined. An example includes where an application or renewal is missing completely from the case file.

Table S32. 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	1,861	1,688	7,538	$956,088.26	$38,673.68	15.69%	14.60% - 16.79%
FFS	2,435	2,087	7,953	$3,722,923.88	$36,978.56	17.71%	16.21% - 19.22%
Total	**4,296**	**3,775**	**15,491**	**$4,679,012.14**	**$75,652.24**	**16.62%**	**15.71% - 17.53%**

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/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Table S33. Specific Causes of Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	436	$659,183.06	$11,933.76	$9,972.61	$13,894.92
Resources verification not on file/incomplete	230	$503,235.38	$7,551.37	$5,239.09	$9,863.65
Signature not obtained	241	$384,347.42	$6,984.15	$5,814.53	$8,153.78
Eligibility process(es) not followed	121	$164,366.50	$2,187.00	$1,631.74	$2,742.27
Residency not verified	67	$71,307.44	$1,919.55	$1,381.13	$2,457.96
Discrepant information not acted upon	14	$25,409.95	$843.22	$223.30	$1,463.14
Level of care not verified	23	$64,090.25	$307.27	$156.55	$457.98
LTC verification not on file/incomplete	15	$46,876.08	$206.94	$28.15	$385.72
Other verification not on file/incomplete	3	$3,162.10	$187.16	-$122.55	$496.87
Other element not verified	8	$10,785.78	$136.70	$31.31	$242.09
Social Security Number not verified	4	$8,868.74	$136.60	-$25.94	$299.15
Immigration status not verified	5	$659.17	$89.98	-$7.82	$187.79
State did not do required disability/blindness determination	4	$1,433.14	$83.15	-$11.81	$178.12
Contribution to care not verified	5	$8,700.75	$64.62	-$6.78	$136.02
TPL verification not on file/incomplete	2	$6,924.45	$55.35	-$31.41	$142.12
Demographic verification not on file/incomplete	2	$681.98	$51.55	-$39.11	$142.21
Residency not verified with appropriate source	2	$1,938.76	$35.97	-$13.98	$85.93
Citizenship not verified	3	$7,382.16	$27.64	-$15.11	$70.38

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Identity not verified	1	$53.89	$12.10	N/A	N/A
Household composition/tax filer status not verified	1	$2,482.45	$7.14	N/A	N/A
Other element not verified with appropriate source	1	$1.00	$2.02	N/A	N/A
Total	**1,188**	**$1,971,890.45**	**$32,823.25**	**$29,443.05**	**$36,203.44**

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 Error (ER1)

Table S34. Specific Causes of Documentation to Support Eligibility Determination Not Maintained Error (ER1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	193	$209,450.68	$6,958.88	$5,576.41	$8,341.36
Other required forms not on file/incomplete	266	$482,374.45	$6,919.38	$5,928.19	$7,910.57
Signature not on file	96	$194,335.63	$2,739.77	$1,748.97	$3,730.58
Resources verification not on file/incomplete	103	$248,662.85	$2,228.88	$1,723.37	$2,734.40
Application/Renewal form not on file	45	$102,750.97	$1,092.03	$587.24	$1,596.83
Level of care determination not on file/incomplete	39	$125,633.39	$962.26	$569.40	$1,355.13
Residency verification not on file/incomplete	25	$15,952.61	$696.10	$386.58	$1,005.61
Blindness/disability determination documentation not on file/incomplete	18	$30,960.53	$529.65	$242.79	$816.51
SSI enrollment documentation not available	17	$21,067.51	$468.10	$215.21	$720.99

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Hospital presumptive eligibility documentation not available	3	$3,352.72	$230.98	-$33.41	$495.37
Other verification not on file/incomplete	6	$24,137.86	$174.00	-$5.64	$353.64
Contribution to care documentation not on file/incomplete	9	$23,035.49	$161.45	$50.66	$272.25
LTC verification not on file/incomplete	6	$31,474.25	$134.27	$23.81	$244.73
Household composition/tax filer status not on file/incomplete	3	$1,252.80	$112.64	-$15.88	$241.17
Citizenship verification not on file	3	$11,072.16	$87.78	-$22.85	$198.41
Title IV-E eligibility documentation not available	4	$228.01	$68.55	-$11.78	$148.88
Social Security Number verification not on file	2	$202.32	$68.09	-$35.59	$171.77
Documentation clarifying discrepant information not on file/incomplete	1	$1,725.71	$67.94	N/A	N/A
Immigration verification not on file	1	$2,329.08	$53.55	N/A	N/A
Demographic verification not on file/incomplete	2	$356.41	$8.35	-$5.92	$22.63
Total	**842**	**$1,530,355.43**	**$23,762.68**	**$21,583.36**	**$25,942.00**

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.

Section 3: 2021 Supplemental CHIP Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for CHIP in 2021 based on the 50 states and the District of Columbia reviewed from 2019-2021. 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% CI
FFS	2,193	11,374	$3,597,215.36	$39,294,795.96	$682.60	$4,993.84	13.67%	12.84% - 14.50%
FFS Medical Review	251	11,374*	$390,178.90	$39,294,795.96	$70.05	$4,993.84	1.40%	1.12% - 1.68%
FFS Data Processing	1,984	11,374	$3,285,033.49	$39,294,795.96	$624.86	$4,993.84	12.51%	11.71% - 13.31%
Managed Care	9	1,739	$1,456.21	$332,136.02	$57.57	$11,885.62	0.48%	(0.03%) - 1.00%
Eligibility	3,837	10,256	$3,391,616.98	$15,787,878.01	$4,846.00	$16,879.46	28.71%	26.84% - 30.58%
Total	**6,039**	**23,369**	**$6,990,288.55**	**$55,414,809.99**	**$5,373.68**	**$16,879.46**	**31.84%**	**30.02% - 33.65%**

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 11,374 cases sampled, 10,242 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	$1.18	18.43%
	Other Monetary Loss	$0.11	1.75%
	Provider Not Enrolled	$0.02	0.37%
Unknown	Insufficient Information to determine eligibility	$3.36	52.38%
	Non-Compliance with Provider Screening and NPI Requirements	$0.80	12.43%
	Other Unknown	$0.06	0.97%
	Other Missing Information	$0.09	1.47%
	Redetermination Not Conducted	$0.78	12.12%
Underpayments		$0.01	0.08%

Note: The table provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Unknown" represents payments where there was no or insufficient documentation to support the payment as proper or a known monetary loss. For example, it represents claims where information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program.

CHIP FFS Component Federal Improper Payment Rate

Table T3. CHIP FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Dental and Oral Surgery Services	790	705	1,531	$205,204.57	$391,305.56	$241.42	$655.91	36.81%	24.70% - 48.91%
Psychiatric, Mental Health, and Behavioral Health Services	728	369	1,849	$322,613.22	$3,148,712.22	$156.73	$839.80	18.66%	16.79% - 20.53%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Prescribed Drugs	509	474	2,370	$1,873,954.10	$11,064,306.71	$92.57	$897.72	10.31%	8.10% - 12.52%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	336	250	854	$42,939.58	$273,295.27	$67.04	$236.05	28.40%	23.15% - 33.65%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	88	77	730	$24,796.17	$302,803.93	$37.87	$463.45	8.17%	4.71% - 11.64%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	97	66	195	$10,115.43	$23,967.72	$31.46	$85.53	36.78%	23.71% - 49.86%
Inpatient Hospital Services	23	23	915	$795,269.35	$20,551,188.67	$14.58	$671.54	2.17%	0.41% - 3.93%
Clinic Services	51	46	704	$16,227.29	$187,572.15	$13.97	$378.10	3.70%	2.26% - 5.13%
Personal Support Services	99	80	192	$23,581.68	$58,250.19	$11.51	$56.51	20.37%	13.57% - 27.16%
Home Health Services	19	15	32	$8,122.90	$13,869.60	$6.72	$17.41	38.60%	17.88% - 59.33%
Outpatient Hospital Services	36	35	895	$148,670.17	$2,068,892.30	$5.47	$365.87	1.50%	0.72% - 2.27%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	14	13	95	$24,199.02	$84,816.60	$1.46	$41.22	3.55%	0.45% - 6.66%
Capitated Care/Fixed Payments	22	22	344	$53,997.59	$709,569.91	$0.99	$200.43	0.49%	0.34% - 0.64%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	6	4	12	$46,917.61	$145,718.97	$0.43	$1.79	24.11%	(0.57%) - 48.79%
Laboratory, X-ray and Imaging Services	10	9	134	$17.63	$22,275.04	$0.26	$49.85	0.51%	(0.06%) - 1.09%
Transportation and Accommodations	3	3	48	$493.52	$37,152.84	$0.12	$17.96	0.65%	(0.22%) - 1.51%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Crossover Claims	2	2	50	$95.53	$2,399.87	$0.00	$1.65	0.03%	(0.01%) - 0.06%
Denied Claims	0	0	417	$0.00	$52.67	$0.00	$3.78	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.62	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	5	$0.00	$199,701.50	$0.00	$8.64	0.00%	0.00% - 0.00%
Total	**2,833**	**2,193**	**11,374**	**$3,597,215.36**	**$39,294,795.96**	**$682.60**	**$4,993.84**	**13.67%**	**12.84% - 14.50%**

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

CHIP FFS Medical Review Federal Improper Payments

Table T4. Summary of CHIP FFS Medical Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	96	$107,024.01	$25.25	$18.46	$32.04
No Documentation Error (MR1)	74	$95,669.72	$22.17	$13.17	$31.18
Procedure Coding Error (MR3)	25	$128,083.91	$9.77	$2.33	$17.22
Improperly Completed Documentation (MR9)	20	$4,040.32	$6.31	$2.29	$10.32
Number of Unit(s) Error (MR6)	20	$56,118.27	$4.68	$1.96	$7.41
Policy Violation Error (MR8)	6	$508.99	$1.65	-$0.43	$3.73
Administrative/Other Error (MR10)	2	$154.28	$0.31	-$0.13	$0.75
Medically Unnecessary Service Error (MR7)	1	$18.59	$0.29	N/A	N/A
Medical Technical Deficiency (MTD)	12	$0.00	$0.00	$0.00	$0.00
Total	**256**	**$391,618.08**	**$70.44**	**$55.99**	**$84.88**

Note: Details do not always sum to the total due to rounding. For error types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanation of Medical Review error types can be found in Section 4: Error Codes, Table A1.

Table T5. Summary of CHIP FFS Medical Review Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Document(s) Absent from Record (MR2)	96	$107,024.01	$25.25	$18.46	$32.04
No Documentation Error (MR1)	74	$95,669.72	$22.17	$13.17	$31.18
Improperly Completed Documentation (MR9)	20	$4,040.32	$6.31	$2.29	$10.32
Procedure Coding Error (MR3)	22	$127,773.45	$4.75	$2.13	$7.37
Number of Unit(s) Error (MR6)	18	$56,096.85	$4.65	$1.92	$7.37
Policy Violation Error (MR8)	6	$508.99	$1.65	-$0.43	$3.73
Administrative/Other Error (MR10)	2	$154.28	$0.31	-$0.13	$0.75
Medically Unnecessary Service Error (MR7)	1	$18.59	$0.29	N/A	N/A

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Medical Technical Deficiency (MTD)	12	$0.00	$0.00	$0.00	$0.00
Total	**251**	**$391,286.20**	**$65.37**	**$52.69**	**$78.06**

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)	3	$310.46	$5.03	-$1.95	$12.00
Number of Unit(s) Error (MR6)	2	$21.42	$0.04	-$0.02	$0.10
Total	**5**	**$331.88**	**$5.06**	**-$1.91**	**$12.03**

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: Document(s) Absent from Record Error (MR2)

Table T7. CHIP FFS Specific Causes of Document(s) Absent from Record Error (MR2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
One or more documents are missing from the record that are required to support payment	96	$107,024.01	$25.25	$18.46	$32.04
Total	**96**	**$107,024.01**	**$25.25**	**$18.46**	**$32.04**

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

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

Documentation Type	Total Count
Provider did not submit the individual plan (ITP, ISP, IEP, or POC)	41
Provider did not submit required progress notes applicable to the sampled DOS	20
Provider did not submit the face-to-face assessment documentation	16
Provider did not submit the pharmacy signature log	13
Other	7
Provider did not submit prior authorization	6
Record does not include a physician's order for the sampled service	6
Provider did not submit a record with daily documentation of specific tasks performed on the sampled DOS	5
Provider did not submit documentation of patient counseling (or refusal)	3
Provider did not submit diagnostic study (laboratory, X-ray, or pathology) results	2
Medication Administration Record (MAR)	1
Provider did not submit a valid prescription	1
Total	**121**

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	34	854
Psychiatric, Mental Health, and Behavioral Health Services	32	1,849
Prescribed Drugs	16	2,370
Dental and Oral Surgery Services	14	1,531
Clinic Services	8	704
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	5	730
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	4	95
Outpatient Hospital Services	4	895
Inpatient Hospital Services	2	915
Personal Support Services	1	192
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	1	195
Total	**121**	**11,374**

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.

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

Table T10. CHIP FFS Specific Causes of No Documentation Error (MR1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider did not respond to the request for records	35	$83,098.79	$14.00	$5.64	$22.36
Documentation was not requested from the provider due to a fraud investigation or pending litigation	15	$2,990.78	$2.04	$0.91	$3.17
Provider responded that he or she did not have the beneficiary on file or in the system	5	$1,091.77	$1.64	-$0.03	$3.31
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	7	$999.63	$1.59	$0.28	$2.90
Provider responded with a statement that the provider had billed in error	4	$2,714.63	$1.29	-$0.59	$3.16

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider responded with a statement that the record is unavailable due to electronic health record issues	1	$107.33	$0.60	N/A	N/A
Provider responded with a statement that records cannot be located	3	$3,604.25	$0.47	-$0.11	$1.04
State could not locate the provider	2	$175.96	$0.29	-$0.25	$0.83
Provider submitted a record for wrong DOS	1	$455.00	$0.18	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	**74**	**$95,669.72**	**$22.17**	**$13.17**	**$31.18**

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

CHIP FFS Medical Review Errors by Service Type

Table T11. CHIP FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Psychiatric, Mental Health, and Behavioral Health Services	72	72	1,849	$92,984.61	$3,148,712.22	$18.32	$839.80	2.18%	1.52% - 2.84%
Dental and Oral Surgery Services	35	35	1,531	$5,308.73	$391,305.56	$17.01	$655.91	2.59%	0.82% - 4.36%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	42	38	854	$5,821.30	$273,295.27	$8.76	$236.05	3.71%	2.09% - 5.33%
Prescribed Drugs	33	33	2,370	$84,263.23	$11,064,306.71	$7.24	$897.72	0.81%	0.31% - 1.30%
Clinic Services	19	19	704	$11,209.56	$187,572.15	$5.03	$378.10	1.33%	0.55% - 2.12%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	19	19	730	$13,158.80	$302,803.93	$4.57	$463.45	0.99%	0.39% - 1.58%
Outpatient Hospital Services	14	14	895	$127,040.45	$2,068,892.30	$3.57	$365.87	0.98%	0.32% - 1.64%
Home Health Services	4	4	32	$1,185.47	$13,869.60	$1.54	$17.41	8.86%	(1.78%) - 19.49%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	4	4	195	$261.38	$23,967.72	$1.38	$85.53	1.61%	(0.96%) - 4.18%
Inpatient Hospital Services	2	2	915	$39,885.68	$20,551,188.67	$1.30	$671.54	0.19%	(0.18%) - 0.57%
Personal Support Services	7	6	192	$4,758.83	$58,250.19	$0.94	$56.51	1.67%	(0.18%) - 3.51%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic	4	4	95	$4,295.54	$84,816.60	$0.30	$41.22	0.73%	(0.33%) - 1.78%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Devices, and Environmental Modifications									
Laboratory, X-ray and Imaging Services	1	1	134	$5.32	$22,275.04	$0.08	$49.85	0.17%	(0.17%) - 0.50%
Capitated Care/Fixed Payments	0	0	344	$0.00	$709,569.91	$0.00	$200.43	0.00%	0.00% - 0.00%
Crossover Claims	0	0	50	$0.00	$2,399.87	$0.00	$1.65	0.00%	0.00% - 0.00%
Denied Claims	0	0	417	$0.00	$52.67	$0.00	$3.78	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.62	0.00%	0.00% - 0.00%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	0	0	12	$0.00	$145,718.97	$0.00	$1.79	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	5	$0.00	$199,701.50	$0.00	$8.64	0.00%	0.00% - 0.00%
Transportation and Accommodations	0	0	48	$0.00	$37,152.84	$0.00	$17.96	0.00%	0.00% - 0.00%
Total	**256**	**251**	**11,374**	**$390,178.90**	**$39,294,795.96**	**$70.05**	**$4,993.84**	**1.40%**	**1.12% - 1.68%**

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 T12. Summary of CHIP FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	2,330	$3,556,043.52	$858.56	$794.55	$922.57
Non-covered Service/Beneficiary Error (DP2)	15	$37,665.71	$4.31	$1.42	$7.21
Administrative/Other Error (DP12)	5	$242.40	$1.95	$0.17	$3.72
Pricing Error (DP5)	24	$18,111.48	$1.21	$0.17	$2.25
Third-Party Liability Error (DP4)	4	$8,770.91	$0.69	-$0.23	$1.61
Duplicate Claim Error (DP1)	8	$130.50	$0.50	-$0.02	$1.02
Data Processing Technical Deficiency (DTD)	191	$0.00	$0.00	$0.00	$0.00
Total	**2,577**	**$3,620,964.52**	**$867.22**	**$803.12**	**$931.32**

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

Table T13. Summary of CHIP FFS Data Processing Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	2,330	$3,556,043.52	$858.56	$794.55	$922.57
Non-covered Service/Beneficiary Error (DP2)	15	$37,665.71	$4.31	$1.42	$7.21
Administrative/Other Error (DP12)	5	$242.40	$1.95	$0.17	$3.72
Pricing Error (DP5)	17	$2,291.21	$0.87	-$0.08	$1.82
Third-Party Liability Error (DP4)	4	$8,770.91	$0.69	-$0.23	$1.61
Duplicate Claim Error (DP1)	8	$130.50	$0.50	-$0.02	$1.02
Data Processing Technical Deficiency (DTD)	191	$0.00	$0.00	$0.00	$0.00
Total	**2,570**	**$3,605,144.25**	**$866.88**	**$802.79**	**$930.97**

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)

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

Table T14. Summary of CHIP FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	7	$15,820.27	$0.34	-$0.09	$0.77
Total	**7**	**$15,820.27**	**$0.34**	**-$0.09**	**$0.77**

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

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

Table T15. CHIP FFS Specific Causes of Provider Information/Enrollment Error (DP10)

Error Category	Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Screening	Provider not appropriately screened using risk based criteria	1,676	$1,693,721.81	$691.14	$634.98	$747.31
National Provider Identifier (NPI)	ORP NPI required, but not listed on claim	384	$1,755,674.66	$81.11	$65.65	$96.58
	Billing provider NPI required, but not listed on claim	59	$24,129.65	$19.87	$12.47	$27.28
	Attending or rendering provider NPI required, but not listed on claim	16	$2,578.17	$4.33	$1.31	$7.35
Missing Provider Information	Other missing provider information	59	$24,253.59	$33.21	$20.92	$45.49
	Missing provider risk based screening information	90	$26,298.68	$4.67	$3.46	$5.88
	Missing provider enrollment information	1	$62.57	$0.15	N/A	N/A
Provider Enrollment	Provider not enrolled	44	$29,080.74	$24.02	-$5.39	$53.44
Provider License/Certification	Provider license not current for DOS	1	$243.66	$0.05	N/A	N/A
Total	**Total**	**2,330**	**$3,556,043.52**	**$858.56**	**$794.55**	**$922.57**

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 T16. DP10 CHIP FFS Errors: NPI Required But Not Listed on Claim Breakdown

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	1
	Wrong NPI on the claim	1
Billing	No NPI on the claim	58
	Wrong NPI on the claim	1
ORP	No NPI on the claim	371
	Wrong NPI on the claim	13
Rendering	No NPI on the claim	9
	Wrong NPI on the claim	5

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors

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 Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Revalidated	1,168
	Newly Enrolled	598
Provider Risk Level	Limited	1,690
	High	44
	Moderate	32
Provider Type	Billing	1,169
	Rendering	409
	ORP	188
	Attending	1
Screening Elements Not Completed	No required databases checked	1,143
	SAM/EPLS not checked	262
	LEIE not checked	247
	DMF not checked	244
	NPPES not checked	144
	On-site not conducted	71
	FCBC not conducted	42

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 T18. DP10 CHIP Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Number of Errors
ORP	23
Billing	18
Attending	3
Rendering	1

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

CHIP FFS Data Processing Errors by Service Type

Table T19. CHIP FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Dental and Oral Surgery Services	755	682	1,531	$203,035.60	$391,305.56	$231.47	$655.91	35.29%	23.64% - 46.94%
Psychiatric, Mental Health, and Behavioral Health Services	656	307	1,849	$300,653.11	$3,148,712.22	$140.85	$839.80	16.77%	15.01% - 18.53%
Prescribed Drugs	476	450	2,370	$1,790,839.18	$11,064,306.71	$86.03	$897.72	9.58%	7.43% - 11.74%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	294	216	854	$38,720.91	$273,295.27	$58.94	$236.05	24.97%	20.14% - 29.80%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	69	60	730	$11,637.37	$302,803.93	$33.31	$463.45	7.19%	3.80% - 10.57%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	93	62	195	$9,854.04	$23,967.72	$30.08	$85.53	35.17%	22.05% - 48.29%
Inpatient Hospital Services	21	21	915	$755,383.67	$20,551,188.67	$13.28	$671.54	1.98%	0.25% - 3.70%
Personal Support Services	92	76	192	$18,848.66	$58,250.19	$10.60	$56.51	18.75%	12.06% - 25.45%
Clinic Services	32	27	704	$5,017.73	$187,572.15	$8.94	$378.10	2.36%	1.20% - 3.52%
Home Health Services	15	14	32	$7,993.46	$13,869.60	$6.60	$17.41	37.93%	17.31% - 58.55%
Outpatient Hospital Services	22	21	895	$21,629.72	$2,068,892.30	$1.90	$365.87	0.52%	0.13% - 0.91%
Durable Medical Equipment (DME) and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	10	9	95	$19,903.48	$84,816.60	$1.16	$41.22	2.82%	0.02% - 5.63%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
Capitated Care/Fixed Payments	22	22	344	$53,997.59	$709,569.91	$0.99	$200.43	0.49%	0.34% - 0.64%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	6	4	12	$46,917.61	$145,718.97	$0.43	$1.79	24.11%	(0.57%) - 48.79%
Laboratory, X-ray and Imaging Services	9	8	134	$12.31	$22,275.04	$0.17	$49.85	0.34%	(0.11%) - 0.80%
Transportation and Accommodations	3	3	48	$493.52	$37,152.84	$0.12	$17.96	0.65%	(0.22%) - 1.51%
Crossover Claims	2	2	50	$95.53	$2,399.87	$0.00	$1.65	0.03%	(0.01%) - 0.06%
Denied Claims	0	0	417	$0.00	$52.67	$0.00	$3.78	0.00%	0.00% - 0.00%
Hospice Services	0	0	2	$0.00	$8,944.25	$0.00	$0.62	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	0	0	5	$0.00	$199,701.50	$0.00	$8.64	0.00%	0.00% - 0.00%
Total	**2,577**	**1,984**	**11,374**	**$3,285,033.49**	**$39,294,795.96**	**$624.86**	**$4,993.84**	**12.51%**	**11.71% - 13.31%**

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 T20. Summary of CHIP Managed Care Data Processing Projected Federal Dollars by Type of Error

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-covered Service/Beneficiary Error (DP2)	8	$1,456.19	$57.36	-$19.20	$133.92
Managed Care Payment Error (DP9)	1	$327.95	$38.97	N/A	N/A
Total	**9**	**$1,784.14**	**$96.33**	**$2.64**	**$190.03**

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

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

Table T21. CHIP Managed Care Specific Causes of Non-covered Service/Beneficiary Error (DP2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Beneficiary was ineligible for the applicable program on the DOS	8	$1,456.19	$57.36	-$19.20	$133.92
Total	**8**	**$1,456.19**	**$57.36**	**-$19.20**	**$133.92**

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: Managed Care Payment Error (DP9)

Table T22. CHIP Managed Care Specific Causes of Managed Care Payment Error (DP9)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Rate programming error	1	$327.95	$38.97	N/A	N/A
Total	**1**	**$327.95**	**$38.97**	**N/A**	**N/A**

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.

CHIP Eligibility Review Errors by Eligibility Category

Table T23. 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% CI
MAGI									
MAGI Total	**4,496**	**3,835**	**10,244**	**$3,391,439.29**	**$15,762,487.65**	**$4,845.69**	**$16,876.65**	**28.71%**	**26.58% - 30.85%**
MAGI - CHIP	2,260	1,939	5,541	$1,960,552.68	$7,351,444.69	$2,768.42	$10,853.48	25.51%	22.38% - 28.63%
MAGI - Medicaid CHIP Expansion	2,094	1,772	4,148	$1,251,318.22	$7,181,020.61	$1,977.71	$5,474.90	36.12%	33.80% - 38.45%
Unborn Child	39	34	184	$112,476.51	$521,459.53	$58.24	$329.57	17.67%	9.40% - 25.94%
MAGI - Pregnant Woman	41	31	56	$2,405.42	$281,232.14	$21.22	$56.10	37.82%	17.75% - 57.90%
MAGI - Children under Age 19	18	16	63	$11,587.19	$36,385.47	$11.34	$53.93	21.03%	7.79% - 34.28%
Unborn Child (Undocumented Pregnant Women)	43	42	242	$42,400.97	$357,337.51	$8.32	$104.01	8.00%	4.02% - 11.97%
Presumptive Eligibility	1	1	8	$10,698.30	$32,717.24	$0.44	$2.84	15.44%	(13.12%) - 43.99%
1115 Waiver Programs	0	0	1	$0.00	$86.14	$0.00	$1.67	0.00%	0.00% - 0.00%
Emergency Services (Including for Non-Citizens)	0	0	1	$0.00	$804.32	$0.00	$0.16	0.00%	0.00% - 0.00%
Non-MAGI									
Non-MAGI Total	**5**	**2**	**12**	**$177.69**	**$25,390.36**	**$0.32**	**$2.82**	**11.24%**	**11.24% - 11.24%**
Aged, Blind, and Disabled - Mandatory Coverage	4	1	3	$177.69	$826.00	$0.32	$1.00	31.53%	31.53% - 31.53%
Home and Community-Based Services	0	0	1	$0.00	$161.53	$0.00	$0.07	0.00%	0.00% - 0.00%
Newborn	0	0	2	$0.00	$20,642.78	$0.00	$0.37	0.00%	0.00% - 0.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% CI
SSI Recipients	0	0	1	$0.00	$3,567.98	$0.00	$0.08	0.00%	0.00% - 0.00%
Transitional Medicaid	1	1	2	$0.00	$155.23	$0.00	$0.95	0.00%	0.00% - 0.00%
Other (None of the Above)	0	0	3	$0.00	$36.84	$0.00	$0.36	0.00%	0.00% - 0.00%

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

CHIP Eligibility Review Federal Improper Payments

Table T24. Summary of CHIP Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	1,325	$1,122,806.95	$2,454.55	$2,112.96	$2,796.13
Documentation to Support Eligibility Determination Not Maintained (ER1)	581	$717,242.88	$889.69	$715.22	$1,064.16
Determination Not Conducted as Required (ER3)	540	$594,975.85	$788.52	$667.44	$909.61
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	499	$916,271.92	$769.41	$620.96	$917.86
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	153	$118,334.23	$308.16	$231.64	$384.68
Not Eligible for Enrolled Program - Financial Issue (ER4)	57	$193,296.38	$90.72	$49.59	$131.84
Other Errors (ER10)	22	$3,269.75	$60.18	$30.39	$89.97
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	4	$23,648.88	$12.35	-$1.69	$26.39
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	120	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	1,200	$0.00	$0.00	$0.00	$0.00
Total	**4,501**	**$3,689,846.84**	**$5,373.58**	**$4,952.27**	**$5,794.89**

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. 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 T25. Summary of CHIP Eligibility Review – MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	1,324	$1,122,629.26	$2,454.23	$2,112.66	$2,795.80
Documentation to Support Eligibility Determination Not Maintained (ER1)	581	$717,242.88	$889.69	$717.12	$1,062.26
Determination Not Conducted as Required (ER3)	540	$594,975.85	$788.52	$667.44	$909.61
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	499	$916,271.92	$769.41	$620.96	$917.86
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	153	$118,334.23	$308.16	$231.64	$384.68
Not Eligible for Enrolled Program - Financial Issue (ER4)	57	$193,296.38	$90.72	$49.59	$131.84
Other Errors (ER10)	22	$3,269.75	$60.18	$30.39	$89.97
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	4	$23,648.88	$12.35	-$1.69	$26.39
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	120	$0.00	$0.00	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	1,196	$0.00	$0.00	$0.00	$0.00
Total	**4,496**	**$3,689,669.15**	**$5,373.26**	**$4,952.75**	**$5,793.78**

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 T26. Summary of CHIP Eligibility Review – Non-MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	1	$177.69	$0.32	N/A	N/A
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	4	$0.00	$0.00	$0.00	$0.00
Total	**5**	**$177.69**	**$0.32**	**-$0.30**	**$0.94**

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 T27. 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	2,789	$2,621,095.77	$2,718.48	$2,430.39	$3,006.58
System	1,095	$594,227.67	$1,393.40	$1,237.31	$1,549.50
Unable to Determine	534	$392,381.32	$741.15	$581.98	$900.32
Policy	66	$64,599.90	$483.18	$233.21	$733.16
Multiple	17	$17,542.18	$37.36	$9.71	$65.01
Total	**4,501**	**$3,689,846.84**	**$5,373.58**	**$4,952.27**	**$5,794.89**

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 T28. 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	3,007	2,572	6,647	$1,932,415.67	$3,195.26	29.07%	26.19% - 31.94%
Change	664	540	1,576	$300,362.04	$849.84	27.87%	23.45% - 32.30%
Application	739	634	1,897	$1,024,029.70	$685.16	25.37%	21.74% - 29.01%
Unknown	85	85	85	$103,371.31	$111.22	100.00%	100.00% - 100.00%
Not Applicable	6	6	51	$31,438.26	$4.53	17.39%	4.14% - 30.64%
Total	**4,501**	**3,837**	**10,256**	**$3,391,616.98**	**$4,846.00**	**28.71%**	**26.57% - 30.85%**

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. A case action of "Not Applicable" applies to cases where eligibility happens automatically. Examples include Title IV-E cases and SSI cases in 1634 states. A case action of "Unknown" applies to cases where the type of action is not able to be determined. An example includes where an application or renewal is missing completely from the case file.

Table T29. 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	2,405	2,072	5,459	$276,924.07	$3,374.04	28.79%	26.18% - 31.40%
FFS	2,096	1,765	4,797	$3,114,692.91	$1,471.96	28.52%	24.81% - 32.23%
Total	**4,501**	**3,837**	**10,256**	**$3,391,616.98**	**$4,846.00**	**28.71%**	**26.57% - 30.85%**

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/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Table T30. Specific Causes of Verification/Documentation Not Done/Collected at the Time of Determination Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Signature not obtained	321	$333,798.35	$960.30	$646.15	$1,274.45
Income verification not on file/incomplete	614	$478,548.22	$767.28	$636.65	$897.90
TPL verification not on file/incomplete	126	$117,241.25	$251.57	$184.06	$319.07
Residency not verified	127	$95,700.07	$232.06	$189.19	$274.93
Discrepant information not acted upon	59	$35,718.88	$132.04	$70.44	$193.63
Other element not verified	15	$4,970.24	$31.76	$10.48	$53.04
Social Security Number not verified	15	$1,759.66	$20.91	$8.22	$33.61
Eligibility process(es) not followed	16	$6,785.80	$17.73	$4.35	$31.10
Household composition/tax filer status not verified	9	$1,499.65	$12.98	$3.13	$22.84
Citizenship not verified	4	$638.52	$7.20	-$0.19	$14.60
Demographic verification not on file/incomplete	5	$537.82	$4.87	-$0.01	$9.76
Identity not verified	2	$169.09	$4.48	-$1.85	$10.81
Immigration status not verified	4	$3,640.70	$4.22	-$0.56	$9.00
Age not verified	1	$180.89	$3.34	N/A	N/A
Resources verification not on file/incomplete	6	$41,250.27	$3.01	-$0.54	$6.57
Level of care not verified	1	$367.54	$0.80	N/A	N/A
Total	**1,325**	**$1,122,806.95**	**$2,454.55**	**$2,112.96**	**$2,796.13**

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.

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

Table T31. Specific Causes of Documentation to Support Eligibility Determination Not Maintained Error (ER1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	188	$178,521.44	$341.29	$201.96	$480.61
Other required forms not on file/incomplete	189	$200,195.14	$244.16	$198.79	$289.53
Signature not on file	134	$185,829.69	$182.10	$99.80	$264.40
Residency verification not on file/incomplete	25	$19,474.61	$40.96	$25.05	$56.87
Documentation clarifying discrepant information not on file/incomplete	2	$2,800.77	$30.38	-$21.82	$82.58
Application/Renewal form not on file	31	$123,591.68	$20.16	$10.12	$30.20
Citizenship verification not on file	3	$622.57	$10.03	-$3.23	$23.29
Social Security Number verification not on file	2	$437.32	$7.96	-$4.63	$20.56
Age verification not on file/incomplete	1	$311.34	$6.17	N/A	N/A
TPL verification not on file/incomplete	2	$413.69	$3.89	-$1.73	$9.51
Demographic verification not on file/incomplete	1	$140.61	$0.94	N/A	N/A
Household composition/tax filer status not on file/incomplete	1	$682.00	$0.83	N/A	N/A
Other verification not on file/incomplete	2	$4,222.02	$0.83	-$0.39	$2.04
Total	**581**	**$717,242.88**	**$889.69**	**$715.22**	**$1,064.16**

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

Section 4: Error Codes

Table A1. Medical Review Error Codes

Error Code	Error	Definition
MR1	No Documentation Error	The provider failed to respond to requests for the medical records or the provider responded that he or she did not have the requested documentation. The provider did not send any documentation related to the sampled payment.
MR2	Document(s) Absent from Record	Claim errors are placed into this category when the submitted medical documentation is missing required information, making the record insufficient to support payment for the services billed. The provider submitted some documentation, but the documentation is inconclusive to support the billed service. Based on the medical records provided, the reviewer could not conclude that some of the allowed services were provided at the level billed and/or medically necessary. Additional documentation was not submitted.
MR3	Procedure Coding Error	The reviewer determines that the medical service, treatment, and/or equipment was medically necessary and was provided at a proper level of care, but billed and paid based on a wrong procedure code.
MR4	Diagnosis Coding Error	According to the medical record, the principal diagnosis code was incorrect or the DRG paid was incorrect and resulted in a payment error.
MR5	Unbundling Error	Unbundling includes instances where a set of medical services was provided and billed as separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set rather than as individual services.
MR6	Number of Unit(s) Error	An incorrect number of units was billed.
MR7	Medically Unnecessary Service Error	There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary. There is affirmative evidence that shows there was an improper diagnosis or deficient treatment plan reasonably connected to the provision of unnecessary medical services or treatment plan for an illness/injury not applicable to improving a patient's condition.
MR8	Policy Violation Error	A policy is in place regarding the service or procedure performed, and medical review indicates that the service or procedure in the record is inconsistent with the documented policy.
MR9	Improperly Completed Documentation	Required forms and documents are present, but are inadequately completed to verify that the services were provided in accordance with policy or regulation.
MR10	Administrative/Other Error	Medical review determined a payment error, but does not fit into one of the other medical review error categories.
MTD	Medical Technical Deficiency	Medical review determined a deficiency that did not result in a payment error. DOS billing errors are included as deficiencies when the DOS on the record is less than 7 days prior to or after the DOS on the claim.

Table A2. Data Processing Error Codes

Error Code	Error	Definition
DP1	Duplicate Claim Error	The sampled line item/claim or capitation payment is an exact duplicate of another line item/claim or capitation payment that was previously paid. Services on a sampled claim conflict with services on another claim during the same DOS.
DP2	Non-covered Service/Beneficiary Error	The state's policy indicates that the service billed on the sampled claim is not payable by the Medicaid program or CHIP and/or the financial system reflects incorrect beneficiary eligibility status for the coverage category for the service.
DP3	FFS Payment for a Managed Care Service Error	The beneficiary is enrolled in an MCO that includes the service on the sampled claim under capitated benefits, but the state inappropriately paid for the sampled service.
DP4	Third-Party Liability Error	Medicaid/CHIP paid the service on the sampled claim as the primary payer, but a third-party carrier should have paid for the service.
DP5	Pricing Error	The payment for the service does not correspond with the pricing schedule on file and in effect for the DOS on the claim.
DP6	System Logic Edit Error	The system did not contain the edit that was necessary to properly administer state policy or the system edit was in place, but was not working correctly and the sampled line item/claim was paid inappropriately.
DP7	Data Entry Error	The sampled line item/claim was paid in error due to clerical errors in the data entry of the claim.
DP8	Managed Care Rate Cell Error	The beneficiary was enrolled in managed care on the sampled DOS and assigned to an incorrect rate cell, resulting in payment made according to the wrong rate cell.
DP9	Managed Care Payment Error	The beneficiary was enrolled in managed care and assigned to the correct rate cell, but the amount paid for that rate cell was incorrect.
DP10	Provider Information/Enrollment Error	The provider was not enrolled in Medicaid/CHIP according to federal regulations and state policy or required provider information was missing from the sampled claim.
DP11	Claim Filed Untimely Error	The sampled claim was not filed in accordance with the timely filing requirements defined by state policy.
DP12	Administrative/Other Error	A payment error was discovered during data processing review, but the error was not a DP1 – DP11 error.
DTD	Data Processing Technical Deficiency	A deficiency was found during data processing review that did not result in a payment error.

Table A3. Eligibility Error Codes

Error Code	Error	Definition
ER1	Documentation to Support Eligibility Determination Not Maintained	The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicated that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.
ER2	Verification/Documentation Not Done/Collected at the Time of Determination	The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.
ER3	Determination Not Conducted as Required	The state could not provide evidence the state conducted an eligibility determination or the state completed an eligibility determination that was not in accordance with timeliness standards (does not apply to application timely processing) defined in federal regulation.
ER4	Not Eligible for Enrolled Program – Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the financial elements of the eligibility determination.
ER5	Not Eligible for Enrolled Program – Non-Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the non-financial elements of the eligibility determination.
ER6	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP)	The beneficiary is not eligible for the enrolled program (i.e., Medicaid or CHIP), but is eligible for the other program.
ER7	Not Eligible for Enrolled Eligibility Category – Incorrect FMAP Assignment	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.
ER8	Not Eligible for Enrolled Eligibility Category – Ineligible for Service	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category, which results in the individual receiving services for which they were not eligible.
ER9	FFE-D Error	Not applicable to states; used for errors when the FFE incorrectly determined eligibility for the beneficiary.
ER10	Other Errors	The beneficiary is improperly denied or terminated, or the contribution to care calculation is incorrectly calculated.
ERTD1	Incorrect Case Determination, But There was No Payment on Claim	The beneficiary is ineligible for any of the reasons cited in the ER1 – ER10, but no payment was made for the claim.
ERTD2	Finding Noted with Case, But Did Not Affect Determination or Payment	The state incorrectly applied federal or state regulations; federal policy or procedure; or made an error during the eligibility determination; however, the beneficiary remains eligible for the enrolled program or category.

Table A4. 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 another occurrence of the same thing 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 sub-regulation 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 policy and took all relevant actions, and state policy was in compliance with federal policy. Something unrelated to these areas that led to this finding.
Unable to Determine	The ERC is unable to determine what led to this error, but the determination was incorrect.

Table A5. Acronym Glossary

Acronym	Definition
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
DMF	Death Master File
DOS	Date Of Service
DP	Data Processing
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
ER	Eligibility Review
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
HIPAA	Health Insurance Portability and Accountability Act
ICF	Intermediate Care Facility
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IP	Improper Payment
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
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
PA	Prior Authorization
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Measurement
POC	Plan Of Care
QMB	Qualified Medicare Beneficiary
RBS	Risk-Based Screening

Acronym	Definition
SAM/EPLS	System for Award Management/Excluded Parties List System
SLMB	Specified Low - Income Medicare Beneficiary
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TD	Technical Deficiency
TPL	Third-Party Liability

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2021 HHS AFR.