2025 Medicaid & CHIP Supplemental Improper Payment Data

January 2026

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 2025 improper payment rate (i.e., Cycle 1) are in **bold**.

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

Year	Fee-For-Service (FFS)	Managed Care (MC)	Eligibility*	Overall**
2007 - Cycle 1	4.7%	N/A	N/A	**N/A**
2008 - Cycle 2	8.9%	3.1%	2.9%	**10.5%**
2009 - Cycle 3	2.6%	0.1%	6.7%	**8.7%**
2010 - Cycle 1	1.9%	0.1%	7.6%	**9.0%**
2011 - Cycle 2	3.6%	0.5%	4.0%	**6.7%**
2012 - Cycle 3	3.3%	0.3%	3.3%	**5.8%**
2013 - Cycle 1	3.4%	0.2%	3.3%	**5.7%**
2014 - Cycle 2	8.8%	0.1%	2.3%	**8.2%**
2015 - Cycle 3	18.63%	0.08%	N/A	**N/A**
2016 - Cycle 1	9.78%	0.49%	N/A	**N/A**
2017 - Cycle 2	10.55%	0.38%	N/A	**N/A**
2018 - Cycle 3	23.91%	0.02%	N/A	**N/A**
2019 - Cycle 1*	15.12%	0.00%	20.60%	**26.18%**
2020 - Cycle 2***	12.67%	0.16%	22.32%	**27.47%**
2021 - Cycle 3	13.91%	0.00%	9.27%	**13.68%**
2022 - Cycle 1	3.72%	0.00%	5.36%	**6.64%**
2023 - Cycle 2	5.13%	0.00%	3.90%	**6.26%**
2024 - Cycle 3	5.46%	0.00%	1.53%	**3.17%**
2025 - Cycle 1	2.97%	0.00%	1.17%	**2.30%**

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

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

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the PHE impact, the Cycle 2-specific rates may not be comparable to other cycles.

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

Year	FFS	Managed Care	Eligibility*	Overall**
2012 - Cycle 3	6.9%	0.1%	5.7%	**8.2%**
2013 - Cycle 1	6.1%	0.5%	4.4%	**6.8%**
2014 - Cycle 2	6.2%	0.0%	2.6%	**4.8%**
2015 - Cycle 3	13.13%	0.64%	N/A	**N/A**
2016 - Cycle 1	14.05%	3.75%	N/A	**N/A**
2017 - Cycle 2	7.68%	1.69%	N/A	**N/A**
2018 - Cycle 3	27.77%	0.24%	N/A	**N/A**
2019 - Cycle 1*	15.29%	2.91%	32.97%	**37.75%**
2020 - Cycle 2***	10.67%	1.15%	32.95%	**36.46%**
2021 - Cycle 3	26.07%	0.00%	20.54%	**22.93%**
2022 - Cycle 1	2.44%	0.68%	10.46%	**11.49%**
2023 - Cycle 2	3.82%	1.20%	3.75%	**5.74%**
2024 - Cycle 3	10.97%	0.26%	1.47%	**3.17%**
2025 - Cycle 1	2.68%	1.55%	4.36%	**6.16%**

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

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

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

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach. Due to the PHE impact, the Cycle 2-specific rates may not be comparable to other cycles.

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

Year	FFS	Managed Care	Eligibility*	Overall**
2010 Rolling Rates	4.4%	1.0%	5.9%	**9.4%**
2011 Rolling Rates	2.7%	0.3%	6.0%	**8.1%**
2012 Rolling Rates	3.0%	0.3%	4.9%	**7.1%**
2013 Rolling Rates	3.6%	0.3%	3.3%	**5.8%**
2014 Rolling Rates	5.1%	0.2%	3.1%	**6.7%**
2015 Rolling Rates	10.59%	0.12%	3.11%*	**9.78%**
2016 Rolling Rates	12.42%	0.25%	3.11%*	**10.48%**
2017 Rolling Rates	12.87%	0.30%	3.11%*	**10.10%**
2018 Rolling Rates	14.31%	0.22%	3.11%*	**9.79%**
2019 Rolling Rates	16.30%	0.12%	8.36%	**14.90%**
2020 Rolling Rates***	16.84%	0.06%	14.94%	**21.36%**
2021 Rolling Rates***	13.90%	0.04%	16.62%	**21.69%**
2022 Rolling Rates***	10.42%	0.03%	11.89%	**15.62%**
2023 Rolling Rates	6.90%	0.00%	5.95%	**8.58%**
2024 Rolling Rates	4.83%	0.00%	3.31%	**5.09%**
2025 Rolling Rates****	4.60%	0.00%	4.42%	**6.12%**

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

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

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach.

****The overall estimate includes impact related to “unwinding” of COVID-19 PHE flexibilities. Following the end of the Medicaid continuous enrollment period, states are expected to gradually return to normal operations for beneficiary and provider enrollment/renewal throughout the “unwinding period”. The unwinding period spans from April 1, 2023, to December 31, 2025.

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

Year	FFS	Managed Care	Eligibility*	Overall**
2013 Rolling Rates	5.7%	0.2%	5.1%	**7.1%**
2014 Rolling Rates	6.2%	0.2%	4.2%	**6.5%**
2015 Rolling Rates	7.33%	0.37%	4.22%*	**6.80%**
2016 Rolling Rates	10.15%	1.01%	4.22%*	**7.99%**
2017 Rolling Rates	10.29%	1.62%	4.22%*	**8.64%**
2018 Rolling Rates	12.55%	1.24%	4.22%*	**8.57%**
2019 Rolling Rates	13.25%	1.25%	11.78%	**15.83%**
2020 Rolling Rates***	14.15%	0.49%	23.53%	**27.00%**
2021 Rolling Rates***	13.67%	0.48%	28.71%	**31.84%**
2022 Rolling Rates***	11.23%	0.62%	24.01%	**26.75%**
2023 Rolling Rates	7.09%	0.59%	10.86%	**12.81%**
2024 Rolling Rates	4.72%	0.72%	4.44%	**6.11%**
2025 Rolling Rates****	4.65%	0.94%	5.23%	**7.05%**

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

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

***Due to the COVID-19 PHE, CMS suspended all improper payment-related engagement/communication or data requests to providers and state agencies in April 2020. Effective August 11, 2020, CMS resumed PERM-related engagements with providers and states. CMS determined that, at the time of the PERM suspension, CMS had completed all data and documentation requests necessary to complete national reporting and did not resume any state or provider outreach.

****The overall estimate includes impact related to “unwinding” of COVID-19 PHE flexibilities. Following the end of the Medicaid continuous enrollment period, states are expected to gradually return to normal operations for beneficiary and provider enrollment/renewal throughout the “unwinding period”. The unwinding period spans from April 1, 2023, to December 31, 2025.

Overall 2025 Improper Payment Findings

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

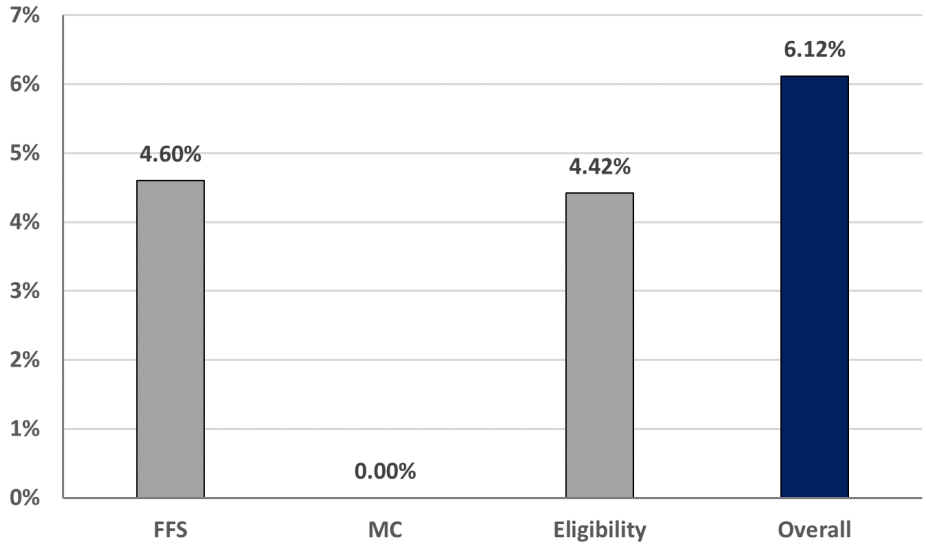


Figure 2. National Rolling CHIP Improper Payment Rate by Component Type

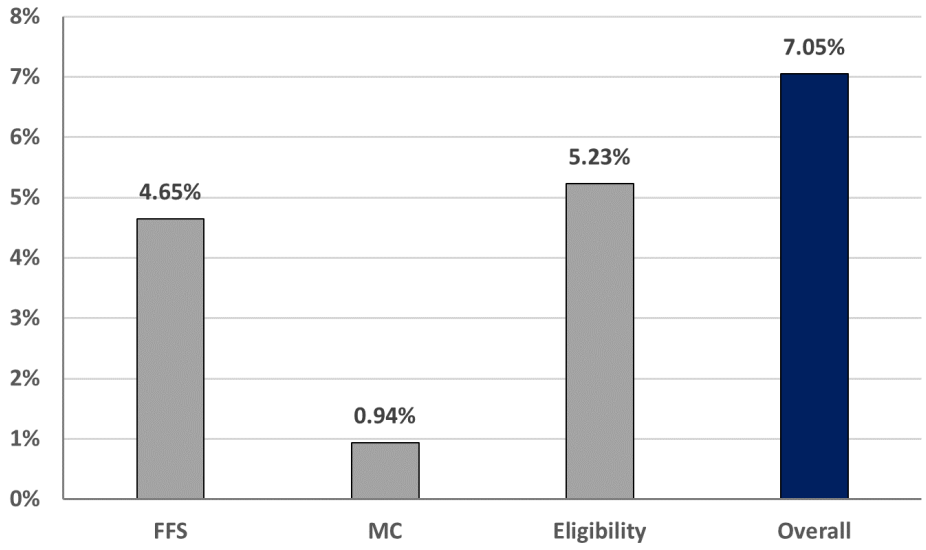


Figure 3. Medicaid Cycle Improper Payments as a Proportion of the National Improper Payments (in Billions)[1]

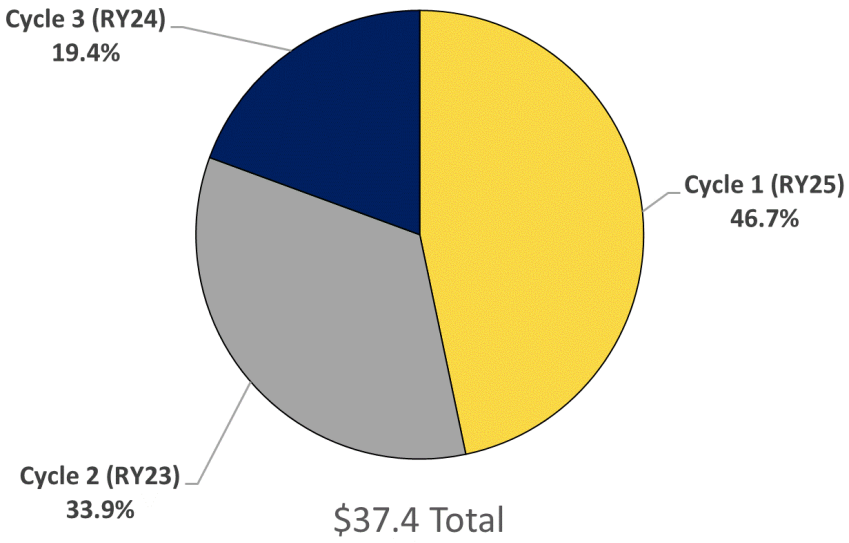
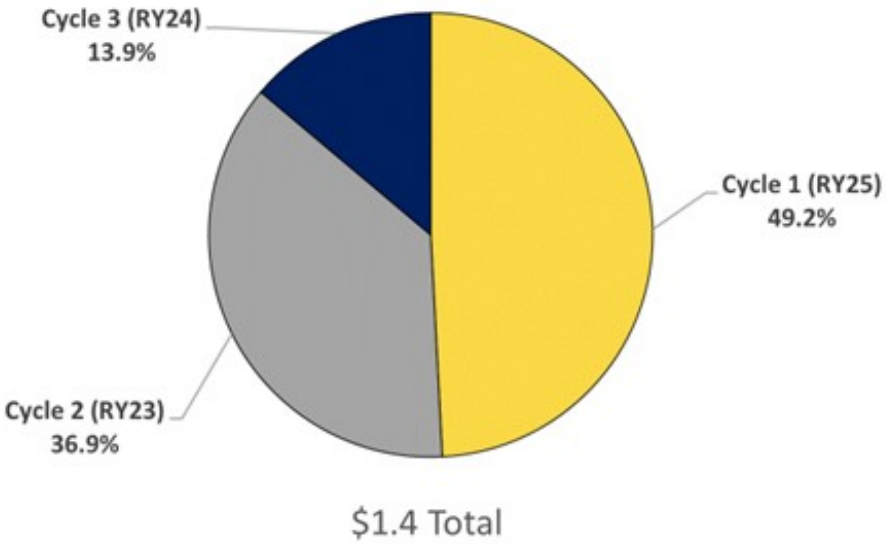


Figure 4. CHIP Cycle Improper Payments as a Proportion of the National Improper Payments (in Billions)[1]



[1] Percentages may not sum to 100.0% due to rounding.

Figure 5. Medicaid Improper Payments by Component Type, Nationally (in Billions)[2]

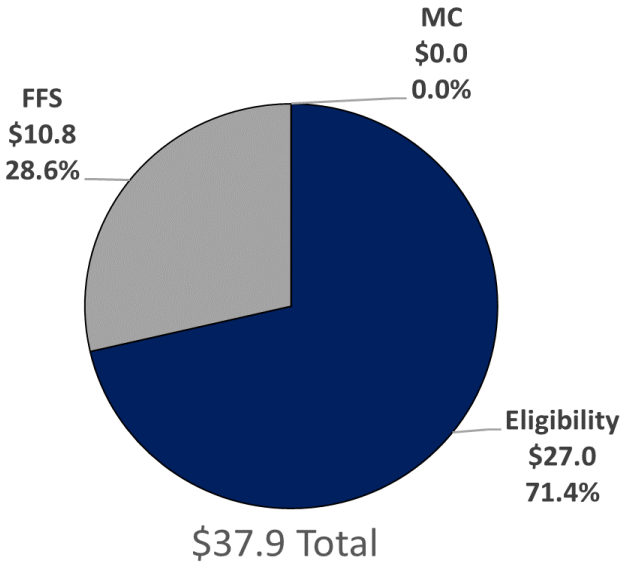
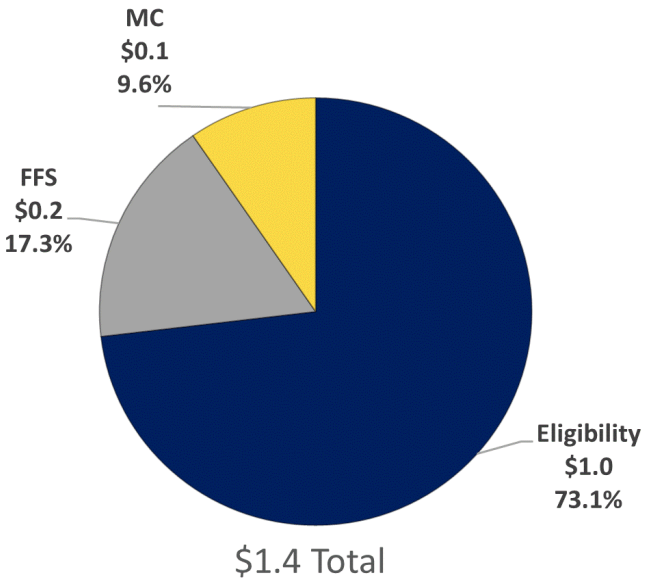


Figure 6. CHIP Improper Payments by Component Type, Nationally (in Billions)[2]



[2] Percentages may not sum to 100.0% due to rounding.

Common Causes of 2025 Improper Payments

Figure 7. Medicaid National Improper Payments by Error Type (Proportional)[3]

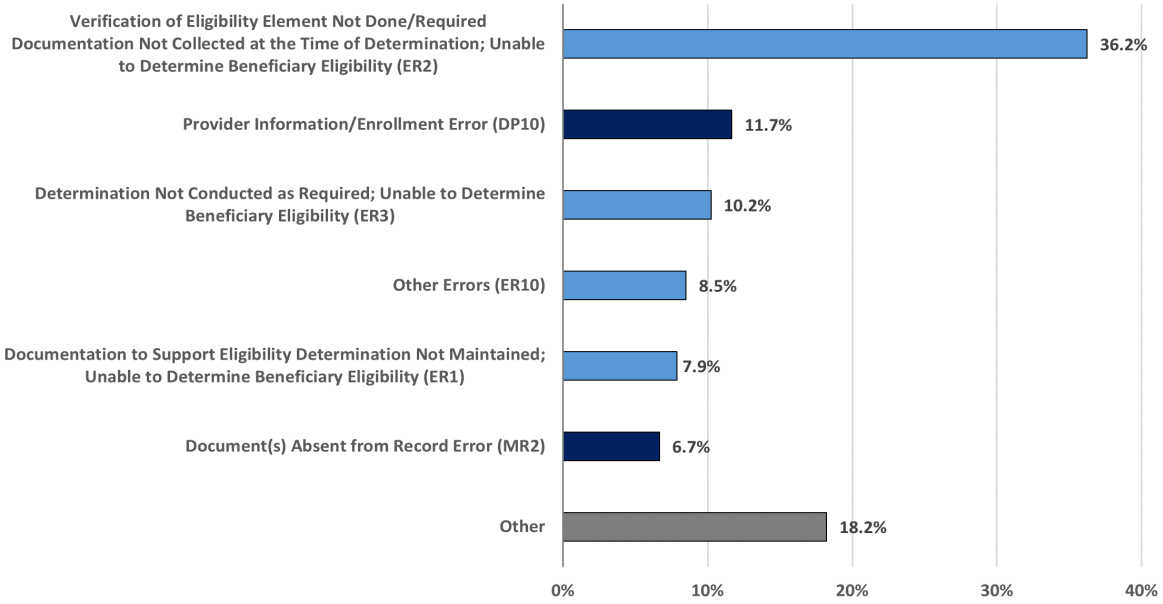
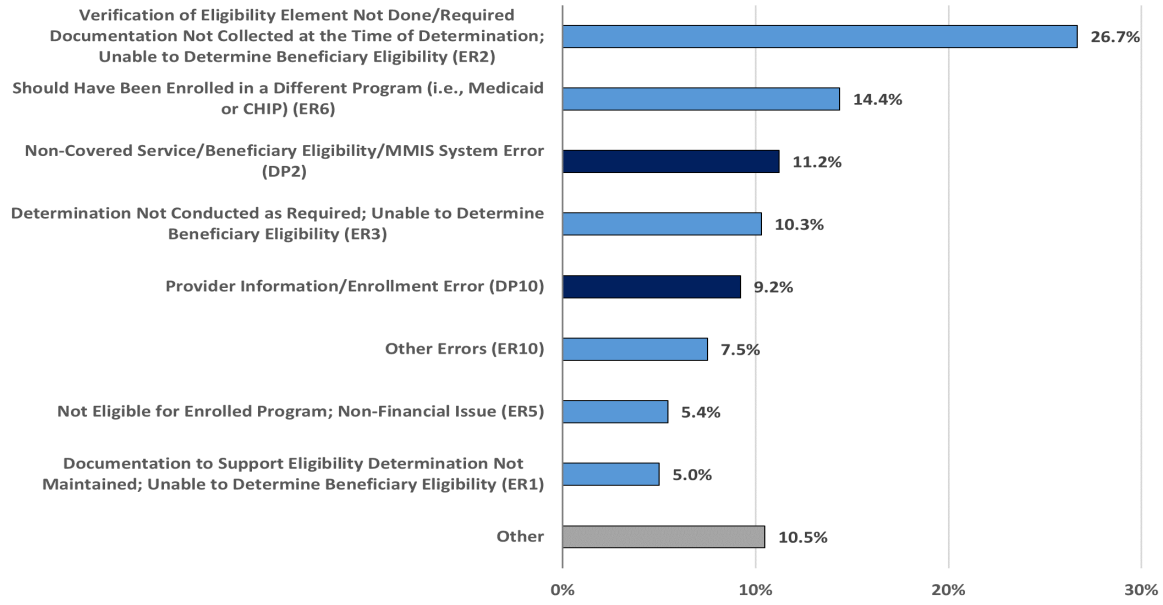


Figure 8. CHIP National Improper Payments by Error Type (Proportional)[3]



[3] Components in the Other error category include those that did not individually account for more than 5.0% of the National Improper Payments. These include, but are not limited to, MR1, ER4, ER5, MR6, and ER6 errors for Medicaid, and MR1, ER4, ER8, and MR2, errors for CHIP. Percentages may not sum to 100.0% due to rounding.

Monetary Loss Findings

Figure 9. Medicaid Improper Payments by Monetary Loss Category (in Millions)[4]

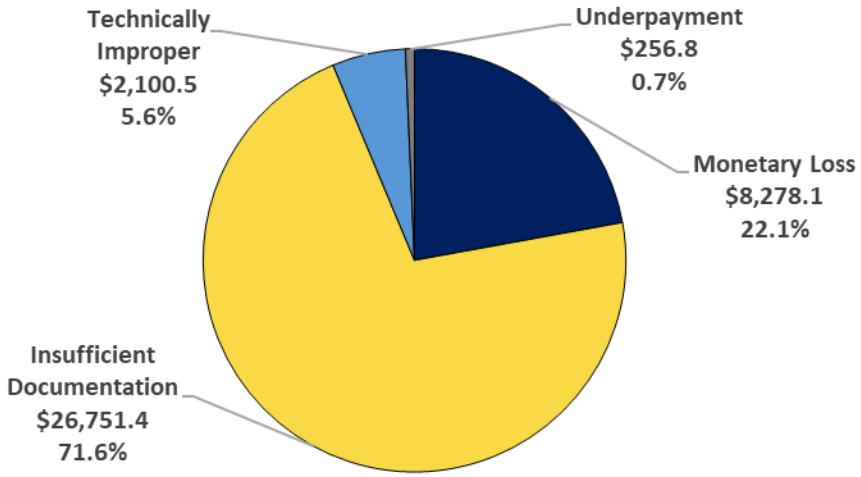
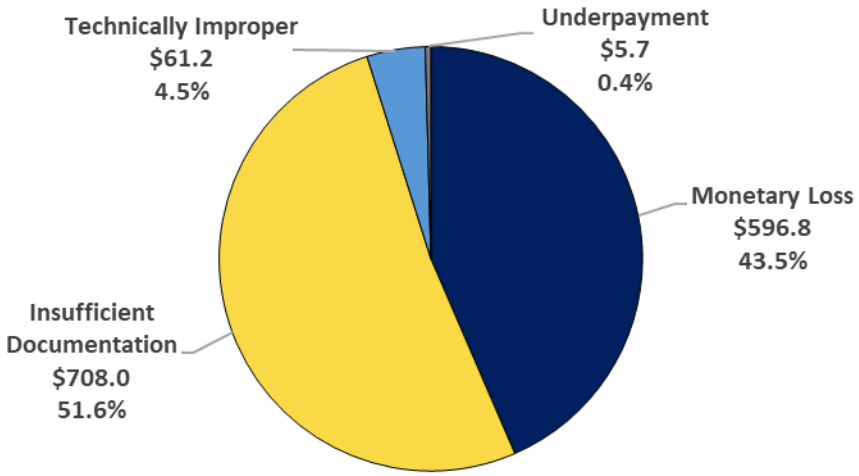


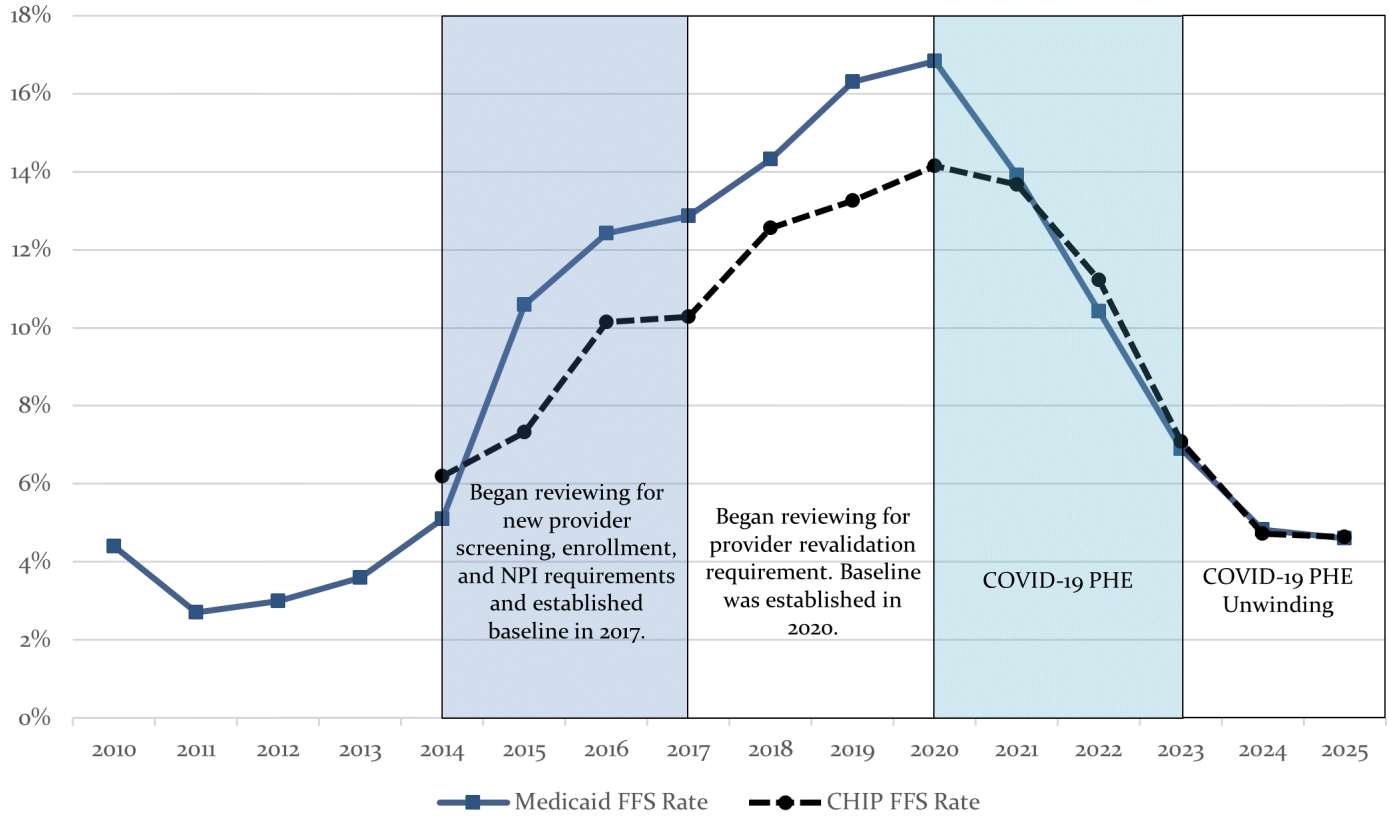
Figure 10. CHIP Improper Payments by Monetary Loss Category (in Millions)[4]



[4] Percentages may not sum to 100.0% due to rounding. In this figure, monetary loss errors are prioritized over insufficient documentation errors, and total dollar amounts are benchmarked to the total improper payments found in Table S1 for Medicaid and T1 for CHIP. In addition, this figure reports Technically Improper Payments, a category included in the AFR and defined further in the "State-Specific Improper Payment Rates …" section of this report. As a result, the methodology used in this figure may be different than that of other figures and tables in this report, which report every improper payment or are tabulated at the claim level. A full breakout of the values in this figure by monetary loss category can be found in Table S2A for Medicaid and T2A for CHIP.

2025 FFS Improper Payment Trends

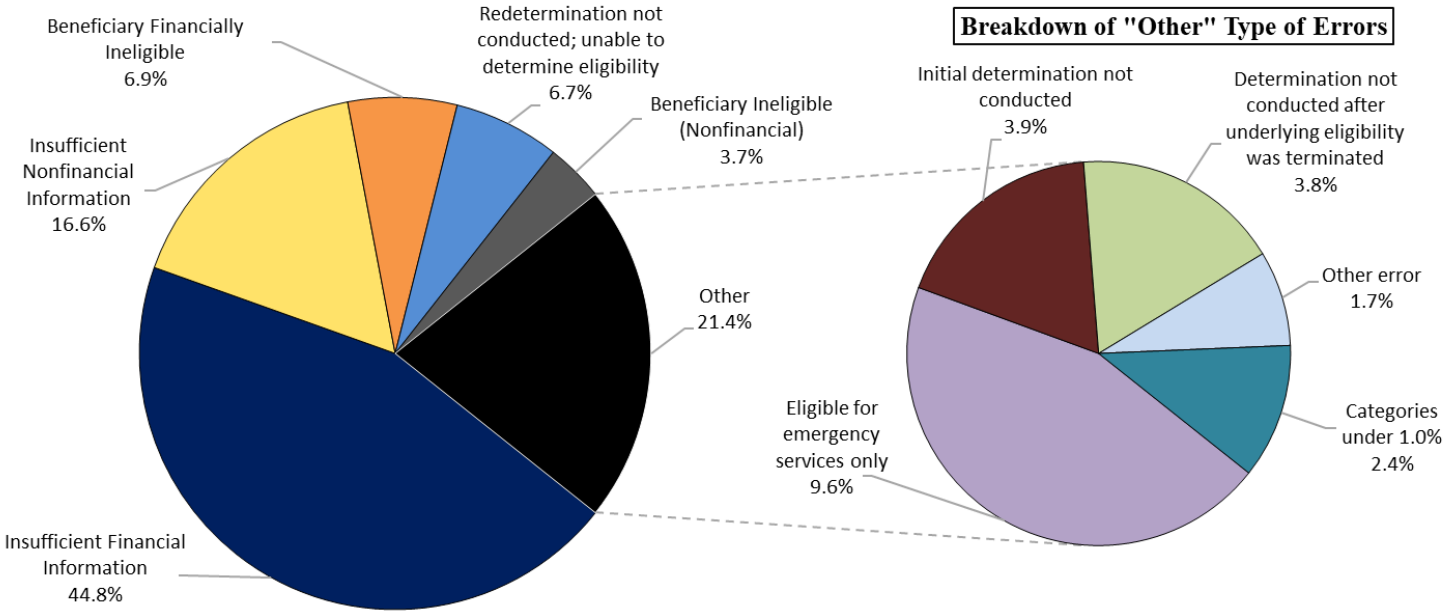
Figure 11. Medicaid and CHIP FFS Improper Payments Timeline Highlighting Key Review Events[5]



[5] Results reported in 2025 still reflect the effects of the PHE, which ended on May 11, 2023.

2025 Eligibility Improper Payment Trends

Figure 12. Medicaid Type of Errors by Percentage of Eligibility Component Improper Payments[6,7,8]

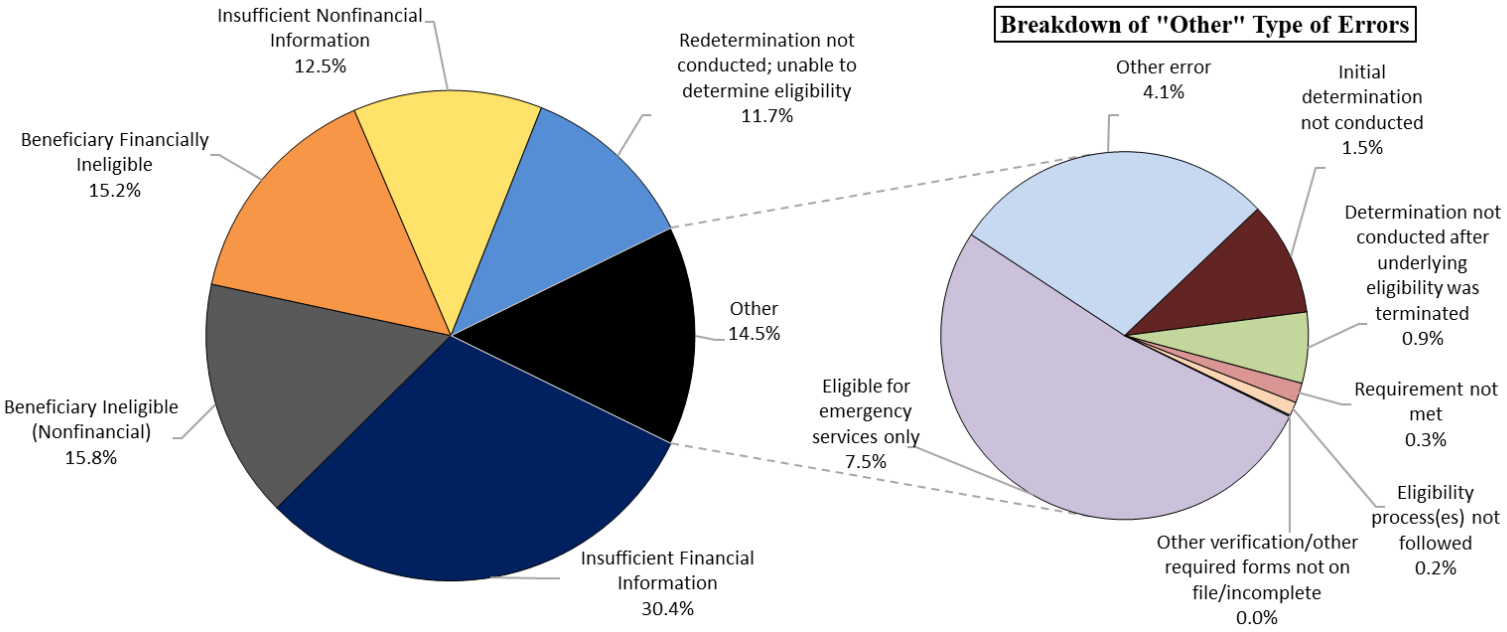


[6] Percentages may not sum to 100.0% due to rounding.

[7] "Categories under 1.0%" includes Contribution to care calculated incorrectly resulting in a partial payment difference, Cost of care incorrect – Beneficiary income, Cost of care incorrect – Maintenance needs allowance spouse/family, Cost of care incorrect – Medical expenses allowed, Cost of care incorrect – Multiple areas, Cost of care incorrect – Personal needs allowance, Cost of care incorrect – SSI SSP benefits, Data entry error, Discrepant information not acted upon, Eligibility process(es) not followed, Income conversion factor incorrect, Income incorrectly calculated, MAGI tax filer/tax dependent status incorrect, Other financial error, Other non-financial error, Other verification/other required forms not on file/incomplete, Requirement not met, and Resources incorrectly calculated.

[8] "Other error" is defined as processes or documentation not followed/maintained that do not fall under other identified categories.

Figure 13. CHIP Type of Errors by Percentage of Eligibility Component Improper Payments[9,10]



[9] Percentages may not sum to 100.0% due to rounding.

[10] "Other error" is defined as processes or documentation not followed/maintained that do not fall under other identified categories.

Figure 14. Medicaid Eligibility Monetary Loss Improper Payment Root Causes[11,12]

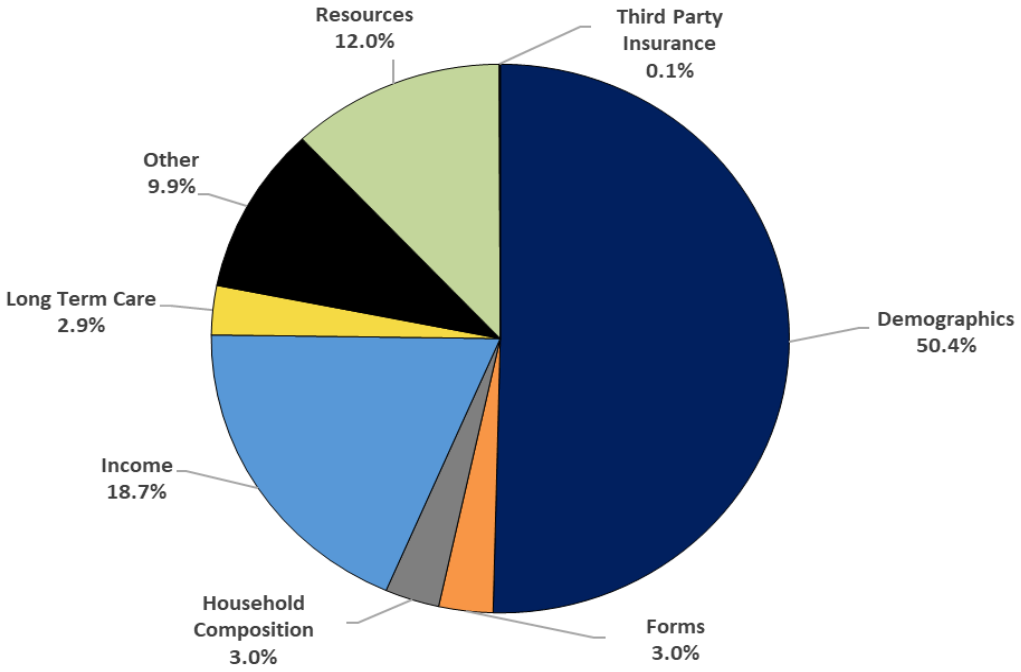
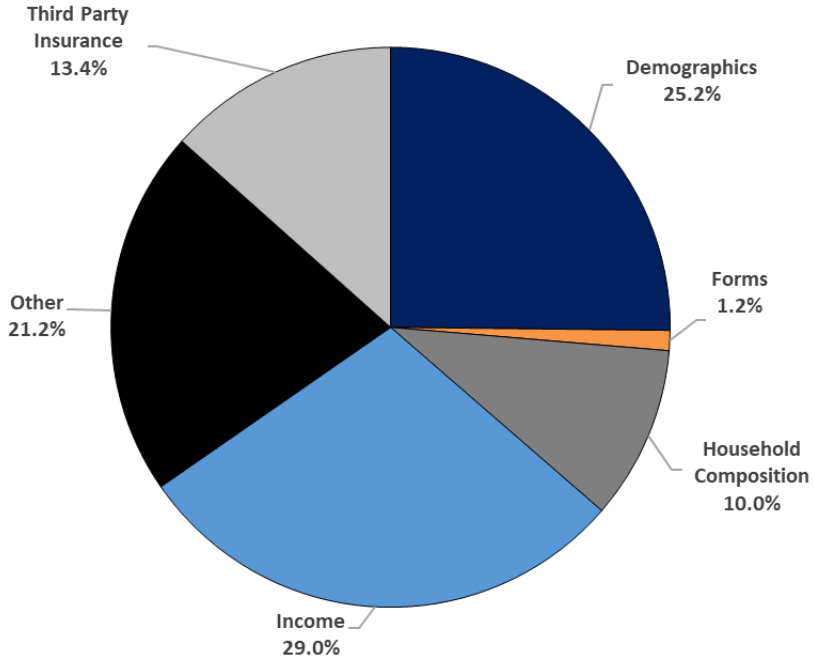


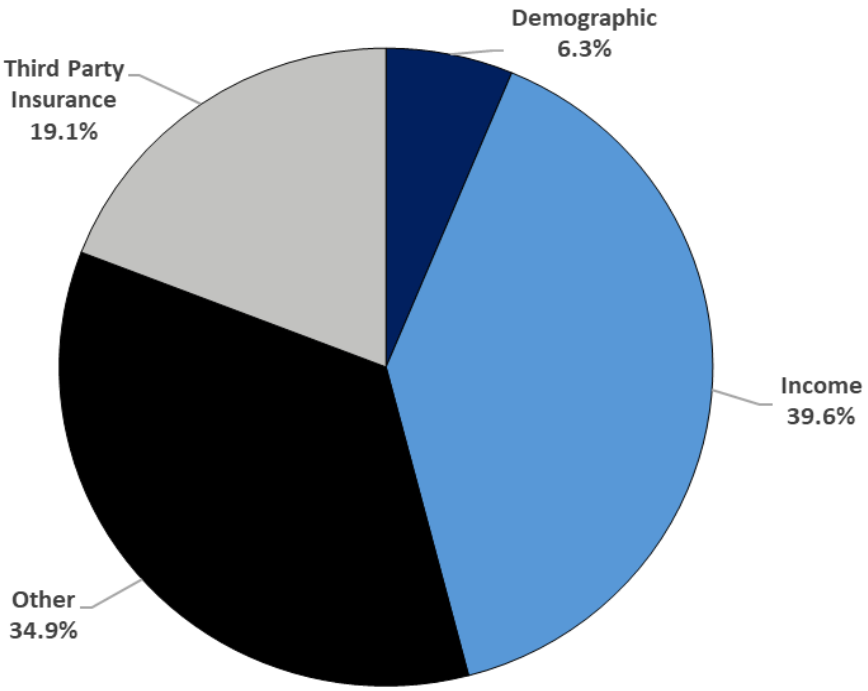
Figure 15. CHIP Eligibility Monetary Loss Improper Payment Root Causes[11,12]



[11] Percentages may not sum to 100.0% due to rounding. Root causes with small improper payments may appear as 0.0% in this figure due to rounding. This figure includes all eligibility monetary loss improper payments.

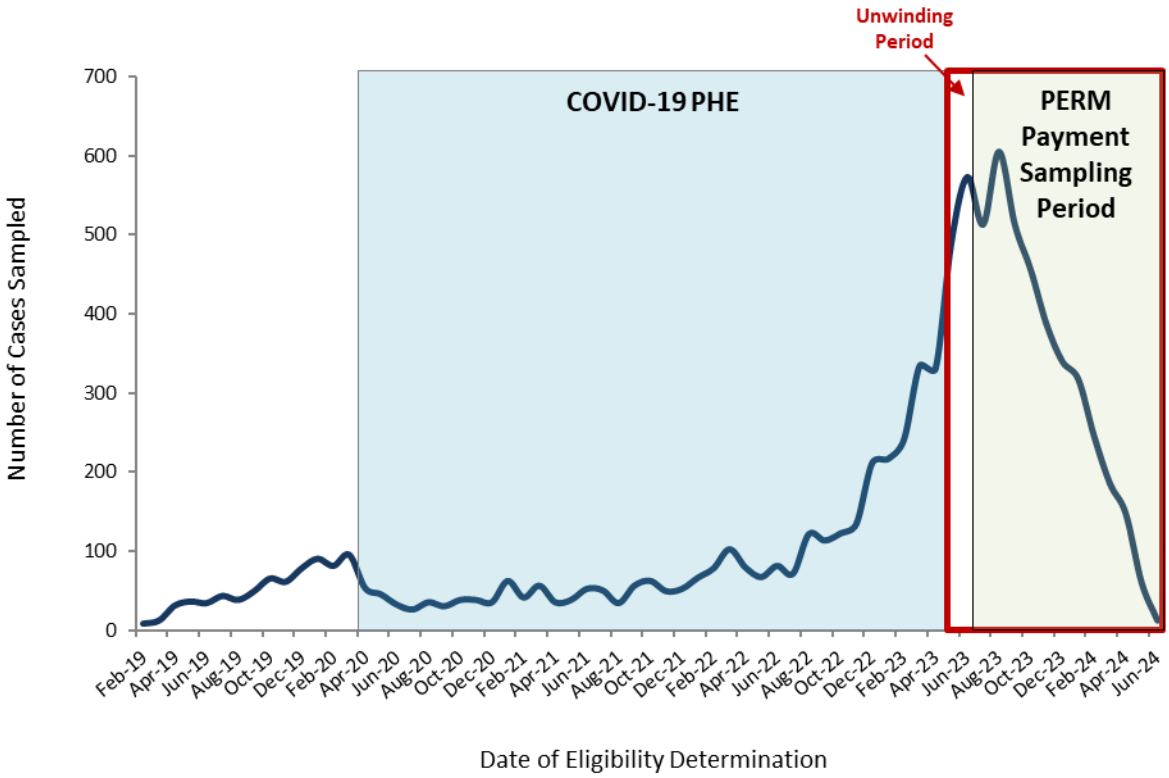
[12] "Other" category includes required documentation and/or processes that were not maintained/performed, which are not covered under the disclosed causes.

Figure 16. CHIP Eligibility Wrong Program Error Root Causes[13]



[13] Percentages may not sum to 100.0% due to rounding. "Wrong Program Errors" included in this figure are findings with error code ER6, Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP). The errors included here are also in the "Beneficiary Financially Ineligible" and "Beneficiary Ineligible (Nonfinancial)" eligibility component category in Figure 13. "Other" category includes required documentation and/or processes that were not maintained/performed, which are not covered under the disclosed causes.

Figure 17. Medicaid and CHIP Eligibility Determination Timeframe for Claims Sampled in the 2025 Review Period[14]



[14] Determination timeframes disclosed in the figure are impacted by PHE flexibilities, where states were afforded the option of extending renewal timeframes. Determinations are expected to increase as the unwinding period progresses into the future.

Section 2: 2025 Supplemental Medicaid Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for Medicaid in 2025 based on the 50 states and the District of Columbia reviewed from 2023-2025. Unless otherwise noted, all tables and figures in Section 2 are based on the rolling rate.

Medicaid Improper Payments

Table S1. Summary of Medicaid Projected Federal Improper Payments

Category	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
FFS	1,611	26,840	$3,131,369.96	$71,921,703.53	$10,830.03	$235,519.55	4.60%	4.27% - 4.92%
FFS Medical Review	824	26,840*	$1,022,536.83	$71,921,703.53	$6,242.35	$235,519.55	2.65%	2.39% - 2.91%
FFS Data Processing	904	26,840	$2,220,048.92	$71,921,703.53	$5,230.77	$235,519.55	2.22%	2.01% - 2.43%
Managed Care	5	2,981	$0.00	$3,099,475.83	$0.00	$375,468.47	0.00%	0.00% - 0.00%
Eligibility	901	17,986	$1,728,252.10	$35,237,385.24	$27,035.99	$610,988.02	4.42%	4.04% - 4.81%
Total	**2,517**	**47,807**	**$4,859,622.06**	**$110,258,564.60**	**$37,386.79**	**$610,988.02**	**6.12%**	**5.73% - 6.51%**

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 26,840 cases sampled, 22,005 were eligible for Medical Reviews.

Table S2A. 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
Insufficient Documentation	Insufficient Information to determine eligibility	$16.74	44.77%
	Non-Compliance with Provider Screening and NPI Requirements	$3.33	8.90%
	Other Missing Information	$4.96	13.26%
	Redetermination Not Conducted	$1.73	4.63%
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$6.24	16.70%
	Other Monetary Loss	$1.32	3.54%
	Provider Not Enrolled	$0.71	1.90%
Technically Improper	Technically Improper	$2.10	5.62%
Underpayments	Underpayments	$0.26	0.69%

Note: The table provides information on improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper 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.

In this table, monetary loss errors are prioritized over insufficient documentation errors, and total dollar amounts are benchmarked to the total improper payments found in Table S1. In addition, this table reports Technically Improper Payments (defined further in the "State-Specific Improper Payment Rates …" section of this report), and the methodology used in this table may be different than that of other figures and tables in this report.

Table S2B. 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
Insufficient Documentation	Insufficient Information to determine eligibility	$21.00	49.58%
	Non-Compliance with Provider Screening and NPI Requirements	$4.13	9.76%
	Other Missing Information	$6.54	15.43%
	Redetermination Not Conducted	$2.03	4.78%
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$6.29	14.84%
	Other Monetary Loss	$1.32	3.12%
	Provider Not Enrolled	$0.72	1.71%
Underpayments	Underpayments	$0.33	0.78%

Note: The table provides information on improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper 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.

In this table, every improper payment is counted, including where there are multiple errors per claim.

Medicaid FFS Component Federal Improper Payment Rate

Table S3. Medicaid FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	748	629	6,634	$620,421.37	$8,811,278.42	$3,079.75	$48,013.55	6.41%	5.65% - 7.18%
Psychiatric, Mental Health, and Behavioral Health Services	314	271	1,610	$391,406.18	$2,597,251.47	$2,069.93	$15,109.10	13.70%	11.18% - 16.22%
Nursing Facility, Chronic Care Services or ICF	196	190	3,625	$562,346.59	$11,368,284.12	$1,174.85	$25,918.51	4.53%	3.16% - 5.91%
Prescribed Drugs	69	66	3,794	$139,923.74	$12,937,701.10	$1,049.09	$33,969.70	3.09%	1.98% - 4.19%
ICF for ICF/IID and ICF/Group Homes	160	141	576	$1,180,452.12	$4,461,144.80	$862.98	$4,927.26	17.51%	14.17% - 20.86%
Personal Support Services	73	71	1,349	$33,997.82	$721,674.70	$807.94	$18,611.66	4.34%	3.05% - 5.63%
Home Health Services	33	24	150	$11,095.74	$100,131.92	$333.00	$1,653.71	20.14%	9.04% - 31.23%
Capitated Care/Fixed Payments	39	39	2,050	$5,554.71	$181,652.79	$197.96	$33,762.48	0.59%	(0.27%) - 1.44%
Transportation and Accommodations	12	12	259	$1,461.88	$160,805.20	$185.40	$2,389.07	7.76%	2.19% - 13.33%
Clinic Services	49	42	614	$22,658.92	$289,308.47	$184.34	$7,733.81	2.38%	1.12% - 3.65%
Laboratory, X-ray and Imaging Services	11	11	158	$454.84	$25,980.42	$165.13	$1,285.78	12.84%	2.40% - 23.29%
Hospice Services	19	16	231	$17,282.75	$729,665.55	$137.36	$1,699.87	8.08%	1.23% - 14.93%
Dental and Oral Surgery Services	13	13	391	$2,462.21	$57,324.51	$136.95	$3,232.67	4.24%	1.61% - 6.86%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	27	21	167	$1,308.86	$24,216.20	$119.58	$1,113.95	10.73%	4.57% - 16.89%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	9	9	555	$3,230.90	$437,335.08	$105.61	$6,126.59	1.72%	0.40% - 3.05%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	22	21	183	$8,157.53	$245,131.15	$101.02	$1,336.30	7.56%	3.76% - 11.36%
Inpatient Hospital Services	14	14	1,589	$99,756.48	$26,488,289.06	$62.71	$18,237.96	0.34%	0.05% - 0.64%
Outpatient Hospital Services	21	19	975	$29,367.30	$2,264,623.10	$53.46	$7,817.64	0.68%	0.17% - 1.19%
Crossover Claims	2	2	687	$30.01	$19,905.46	$2.97	$2,579.94	0.12%	(0.11%) - 0.34%
Denied Claims	0	0	1,243	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**1,831**	**1,611**	**26,840**	**$3,131,369.96**	**$71,921,703.53**	**$10,830.03**	**$235,519.55**	**4.60%**	**4.27% - 4.92%**

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 Error (MR2)	344	$512,950.99	$2,826.17	$2,291.96	$3,360.38
No Reviewable Documentation Received Error (MR1)	224	$295,454.24	$2,007.79	$1,642.97	$2,372.62
Number of Unit(s) Error (MR6)	225	$190,538.85	$931.95	$755.78	$1,108.12
Improperly Completed Documentation Error (MR9)	34	$18,945.12	$392.09	$143.62	$640.56
Administrative/Other Error (MR10)	5	$4,918.17	$87.73	-$10.30	$185.77
Procedure Coding Error (MR3)	9	$725.29	$70.50	-$11.94	$152.94
Policy Violation Error (MR8)	2	$2,359.61	$55.99	-$48.38	$160.36
Medically Unnecessary Service Error (MR7)	2	$3,559.25	$21.34	-$13.24	$55.92
Diagnosis Coding/DRG Error (MR4)	2	$35,098.01	$0.13	-$0.11	$0.37
Total	**847**	**$1,064,549.54**	**$6,393.69**	**$5,671.62**	**$7,115.77**

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. 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 Error (MR2)	344	$512,950.99	$2,826.17	$2,291.96	$3,360.38
No Reviewable Documentation Received Error (MR1)	224	$295,454.24	$2,007.79	$1,642.97	$2,372.62
Number of Unit(s) Error (MR6)	174	$121,408.63	$750.88	$603.69	$898.06
Improperly Completed Documentation Error (MR9)	34	$18,945.12	$392.09	$143.62	$640.56
Administrative/Other Error (MR10)	5	$4,918.17	$87.73	-$10.30	$185.77
Procedure Coding Error (MR3)	8	$625.13	$57.15	-$21.03	$135.33
Policy Violation Error (MR8)	2	$2,359.61	$55.99	-$48.38	$160.36
Medically Unnecessary Service Error (MR7)	2	$3,559.25	$21.34	-$13.24	$55.92
Diagnosis Coding/DRG Error (MR4)	2	$35,098.01	$0.13	-$0.11	$0.37
Total	**795**	**$995,319.16**	**$6,199.27**	**$5,483.21**	**$6,915.32**

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. 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)	51	$69,130.22	$181.07	$83.15	$279.00
Procedure Coding Error (MR3)	1	$100.16	$13.35	N/A	N/A
Total	**52**	**$69,230.38**	**$194.43**	**$93.07**	**$295.79**

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

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

Table S7. Medicaid FFS Specific Causes of No Reviewable Documentation Received Error (MR1)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Documentation was not requested from the provider due to a fraud investigation or pending litigation	78	$58,005.49	$724.96	$496.21	$953.70
Provider did not respond to the request for records	86	$151,163.64	$687.28	$498.27	$876.28
Provider responded with a statement that the beneficiary was not seen on the sampled DOS	14	$19,324.60	$219.18	$76.55	$361.81
Provider responded with a statement that they had billed in error	16	$5,318.89	$107.76	$30.21	$185.30
Provider responded that they are no longer operating business/practice, and the record is unavailable	10	$14,404.25	$98.02	$31.60	$164.43
Provider responded with a request to redirect the records request letter	1	$1,387.62	$52.82	N/A	N/A
Provider responded that they did not have the beneficiary on file or in the system	6	$14,149.62	$28.31	$3.10	$53.52
Provider responded with a statement that they billed for the wrong beneficiary	1	$36.00	$27.62	N/A	N/A
Provider responded with a statement they were unable to locate the records	4	$12,922.62	$25.25	-$4.86	$55.36
Provider submitted a record for wrong date of service	3	$5,046.89	$25.12	-$5.23	$55.47
Provider responded with a statement that there was no documentation for the encounter/billed service	2	$468.45	$5.85	-$5.58	$17.27
Provider did not submit medical records, only billing information, which is insufficient to support the sampled claim	1	$10,583.45	$2.72	N/A	N/A
Other	1	$2,067.02	$2.41	N/A	N/A
No reviewable record was received after notifying the provider that there was an issue with the faxed document(s)	1	$575.70	$0.51	N/A	N/A
Total	**224**	**$295,454.24**	**$2,007.79**	**$1,642.97**	**$2,372.62**

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

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

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

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

Documentation Type	Total Count
Provider did not submit the individual plan (ITP, ISP, IFSP, IEP, or POC) or records did not support all sampled DOS	137
Provider did not submit progress notes or records did not support all sampled DOS	71
Provider did not submit the signed timesheet/Electronic Visit Verification (EVV) record or records did not support all sampled DOS	59
Provider did not submit the physician/non-physician provider visit progress notes or records did not support all sampled DOS	27
Provider did not submit the face-to-face assessment documentation	21
Provider did not submit a physician's order for the sampled service	15
Provider did not submit the signature page(s) pertaining to ITP, ISP, IFSP, IEP or POC	14
Provider did not submit the documentation of daily presence (progress notes, MAR, flowsheets, nursing notes, or attendance log) or records did not support all sampled DOS	11
Provider did not submit the required supervision documentation	10
Provider did not submit the physician certification/recertification of services or records did not support all sampled DOS	6
Provider did not submit the regulatory 30/60-day physician visit note	6
Other	4
Provider did not submit proof of delivery	4
Provider did not submit the therapy visit notes (PT/OT/ST) or records did not support all sampled DOS	4
Provider did not submit transportation log or records did not support all sampled DOS	4
Provider did not submit the school-based services service note (behavioral, medication administration, nursing, attendance record) or records did not support all sampled DOS	3
Provider did not submit diagnostic study (laboratory, X-ray, or pathology) results	2
Provider did not submit a valid prescription	1
Provider did not submit all postpartum/postnatal visit records	1
Provider did not submit psychiatric/mental health evaluation	1
Provider did not submit the annual physical exam	1
Provider did not submit the pharmacy signature log	1
Total	**403**

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

Table S9. Medicaid FFS Specific Provider Types with Document(s) Absent from Record

Provider Type	Number of Document(s) Absent from Record	Number of Claims Sampled
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	242	6,634
Nursing Facility, Chronic Care Services or ICF	56	3,625
Psychiatric, Mental Health, and Behavioral Health Services	43	1,610
Personal Support Services	24	1,349
ICF for ICF/IID and ICF/Group Homes	9	576
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	7	183
Clinic Services	6	614
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	6	167
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	3	555
Outpatient Hospital Services	2	975
Home Health Services	1	150
Hospice Services	1	231
Laboratory, X-ray and Imaging Services	1	158
Prescribed Drugs	1	3,794
Transportation and Accommodations	1	259
Total	**403**	**26,840**

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. Provider type association is based on the category of service in which the claim was sampled/identified.

Medicaid FFS Medical Review Errors by Service Type

Table S10. Medicaid FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	510	490	6,634	$533,782.31	$8,811,278.42	$2,501.86	$48,013.55	5.21%	4.50% - 5.92%
Psychiatric, Mental Health, and Behavioral Health Services	119	118	1,610	$135,908.77	$2,597,251.47	$1,388.64	$15,109.10	9.19%	6.94% - 11.45%
Personal Support Services	59	58	1,349	$26,634.44	$721,674.70	$711.22	$18,611.66	3.82%	2.59% - 5.05%
Nursing Facility, Chronic Care Services or ICF	59	59	3,625	$143,957.28	$11,368,284.12	$583.60	$25,918.51	2.25%	0.88% - 3.62%
Prescribed Drugs	16	16	3,794	$25,949.94	$12,937,701.10	$347.08	$33,969.70	1.02%	0.38% - 1.66%
Home Health Services	9	8	150	$640.99	$100,131.92	$156.46	$1,653.71	9.46%	1.90% - 17.02%
Transportation and Accommodations	9	9	259	$1,387.60	$160,805.21	$114.57	$2,389.07	4.80%	0.41% - 9.18%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	8	8	555	$3,034.86	$437,335.08	$97.44	$6,126.59	1.59%	0.30% - 2.88%
Clinic Services	10	10	614	$13,229.09	$289,308.47	$79.25	$7,733.81	1.02%	0.01% - 2.04%
ICF for ICF/IID and ICF/Group Homes	11	11	576	$42,490.88	$4,461,144.80	$62.67	$4,927.26	1.27%	0.26% - 2.28%
Dental and Oral Surgery Services	5	5	391	$187.72	$57,324.51	$50.30	$3,232.67	1.56%	0.12% - 2.99%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	10	10	183	$2,690.18	$245,131.15	$48.11	$1,336.30	3.60%	0.96% - 6.24%
Inpatient Hospital Services	6	6	1,589	$67,003.82	$26,488,289.06	$33.42	$18,237.96	0.18%	(0.03%) - 0.39%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	7	7	167	$424.31	$24,216.20	$28.28	$1,113.95	2.54%	(0.59%) - 5.67%
Laboratory, X-ray and Imaging Services	2	2	158	$19.39	$25,980.42	$17.09	$1,285.78	1.33%	(1.02%) - 3.67%
Outpatient Hospital Services	5	5	975	$21,048.26	$2,264,623.10	$12.75	$7,817.64	0.16%	(0.01%) - 0.34%
Hospice Services	2	2	231	$4,146.99	$729,665.55	$9.59	$1,699.87	0.56%	(0.23%) - 1.36%
Capitated Care/Fixed Payments	0	0	2,050	$0.00	$181,652.79	$0.00	$33,762.48	0.00%	0.00% - 0.00%
Crossover Claims	0	0	687	$0.00	$19,905.46	$0.00	$2,579.94	0.00%	0.00% - 0.00%
Denied Claims	0	0	1,243	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**847**	**824**	**26,840**	**$1,022,536.83**	**$71,921,703.53**	**$6,242.35**	**$235,519.55**	**2.65%**	**2.39% - 2.91%**

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

Medicaid FFS Data Processing Federal Improper Payments

Table S11. Summary of Medicaid FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	782	$2,402,747.25	$4,948.06	$4,409.95	$5,486.17
Administrative/Other Error (DP12)	79	$41,344.83	$455.67	$355.74	$555.61
Non-Covered Service/Beneficiary Eligibility/MMIS System Error (DP2)	14	$12,480.46	$239.34	-$55.27	$533.96
Claim Filed Untimely (DP11)	2	$4,486.08	$43.63	-$26.73	$114.00
Pricing Error (DP5)	89	$16,386.81	$38.50	$1.68	$75.32
Third-Party Liability Error (DP4)	5	$7,212.96	$21.98	-$6.46	$50.43
Data Processing Technical Deficiency (DTD)	13	$0.00	$0.00	$0.00	$0.00
Total	**984**	**$2,484,658.38**	**$5,747.19**	**$5,120.97**	**$6,373.42**

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.

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S12. Summary of Medicaid FFS Data Processing Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	782	$2,402,747.25	$4,948.06	$4,409.95	$5,486.17
Administrative/Other Error (DP12)	79	$41,344.83	$455.67	$355.74	$555.61
Non-Covered Service/Beneficiary Eligibility/MMIS System Error (DP2)	14	$12,480.46	$239.34	-$55.27	$533.96
Claim Filed Untimely (DP11)	2	$4,486.08	$43.63	-$26.73	$114.00
Pricing Error (DP5)	26	$12,353.02	$23.44	-$11.84	$58.72
Third-Party Liability Error (DP4)	5	$7,212.96	$21.98	-$6.46	$50.43
Data Processing Technical Deficiency (DTD)	13	$0.00	$0.00	$0.00	$0.00
Total	**921**	**$2,480,624.59**	**$5,732.13**	**$5,105.97**	**$6,358.29**

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.

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S13. Summary of Medicaid FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	63	$4,033.79	$15.06	$4.52	$25.60
Total	**63**	**$4,033.79**	**$15.06**	**$4.52**	**$25.60**

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

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

Table S14. Medicaid FFS Specific Causes of Provider Information/Enrollment Error (DP10)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
National Provider Identifier (NPI)	453	$2,141,687.82	$2,898.47	$2,530.41	$3,266.53
Attending or rendering provider NPI required, but not listed on claim	17	$2,904.92	$72.70	$23.60	$121.80
Provider Screening	248	$147,639.46	$1,163.26	$966.72	$1,359.80
Provider Enrollment	41	$89,655.16	$723.50	$385.66	$1,061.34
Other missing provider information	17	$14,363.01	$48.54	$24.70	$72.37
Provider License/ Certification	6	$6,496.88	$41.60	$2.62	$80.57
Total	**782**	**$2,402,747.25**	**$4,948.06**	**$4,409.95**	**$5,486.17**

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

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

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	35
	Wrong NPI on the claim	31
Billing	No NPI on the claim	156
	Wrong NPI on the claim	1
ORP	No NPI on the claim	217
	Wrong NPI on the claim	14
Rendering	No NPI on the claim	15
	Wrong 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 S16. DP10 Medicaid FFS Errors: Provider Not Appropriately Screened Breakdown

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Newly Enrolled	246
	Revalidated	2
Provider Risk Level	Limited	206
	High	39
	Moderate	3
Provider Type	Billing	154
	Rendering	74
	ORP	19
	Attending	1
Screening Elements Not Completed	LEIE not checked	134
	NPPES not checked	54
	SAM/EPLS not checked	43
	DMF not checked	29
	No required databases checked	28
	FCBC not conducted	2
	On-site not conducted	2

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Revalidations, including Risk-based screenings, were paused due to covid flexibilities afforded to states. No revalidated providers were reviewed during the PHE for screening requirements.

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

Provider Type Not Enrolled	Number of Errors
ORP	32
Attending	5
Billing	4

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

Medicaid FFS Data Processing Errors by Service Type

Table S18. Medicaid FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	238	232	6,634	$134,779.46	$8,811,278.42	$1,059.66	$48,013.55	2.21%	1.86% - 2.56%
ICF for ICF/IID and ICF/Group Homes	149	137	576	$1,176,924.61	$4,461,144.80	$841.90	$4,927.26	17.09%	13.82% - 20.35%
Prescribed Drugs	53	51	3,794	$113,986.69	$12,937,701.10	$717.60	$33,969.70	2.11%	1.20% - 3.03%
Psychiatric, Mental Health, and Behavioral Health Services	195	158	1,610	$257,377.25	$2,597,251.47	$694.25	$15,109.10	4.59%	3.40% - 5.79%
Nursing Facility, Chronic Care Services or ICF	137	135	3,625	$435,709.77	$11,368,284.12	$618.51	$25,918.51	2.39%	2.10% - 2.67%
Capitated Care/Fixed Payments	39	39	2,050	$5,554.71	$181,652.79	$197.96	$33,762.48	0.59%	(0.27%) - 1.44%
Home Health Services	24	17	150	$10,677.90	$100,131.92	$195.70	$1,653.71	11.83%	2.33% - 21.34%
Laboratory, X-ray and Imaging Services	9	9	158	$435.45	$25,980.42	$148.04	$1,285.78	11.51%	1.28% - 21.75%
Hospice Services	17	16	231	$17,282.75	$729,665.55	$137.36	$1,699.87	8.08%	1.23% - 14.93%
Personal Support Services	14	14	1,349	$7,422.27	$721,674.70	$117.56	$18,611.66	0.63%	0.16% - 1.10%
Clinic Services	39	33	614	$9,599.37	$289,308.47	$108.80	$7,733.81	1.41%	0.65% - 2.16%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	20	15	167	$954.36	$24,216.20	$97.50	$1,113.95	8.75%	3.31% - 14.19%
Dental and Oral Surgery Services	8	8	391	$2,274.50	$57,324.51	$86.64	$3,232.67	2.68%	0.47% - 4.89%
Transportation and Accommodations	3	3	259	$74.28	$160,805.21	$70.83	$2,389.07	2.96%	(0.67%) - 6.60%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	12	12	183	$5,697.78	$245,131.15	$57.32	$1,336.30	4.29%	1.48% - 7.10%
Outpatient Hospital Services	16	14	975	$8,319.04	$2,264,623.10	$40.71	$7,817.64	0.52%	0.04% - 1.00%
Inpatient Hospital Services	8	8	1,589	$32,752.67	$26,488,289.06	$29.29	$18,237.96	0.16%	(0.04%) - 0.36%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	1	1	555	$196.05	$437,335.08	$8.17	$6,126.59	0.13%	(0.13%) - 0.40%
Crossover Claims	2	2	687	$30.01	$19,905.46	$2.97	$2,579.94	0.12%	(0.11%) - 0.34%
Denied Claims	0	0	1,243	$0.00	$0.00	$0.00	$0.00	N/A	N/A
Total	**984**	**904**	**26,840**	**$2,220,048.92**	**$71,921,703.53**	**$5,230.77**	**$235,519.55**	**2.22%**	**2.01% - 2.43%**

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

Medicaid Eligibility Review Errors by Eligibility Category

Table S19A. Medicaid Eligibility Review Errors by Eligibility Category – MAGI

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
MAGI Total	**378**	**366**	**7,780**	**$354,671.14**	**$10,738,890.63**	**$14,780.10**	**$299,941.56**	**4.93%**	**4.04% - 5.82%**
MAGI - Medicaid Expansion - Newly Eligible	161	159	3,494	$223,598.34	$5,533,792.01	$8,358.66	$150,926.09	5.54%	4.05% - 7.03%
MAGI - Children under Age 19	111	106	1,921	$52,810.86	$1,395,669.58	$2,953.79	$63,141.49	4.68%	3.24% - 6.12%
MAGI - Parent Caretaker	65	63	1,260	$22,332.09	$1,332,034.74	$2,034.29	$41,896.22	4.86%	2.57% - 7.14%
MAGI - Pregnant Woman	12	11	241	$19,133.40	$372,479.34	$514.51	$10,545.89	4.88%	1.71% - 8.04%
MAGI - Medicaid Expansion - Not Newly Eligible	17	15	600	$28,308.18	$1,280,267.76	$435.09	$25,146.30	1.73%	0.70% - 2.76%
Family Planning and Related Services	4	4	21	$976.40	$2,645.21	$160.40	$513.30	31.25%	4.18% - 58.32%
Emergency Services (Including for Non-Citizens)	2	2	94	$5,913.87	$559,737.82	$57.34	$3,408.65	1.68%	(0.84%) - 4.20%
1115 Waiver Programs	1	1	78	$31.56	$91,678.56	$12.17	$2,314.54	0.53%	(0.50%) - 1.56%
MAGI - Medicaid CHIP Expansion	2	2	33	$1,493.50	$77,302.14	$3.82	$273.28	1.40%	(0.46%) - 3.25%
Former Foster Care	0	0	1	$0.00	$36.51	$0.00	$61.11	0.00%	0.00% - 0.00%
MAGI - CHIP	0	0	1	$0.00	$0.00	$0.00	$0.00	$0.00	0.00% - 0.00%
Presumptive Eligibility	0	0	19	$0.00	$73,528.05	$0.00	$645.86	0.00%	0.00% - 0.00%
Other (None of the Above)	3	3	17	$72.94	$19,718.91	$250.05	$1,068.84	23.39%	(4.78%) - 51.57%

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

Table S19B. Medicaid Eligibility Review Errors by Eligibility Category – Non-MAGI

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Non-MAGI Total	**671**	**535**	**10,206**	**$1,373,580.96**	**$24,498,494.61**	**$12,255.89**	**$311,046.46**	**3.94%**	**3.40% - 4.48%**
LTC/Nursing Home	285	205	1,410	$685,749.08	$5,090,837.53	$3,396.44	$34,708.16	9.79%	7.66% - 11.91%
Aged, Blind, and Disabled - Mandatory and Optional Categorically Needy	152	124	1,660	$225,536.77	$3,096,695.92	$3,342.20	$43,595.85	7.67%	5.58% - 9.76%
Home and Community-Based Services	128	112	1,176	$275,885.42	$2,332,968.81	$2,493.00	$38,348.84	6.50%	4.71% - 8.29%
SSI Recipients	29	29	4,020	$98,327.49	$10,363,911.94	$948.61	$135,077.45	0.70%	0.18% - 1.22%
Medically Needy	33	25	336	$21,073.77	$1,012,501.76	$598.40	$7,264.63	8.24%	3.16% - 13.31%
Transitional Medicaid	12	11	250	$10,958.63	$174,165.36	$596.00	$8,509.28	7.00%	2.05% - 11.96%
QMB	5	5	192	$311.75	$27,336.41	$206.68	$8,947.65	2.31%	(0.30%) - 4.92%
Emergency Services (Including for Non-Citizens)	4	3	25	$26,081.83	$398,033.50	$190.40	$654.06	29.11%	(5.28%) - 63.50%
Other Full Benefit Dual Eligible (FBDE)	12	12	175	$14,643.29	$344,513.47	$185.50	$4,434.55	4.18%	1.47% - 6.90%
Women with Breast or Cervical Cancer	3	3	20	$13,554.80	$87,628.63	$92.32	$694.17	13.30%	(2.74%) - 29.34%
Qualified Individuals	3	1	17	$174.70	$2,175.50	$73.26	$857.83	8.54%	(6.90%) - 23.98%
Title IV-E	3	3	248	$999.81	$328,717.34	$33.17	$6,957.30	0.48%	0.05% - 0.90%
TEFRA/Katie Beckett	1	1	37	$149.56	$106,064.49	$10.90	$722.15	1.51%	(1.50%) - 4.52%
1115 Waiver Programs	0	0	8	$0.00	$17,716.82	$0.00	$102.26	0.00%	0.00% - 0.00%
Community First Choice 1915(k)	0	0	3	$0.00	$361.36	$0.00	$200.24	0.00%	0.00% - 0.00%
Former Foster Care	0	0	5	$0.00	$2,200.93	$0.00	$88.73	0.00%	0.00% - 0.00%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Newborn	0	0	492	$0.00	$915,808.78	$0.00	$15,077.77	0.00%	0.00% - 0.00%
Presumptive Eligibility	0	0	2	$0.00	$335.90	$0.00	$29.99	0.00%	0.00% - 0.00%
Qualified Disabled and Working Individuals	0	0	13	$0.00	$15,819.12	$0.00	$459.76	0.00%	0.00% - 0.00%
SLMB	0	0	31	$0.00	$3,082.66	$0.00	$1,729.43	0.00%	0.00% - 0.00%
Other (None of the Above)	1	1	86	$134.06	$177,618.38	$89.02	$2,586.37	3.44%	(3.15%) - 10.04%

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 S20. Summary of Medicaid Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	470	$1,065,997.85	$15,350.74	$12,810.86	$17,890.63
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	172	$403,140.50	$4,334.34	$3,235.72	$5,432.96
Other Errors (ER10)	135	$48,837.54	$3,608.70	$2,295.33	$4,922.08
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	138	$291,421.21	$3,343.55	$2,407.01	$4,280.09
Not Eligible for Enrolled Program; Financial Issue (ER4)	63	$143,897.18	$1,673.03	$1,115.49	$2,230.58
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	18	$17,765.83	$953.63	$295.16	$1,612.10
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	17	$12,514.62	$572.98	$148.12	$997.83
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	11	$33,191.01	$210.67	$68.73	$352.60
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment (ER7)	13	$9,461.01	$174.04	$54.95	$293.13
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	12	$0.00	$0.00	$0.00	$0.00
Total	**1,049**	**$2,026,226.75**	**$30,221.69**	**$26,926.48**	**$33,516.89**

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

*Deficiencies (ERTDs) were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S21. Summary of Medicaid Eligibility Review Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/ Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	470	$1,065,997.85	$15,350.74	$12,810.86	$17,890.63
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	172	$403,140.50	$4,334.34	$3,235.72	$5,432.96
Other Errors (ER10)	119	$44,215.23	$3,589.12	$2,275.81	$4,902.43
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	138	$291,421.21	$3,343.55	$2,407.01	$4,280.09
Not Eligible for Enrolled Program; Financial Issue (ER4)	63	$143,897.18	$1,673.03	$1,115.49	$2,230.58
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	18	$17,765.83	$953.63	$295.16	$1,612.10
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	17	$12,514.62	$572.98	$148.12	$997.83
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	11	$33,191.01	$210.67	$68.73	$352.60
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment (ER7)	6	$4,745.15	$73.46	-$7.31	$154.24
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	12	$0.00	$0.00	$0.00	$0.00
Total	**1,026**	**$2,016,888.58**	**$30,101.53**	**$26,807.08**	**$33,395.99**

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 (ERTDs) were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S22. Summary of Medicaid Eligibility Review Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment (ER7)	7	$4,715.86	$100.57	$13.06	$188.08
Other Errors (ER10)	16	$4,622.31	$19.58	$3.99	$35.17
Total	**23**	**$9,338.17**	**$120.15**	**$31.27**	**$209.04**

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

Table S23. Summary of Medicaid Eligibility Review – MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	175	$203,044.85	$6,964.21	$4,801.74	$9,126.68
Other Errors (ER10)	35	$14,785.92	$2,954.96	$1,699.74	$4,210.18
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	58	$26,579.07	$1,764.22	$1,096.94	$2,431.50
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	48	$76,401.77	$1,539.79	$787.99	$2,291.59
Not Eligible for Enrolled Program; Financial Issue (ER4)	26	$15,210.16	$942.62	$490.85	$1,394.39
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	16	$12,377.53	$453.22	$99.09	$807.36
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	7	$2,530.01	$235.09	-$3.84	$474.02
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment (ER7)	12	$9,285.66	$171.35	$52.37	$290.32
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	1	$0.00	$0.00	N/A	N/A
Total	**378**	**$360,214.97**	**$15,025.46**	**$12,273.77**	**$17,777.14**

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 (ERTDs) were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S24. Summary of Medicaid Eligibility Review – Non-MAGI Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	295	$862,953.00	$8,386.54	$7,044.85	$9,728.23
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	114	$376,561.43	$2,570.13	$1,696.85	$3,443.40
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	90	$215,019.44	$1,803.76	$1,245.06	$2,362.46
Not Eligible for Enrolled Program; Financial Issue (ER4)	37	$128,687.02	$730.42	$403.67	$1,057.16
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	11	$15,235.82	$718.54	$104.95	$1,332.13
Other Errors (ER10)	100	$34,051.62	$653.74	$254.40	$1,053.08
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	11	$33,191.01	$210.67	$68.73	$352.60
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	1	$137.09	$119.75	N/A	N/A
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment (ER7)	1	$175.35	$2.69	N/A	N/A
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	11	$0.00	$0.00	$0.00	$0.00
Total	**671**	**$1,666,011.78**	**$15,196.23**	**$13,359.99**	**$17,032.46**

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

*Deficiencies (ERTDs) were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table S25. 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	696	$1,344,817.04	$16,293.87	$14,440.10	$18,147.63
System	219	$486,944.00	$8,482.46	$6,136.40	$10,828.51
Policy	75	$79,102.63	$4,412.51	$3,010.10	$5,814.93
Multiple	58	$113,590.38	$986.37	$593.15	$1,379.59
Unable to Determine	1	$1,772.70	$46.47	N/A	N/A
Total	**1,049**	**$2,026,226.75**	**$30,221.69**	**$26,926.48**	**$33,516.89**

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 S26. 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	483	453	6,182	$823,153.57	$13,204.47	5.94%	4.88% - 7.01%
Application	308	232	1,900	$502,048.26	$5,737.38	9.86%	7.81% - 11.90%
Change	200	159	2,163	$314,327.18	$4,894.79	7.29%	5.62% - 8.96%
Not Applicable	47	46	7,729	$77,471.22	$2,824.29	1.07%	0.58% - 1.57%
Unknown	11	11	12	$11,251.87	$375.05	100.00%	100.00% - 100.00%
Total	**1,049**	**901**	**17,986**	**$1,728,252.10**	**$27,035.99**	**4.42%**	**4.04% - 4.81%**

Note: Details do not always sum to the total due to rounding. For case action categories with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report. Further explanation of case actions can be found in Section 4: Case Action Glossary, Table A5.

Table S27. 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	443	418	9,350	$463,409.76	$14,432.64	4.12%	3.57% - 4.67%
FFS	606	483	8,636	$1,264,842.34	$12,603.35	4.83%	3.88% - 5.79%
Total	**1,049**	**901**	**17,986**	**$1,728,252.10**	**$27,035.99**	**4.42%**	**4.04% - 4.81%**

Note: Details do not always sum to the total due to rounding. For claim types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

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

Table S28. Specific Causes of Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	154	$260,388.07	$5,768.87	$3,709.88	$7,827.86
Resources verification not on file/incomplete	171	$502,930.25	$5,644.16	$4,482.46	$6,805.86
Signature not obtained	47	$103,233.53	$1,377.13	$883.13	$1,871.13
Level of care verification not on file/incomplete	47	$122,971.55	$903.33	$481.16	$1,325.51
Demographic verification not on file/incomplete	12	$16,151.80	$586.30	-$7.92	$1,180.51
Other verification/other required forms not on file/incomplete	9	$6,749.04	$457.02	$139.83	$774.20
Discrepant information not acted upon	24	$35,933.08	$405.34	$197.97	$612.71
Eligibility process(es) not followed	6	$17,640.53	$208.60	-$26.72	$443.91
Total	**470**	**$1,065,997.85**	**$15,350.74**	**$12,810.86**	**$17,890.63**

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

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

Table S29. Specific Causes of Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Redetermination not conducted within 12 months before date of payment for services	122	$300,598.57	$2,026.72	$1,512.28	$2,541.16
Initial determination not conducted	25	$28,029.33	$1,172.54	$584.39	$1,760.70
Determination not conducted after underlying eligibility was terminated	25	$74,512.60	$1,135.08	$362.38	$1,907.78
Total	**172**	**$403,140.50**	**$4,334.34**	**$3,235.72**	**$5,432.96**

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: Other Errors (ER10)

Table S30. Specific Causes of Other Errors (ER10)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Eligible for emergency services only	32	$8,898.41	$2,877.13	$1,632.07	$4,122.20
Other error	16	$20,356.86	$518.28	$133.52	$903.04
Cost of care incorrect – Medical expenses allowed	16	$4,793.68	$76.59	-$57.88	$211.07
Cost of care incorrect – Multiple areas	13	$3,257.25	$47.07	-$39.55	$133.69
Cost of care incorrect – SSI SSP benefits	5	$951.72	$38.58	-$30.78	$107.94
Cost of care – Verifications not on file/not verified	10	$1,751.00	$16.22	-$1.22	$33.66
Contribution to care calculated incorrectly resulting in a partial payment difference	11	$3,557.97	$12.05	-$0.04	$24.14
Cost of care incorrect – Maintenance needs allowance spouse/family	6	$1,866.17	$8.15	-$1.53	$17.83
Cost of care incorrect – Personal needs allowance	3	$1,221.30	$7.33	-$6.84	$21.49
Cost of care incorrect – Beneficiary income	23	$2,183.18	$7.30	$1.02	$13.57
Total	**135**	**$48,837.54**	**$3,608.70**	**$2,295.33**	**$4,922.08**

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

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

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

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Signature not on file	34	$68,289.98	$1,095.98	$385.41	$1,806.56
Resources verification not on file/incomplete	38	$92,598.35	$1,013.29	$522.34	$1,504.23
Income verification not on file/incomplete	26	$68,903.89	$576.84	$307.43	$846.24
Application form not on file	13	$15,141.72	$307.42	$117.29	$497.56
Renewal form not on file	16	$38,732.38	$171.56	$67.49	$275.64
Other verification/other required forms not on file/ incomplete	5	$6,229.36	$95.14	-$2.01	$192.28
Level of care verification not on file/incomplete	4	$1,056.70	$70.83	-$4.10	$145.77
Demographic verification not on file/incomplete	1	$468.03	$12.14	N/A	N/A
TPL verification not on file/incomplete	1	$0.80	$0.35	N/A	N/A
Total	**138**	**$29,1421.21**	**$3,343.55**	**$2,407.01**	**$4,280.09**

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

State-Specific Improper Payment Rates for the States Measured in 2025 Cycle 1

Considerations for viewing state-specific PERM rates:

- What is included in PERM rates and represented in this table
    - **Three components** – PERM measures FFS payments made to providers, managed care capitation payments made to Managed Care Organizations (MCOs), and beneficiary eligibility determinations made by state agencies and combines them to form the overall rate per state. The overall improper payment rate is computed by proportionally combining the FFS and managed care components based on expenditures for each component (the claims rate), then adding the eligibility component and subtracting out the overlap between the claims and eligibility component. Because of this, you cannot simply average the three components to reach the overall rate.
    - **Three cycles** – PERM measures on a three-year rotation cycle, meaning that each state is measured once every three years and each PERM cycle measurement includes one third of all states. The most recent three cycles combine to form each year's overall national rate.
    - **Sample vs projection** –
        - *Sample improper payments* – The improper payments associated with the actual reviewed sample of claims. These are then extrapolated out to represent the entire universe of claims (the projected improper payments). The federal share of the sampled overpayments is the only portion that CMS has the authority to recover from the FFS and managed care universes.
        - *Projected improper payments* – The estimated improper payments used for national reporting to represent the entire Medicaid program (derived by projecting out the actual sampled improper payments to represent all Medicaid improper payments).
    - **Insufficient Documentation vs Monetary Loss Errors –**
        - *Insufficient Documentation Errors* – Improper payments also include instances where there is insufficient or no documentation to support the payment as proper or improper. A majority of Medicaid improper payments were due to instances where information required for payment or eligibility determination was missing from the claim or state systems (e.g., not properly saving documentation after verification) and/or states did not follow the appropriate process for enrolling providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to incorrect providers or beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable.
        - *Monetary Loss Errors* – Instances of monetary loss errors occur when CMS has sufficient information to determine that the Medicaid payment should not have occurred or should have been made in a different amount. Monetary loss errors represent a smaller proportion of Medicaid improper payments.
    - **Technically Improper Payments –**
        - Since RY 2023, the review contractors have been working independently and with states to verify certain situations where documentation to support state action could not be provided. This process includes reviewing databases related to provider enrollment requirements and/or eligibility determination information to evaluate if a provider or beneficiary would have been eligible to provide or receive services, had the state properly documented its required actions to confirm eligibility or enrollment requirements. While any findings related to this additional step of independent verification did not change the actual finding of the PERM review, if the contractor is able to confirm that the provider or beneficiary would have been eligible to be enrolled, these findings will be considered technically improper. Appendix C of the Office of Management and Budget A-123 Circular defines "A 'technically improper' payment as a

payment to the right recipient for the right amount and therefore does not result in the need for the program to recover funds due to overpayment." Technically improper payments will not be included on the state's Final Errors for Recovery, or FEFR, report. Therefore, recovery of funds for the overpayment will not be required. However, an overpayment recovery may still be assessed if a medical review error or a separate data processing error also exists on the claim. The state will still be required to respond to technically improper payments within their Corrective Action Plan.

- **State-specific Improper Payment Rates Are Not Comparable**
  States have flexibility to design their policies and operate their programs to meet the individual needs of the state, such as establishing a managed care delivery system rather than relying on FFS. Variation between states and the resulting methodological differences between states' PERM rates makes it impossible to accurately compare state-specific PERM rates between states. Additional reasons include:
  - *Eligibility Measurement* – CMS established a baseline measurement of all 50 states and the District of Columbia in 2021, which allows CMS to measure the progress made by states since they were last reviewed, and target areas for additional oversight. Due to the PHE, Cycle 2 states did not receive state-specific rates or reports in RY20. Therefore, states in Cycle 2 have not yet had the opportunity to be measured a second time and show improved compliance with the new requirements. Cycle 1 and Cycle 3 states have been measured a second time under the new eligibility requirements.
  - *COVID-19 Flexibilities Afforded to States* – Given the timing of the PHE and subsequent unwinding, each cycle of states was impacted differently by the associated flexibilities afforded to states, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. Depending on when these flexibilities were lifted, as well as the timing of each state's unwinding and associated flexibilities adopted, they could also impact future cycle rates differently, potentially leading to higher rates as the flexibilities may no longer be in place. Please note that the effect of the PHE unwinding will continue to become more prevalent in future report periods.
  - *State-level precision/confidence interval* – The national PERM rate is established by capturing a statistically valid random sample representative of all Medicaid payments matched with federal funds. The national PERM improper payment rate meets a national precision requirement where CMS is 95 percent confident that the Medicaid improper payment rate is within +/- 3 percentage points. The PERM program was not designed to produce that level of precision at the state level. Therefore, state-level precision can vary, leading to wider confidence intervals in some states.
  - *Program structure* – PERM has historically seen a lower instance of improper payments in managed care than FFS, based on differences in the review standards that apply to claims from the two service delivery models. Due to the differing review methodology, states' rates are often not comparable due to the varying distribution between FFS and managed care expenditures.
    - The definition of a FFS delivery system used below includes states' direct payment to providers for each service rendered to individual beneficiaries. Managed care is a delivery system in which a state makes a risk-based monthly capitated payment to an MCO, prepaid inpatient health plan, or prepaid ambulatory health plan, which is responsible for managing beneficiary care. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to only a data processing review.
  - *State Policies* – Policies vary by state, which leads to differences in the states' specific Medicaid rates. These varying policies may include medical documentation and coverage requirements, integration and coordination of payment and eligibility systems, and prioritization of resources based on budget limitation.

- **Other Considerations**
  - Some states rely solely on FFS and do not have a managed care program at all (those states are marked with "--" in the managed care columns).
  - 77% of Medicaid estimated improper payments in RY 2025 were those with insufficient documentation. These include improper payments with no documentation and insufficient documentation (such as failing to submit or maintain the appropriate documentation for someone who *may* be eligible for care). To provide more meaningful improper payment data about the no documentation and insufficient documentation errors, CMS is implementing PERM independent review verifications to verify, for example, if the beneficiary was truly eligible, even if the state did not document or perform the required eligibility or provider enrollment verification.

State-Specific Improper Payment Rates for the States Measured in 2025 Cycle 1

State	Overall					FFS						
	Projected IP Rate	Projected Monetary Loss IP Rate	Projected Confidence Interval	Projected IP ($ mil)	Sampled IP	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	% of Total Projected Expenditures	Sampled Expenditures
Arkansas	0.6%	0.0%	(-0.0%) - 1.3%	$37.1	$2,916.2	0.4%	0.0%	$22.1	$1,342.5	$5,106.7	84.5%	$1,049,228.9
Connecticut	5.6%	1.4%	3.3% - 7.9%	$365.3	$71,162.2	2.6%	0.4%	$171.5	$43,908.7	$6,535.1	100.0%	$4,606,841.6
Delaware	6.9%	0.0%	4.2% - 9.5%	$165.6	$114,701.0	4.4%	0.0%	$18.8	$12,604.9	$425.3	17.7%	$1,402,099.6
Idaho	6.1%	0.3%	3.3% - 8.8%	$160.6	$37,344.0	4.7%	0.3%	$100.7	$10,032.3	$2,128.1	80.8%	$1,253,616.7
Illinois	1.2%	0.4%	0.7% - 1.7%	$227.4	$43,640.5	1.6%	0.7%	$55.1	$18,963.3	$3,467.5	18.1%	$1,578,109.8
Kansas	0.1%	0.0%	0.0% - 0.2%	$2.5	$87,945.4	0.1%	0.1%	$0.1	$35,093.1	$164.9	5.2%	$3,688,513.0
Michigan	3.3%	0.0%	1.7% - 5.0%	$621.0	$64,222.8	0.4%	0.0%	$20.7	$9,092.8	$5,304.3	28.3%	$1,539,200.7
Minnesota	2.2%	0.2%	0.8% - 3.6%	$253.6	$19,252.0	1.3%	0.2%	$75.7	$2,303.8	$5,751.3	48.9%	$452,786.0
Missouri	1.3%	0.3%	0.1% - 2.4%	$145.7	$16,792.2	0.8%	0.4%	$56.7	$618.8	$7,489.1	65.6%	$895,749.1
New Mexico	3.7%	1.5%	1.2% - 6.2%	$240.4	$27,104.5	9.9%	0.7%	$108.7	$26,118.3	$1,096.0	16.8%	$320,414.0
North Dakota	2.7%	0.0%	0.9% - 4.6%	$29.7	$15,088.2	3.3%	0.0%	$26.5	$14,415.6	$791.2	72.5%	$775,731.4
Ohio	2.0%	0.6%	1.0% - 3.1%	$497.5	$45,289.8	3.6%	1.9%	$236.9	$17,986.4	$6,606.1	27.2%	$1,092,298.5
Oklahoma	0.2%	0.0%	(-0.2%) - 0.5%	$10.6	$121.8	0.2%	0.0%	$10.6	$121.8	$6,954.3	100.0%	$601,394.9
Pennsylvania	0.3%	0.1%	0.0% - 0.5%	$63.8	$36,539.7	1.5%	0.2%	$60.1	$32,833.8	$4,058.7	16.3%	$966,669.5
Virginia	2.2%	0.4%	1.2% - 3.2%	$259.6	$68,637.4	6.5%	1.5%	$196.7	$53,782.7	$3,047.6	25.9%	$1,346,342.2
Wisconsin	9.1%	4.5%	7.7% - 10.4%	$731.3	$78,528.4	16.6%	8.3%	$731.3	$78,527.2	$4,413.8	54.6%	$2,656,058.0
Wyoming	2.1%	0.6%	(-0.8%) - 5.0%	$7.8	$3,969.5	0.4%	0.4%	$1.6	$506.4	$377.5	100.0%	$757,040.2

State	MC			Eligibility					
	Projected IP Rate	Projected IP ($ mil)	Projected Expenditures ($ mil)	Projected IP Rate	Projected Monetary Loss IP Rate	Projected IP ($ mil)	Sampled IP	Projected Expenditures ($ mil)	Sampled Expenditures
Arkansas	0.0%	$0.0	$934.3	0.2%	0.0%	$15.0	$1,573.7	$6,041.0	$704,781.8
Connecticut	--	--	--	3.0%	1.1%	$199.0	$27,253.5	$6,535.1	$1,040,717.7
Delaware	0.0%	$0.0	$1,982.8	6.1%	0.0%	$148.0	$102,096.0	$2,408.0	$795,290.6
Idaho	0.0%	$0.0	$506.7	2.4%	0.0%	$62.3	$27,311.8	$2,634.9	$838,953.9
Illinois	0.0%	$0.0	$15,674.0	0.9%	0.3%	$172.8	$24,677.2	$19,141.5	$1,279,487.8
Kansas	0.0%	$0.0	$2,975.4	0.1%	0.0%	$2.4	$52,852.3	$3,140.3	$1,576,732.2
Michigan	0.0%	$0.0	$13,421.3	3.2%	0.0%	$600.9	$55,130.0	$18,725.6	$922,712.0
Minnesota	0.0%	$0.0	$6,002.7	1.5%	0.1%	$179.1	$16,948.1	$11,753.9	$252,696.0
Missouri	0.0%	$0.0	$3,930.1	0.8%	0.0%	$89.4	$16,173.4	$11,419.2	$536,291.1
New Mexico	0.0%	$0.0	$5,428.5	2.1%	1.4%	$133.9	$986.2	$6,524.5	$203,713.4
North Dakota	0.0%	$0.0	$300.4	0.3%	0.0%	$3.3	$672.6	$1,091.6	$364,673.0
Ohio	0.0%	$0.0	$17,686.1	1.1%	0.1%	$263.1	$27,303.5	$24,292.2	$1,262,055.9
Oklahoma	--	--	--	0.0%	0.0%	$0.0	$0.0	$6,954.3	$230,668.5
Pennsylvania	0.0%	$0.0	$20,798.6	0.0%	0.0%	$3.7	$3,705.9	$24,857.3	$941,500.0
Virginia	0.0%	$0.0	$8,724.4	0.5%	0.0%	$64.0	$14,854.7	$11,772.0	$804,362.8
Wisconsin	0.0%	$0.0	$3,663.0	0.0%	0.0%	$0.0	$1.2	$8,076.8	$444,969.6
Wyoming	--	--	--	1.6%	0.2%	$6.2	$3,463.1	$377.5	$274,282.6

Note: IP is the abbreviation for improper payment.

Section 3: 2025 Supplemental CHIP Federal Improper Payment Data

CMS reported a rolling federal improper payment rate for CHIP in 2025 based on the 50 states and the District of Columbia reviewed from 2023-2025. Unless otherwise noted, all tables and figures in Section 3 are based on the rolling rate.

CHIP Improper Payments

Table T1. Summary of CHIP Projected Federal Improper Payments

Category	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
FFS	1,150	15,970	$1,421,594.21	$55,553,322.80	$240.00	$5,164.98	4.65%	4.08% - 5.21%
FFS Medical Review	292	15,970*	$196,560.65	$55,553,322.80	$89.82	$5,164.98	1.74%	1.32% - 2.16%
FFS Data Processing	888	15,970	$1,231,896.13	$55,553,322.80	$157.10	$5,164.98	3.04%	2.63% - 3.45%
Managed Care	16	1,800	$2,052.11	$406,629.89	$133.68	$14,283.79	0.94%	0.18% - 1.70%
Eligibility	775	12,020	$3,527,633.63	$26,202,435.34	$1,017.58	$19,448.78	5.23%	4.66% - 5.81%
Total	**1,941**	**29,790**	**$4,951,279.95**	**$82,162,388.03**	**$1,371.71**	**$19,448.78**	**7.05%**	**6.27% - 7.84%**

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 15,970 cases sampled, 13,946 were eligible for Medical Reviews.

Table T2A. 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
Insufficient Documentation	Insufficient Information to determine eligibility	$0.41	29.94%
	Non-Compliance with Provider Screening and NPI Requirements	$0.08	5.84%
	Other Missing Information	$0.10	7.38%
	Redetermination Not Conducted	$0.12	8.45%
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$0.42	30.48%
	Other Monetary Loss	$0.16	11.98%
	Provider Not Enrolled	$0.01	1.05%
Technically Improper	Technically Improper	$0.06	4.46%
Underpayments	Underpayments	$0.01	0.42%

Note: The table provides information on improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper 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.

In this table, monetary loss errors are prioritized over insufficient documentation errors, and total dollar amounts are benchmarked to the total improper payments found in Table T1. In addition, this table reports Technically Improper Payments (defined further in the "State-Specific Improper Payment Rates …" section of this report), and the methodology used in this table may be different than that of other figures and tables in this report.

Table T2B. 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
Insufficient Documentation	Insufficient Information to determine eligibility	$0.50	33.13%
	Non-Compliance with Provider Screening and NPI Requirements	$0.12	7.93%
	Other Missing Information	$0.14	9.15%
	Redetermination Not Conducted	$0.13	8.57%
Monetary Loss	Beneficiary Ineligible for Program or Service Provided	$0.43	28.27%
	Other Monetary Loss	$0.18	11.52%
	Provider Not Enrolled	$0.02	1.00%
Underpayments	Underpayments	$0.01	0.43%

Note: The table provides information on improper payments that are a known monetary loss to the program (i.e., provider not enrolled, incorrect coding, and other errors). In the table, "Insufficient Documentation" represents payments where there was no or insufficient documentation to support the payment as proper 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.

In this table, every improper payment is counted, including where there are multiple errors per claim.

CHIP FFS Component Federal Improper Payment Rate

Table T3. CHIP FFS Federal Improper Payments by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Psychiatric, Mental Health, and Behavioral Health Services	595	464	2,408	$214,222.83	$2,751,705.15	$72.59	$741.84	9.78%	8.51% - 11.06%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	301	286	1,448	$39,765.02	$494,822.72	$41.14	$400.47	10.27%	7.28% - 13.26%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	48	46	961	$23,164.99	$277,950.40	$22.71	$314.77	7.22%	2.72% - 11.71%
Prescribed Drugs	58	55	2,914	$196,447.00	$18,403,103.15	$20.25	$1,096.16	1.85%	0.50% - 3.19%
Clinic Services	53	51	1,286	$20,476.65	$381,330.78	$15.88	$463.46	3.43%	1.67% - 5.18%
Outpatient Hospital Services	53	50	1,384	$34,529.70	$2,012,333.95	$13.09	$394.61	3.32%	0.77% - 5.86%
Dental and Oral Surgery Services	56	52	1,925	$9,462.74	$405,185.50	$12.11	$551.88	2.19%	1.31% - 3.08%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	39	37	309	$2,411.02	$23,078.84	$11.25	$86.65	12.99%	6.88% - 19.10%
Inpatient Hospital Services	40	39	1,101	$825,176.09	$29,448,191.96	$8.56	$504.94	1.70%	1.04% - 2.36%
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	17	16	161	$4,738.13	$139,357.09	$5.50	$56.34	9.77%	2.12% - 17.41%
Laboratory, X-ray and Imaging Services	10	10	206	$9,555.84	$47,444.59	$5.22	$64.60	8.08%	(1.73%) - 17.89%
Home Health Services	16	11	68	$21,566.28	$40,299.15	$4.98	$25.24	19.75%	5.98% - 33.52%
Transportation and Accommodations	6	6	229	$1,555.11	$335,941.26	$2.56	$27.93	9.15%	(5.42%) - 23.72%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Capitated Care/Fixed Payments	7	7	692	$416.40	$538,266.60	$1.99	$383.34	0.52%	(0.03%) - 1.07%
Personal Support Services	15	14	220	$4,877.26	$82,520.86	$1.96	$42.54	4.60%	1.05% - 8.15%
ICF for ICF/IID and ICF/Group Homes	2	2	11	$12,806.67	$129,747.91	$0.20	$5.05	3.97%	(3.52%) - 11.46%
Crossover Claims	4	4	36	$422.49	$1,522.20	$0.00	$0.45	0.19%	(0.06%) - 0.45%
Denied Claims	0	0	600	$0.00	$111.23	$0.00	$0.88	0.00%	0.00% - 0.00%
Hospice Services	0	0	9	$0.00	$28,455.11	$0.00	$3.70	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or ICF	0	0	2	$0.00	$11,954.35	$0.00	$0.13	0.00%	0.00% - 0.00%
Total	**1,320**	**1,150**	**15,970**	**$1,421,594.21**	**$55,553,322.80**	**$240.00**	**$5,164.98**	**4.65%**	**4.08% - 5.21%**

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

CHIP FFS Medical Review Federal Improper Payments

Table T4. Summary of CHIP FFS Medical Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
No Reviewable Documentation Received Error (MR1)	124	$80,568.13	$44.96	$29.52	$60.39
Document(s) Absent from Record Error (MR2)	88	$105,453.30	$18.04	$11.85	$24.23
Number of Unit(s) Error (MR6)	49	$7,472.87	$11.21	$2.82	$19.60
Improperly Completed Documentation Error (MR9)	13	$1,046.90	$6.60	$0.42	$12.77
Policy Violation Error (MR8)	4	$1,740.68	$5.49	-$4.88	$15.87
Procedure Coding Error (MR3)	16	$1,456.14	$4.74	-$0.14	$9.62
Administrative/Other Error (MR10)	1	$94.11	$0.04	N/A	N/A
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**296**	**$197,832.14**	**$91.07**	**$68.43**	**$113.72**

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

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table T5. Summary of CHIP FFS Medical Review Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
No Reviewable Documentation Received Error (MR1)	124	$80,568.13	$44.96	$29.52	$60.39
Document(s) Absent from Record Error (MR2)	88	$105,453.30	$18.04	$11.85	$24.23
Number of Unit(s) Error (MR6)	34	$6,211.03	$9.13	$0.99	$17.28
Improperly Completed Documentation Error (MR9)	13	$1,046.90	$6.60	$0.42	$12.77
Policy Violation Error (MR8)	4	$1,740.68	$5.49	-$4.88	$15.87
Procedure Coding Error (MR3)	13	$1,190.69	$3.80	-$0.94	$8.54
Administrative/Other Error (MR10)	1	$94.11	$0.04	N/A	N/A
Medical Technical Deficiency (MTD)	1	$0.00	$0.00	N/A	N/A
Total	**278**	**$196,304.86**	**$88.06**	**$65.53**	**$110.58**

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

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

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)
Number of Unit(s) Error (MR6)	15	$1,261.83	$2.08	$0.05	$4.11
Procedure Coding Error (MR3)	3	$265.45	$0.93	-$0.22	$2.09
Total	**18**	**$1,527.28**	**$3.02**	**$0.68**	**$5.35**

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

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

Table T7. CHIP FFS Specific Causes of No Reviewable Documentation Received 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 responded with a statement that the beneficiary was not seen on the sampled DOS	25	$16,406.83	$11.69	$3.45	$19.93
Provider did not respond to the request for records	34	$23,366.36	$11.64	$2.90	$20.39
Documentation was not requested from the provider due to a fraud investigation or pending litigation	23	$25,129.41	$11.03	$2.78	$19.29
Provider responded that they did not have the beneficiary on file or in the system	6	$1,917.89	$2.85	-$0.47	$6.16
Provider responded with a statement that they had billed in error	19	$6,376.87	$2.33	$1.03	$3.62
Provider did not submit medical records, only billing information, which is insufficient to support the sampled claim	2	$281.19	$1.66	-$1.44	$4.75
Provider responded with a statement they were unable to locate the records	4	$3,207.51	$1.13	-$0.73	$2.99
Provider responded with a statement that there was no documentation for the encounter/billed service	2	$201.34	$1.01	-$0.44	$2.46
Provider submitted a record for wrong date of service	1	$20.16	$0.54	N/A	N/A
State could not locate the provider	2	$187.16	$0.42	-$0.26	$1.11
Provider responded with a statement that they billed for the wrong beneficiary	3	$227.62	$0.36	-$0.07	$0.79
Provider responded that they are no longer operating business/practice, and the record is unavailable	2	$1,836.83	$0.20	-$0.08	$0.49
Other	1	$1,408.95	$0.09	N/A	N/A
Total	**124**	**$80,568.13**	**$44.96**	**$29.52**	**$60.39**

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

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

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

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

Documentation Type	Total Count
Provider did not submit the individual plan (ITP, ISP, IFSP, IEP, or POC) or records did not support all sampled DOS	45
Provider did not submit progress notes or records did not support all sampled DOS	15
Provider did not submit a physician's order for the sampled service	9
Provider did not submit all antepartum/prenatal visit records	7
Provider did not submit all postpartum/postnatal visit records	7
Provider did not submit the therapy visit notes (PT/OT/ST) or records did not support all sampled DOS	5
Provider did not submit the signed timesheet/Electronic Visit Verification (EVV) record or records did not support all sampled DOS	4
Other	3
Provider did not submit the school-based services service note (behavioral, medication administration, nursing, attendance record) or records did not support all sampled DOS	3
Provider did not submit psychiatric/mental health evaluation	2
Provider did not submit proof of delivery	1
Provider did not submit the signature page(s) pertaining to ITP, ISP, IFSP, IEP or POC	1
Provider did not submit transportation log or records did not support all sampled DOS	1
Total	**103**

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	40	1,448
Psychiatric, Mental Health, and Behavioral Health Services	30	2,408
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	16	961
Clinic Services	4	1,286
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	4	309
Personal Support Services	3	220
Home Health Services	2	68
Outpatient Hospital Services	2	1,384
DME and Supplies, Prosthetic/Orthopedic Devices, and Environmental Modifications	1	161
Prescribed Drugs	1	2,914
Total	**103**	**15,970**

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. Provider type association is based on the category of service in which the claim was sampled/identified.

CHIP FFS Medical Review Errors by Service Type

Table T10. CHIP FFS Medical Review Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	36	36	961	$21,454.18	$277,950.40	$21.87	$314.77	6.95%	2.46% - 11.44%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	76	74	1,448	$21,162.80	$494,822.72	$14.97	$400.47	3.74%	1.55% - 5.92%
Psychiatric, Mental Health, and Behavioral Health Services	90	89	2,408	$120,145.78	$2,751,705.15	$13.27	$741.84	1.79%	1.06% - 2.52%
Clinic Services	21	21	1,286	$4,723.22	$381,330.78	$11.40	$463.46	2.46%	0.96% - 3.96%
Dental and Oral Surgery Services	20	20	1,925	$3,281.38	$405,185.50	$5.03	$551.88	0.91%	0.33% - 1.50%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	13	13	309	$1,415.09	$23,078.84	$4.92	$86.65	5.68%	1.44% - 9.91%
Outpatient Hospital Services	9	9	1,384	$2,842.58	$2,012,333.95	$4.83	$394.61	1.22%	(0.30%) - 2.74%
Laboratory, X-ray and Imaging Services	4	4	206	$178.59	$47,444.59	$4.49	$64.60	6.95%	(2.87%) - 16.77%
DME and Supplies, Prosthetic/ Orthopedic Devices, and Environmental Modifications	7	7	161	$2,280.69	$139,357.09	$3.26	$56.34	5.79%	(0.64%) - 12.22%
Transportation and Accommodations	2	2	229	$318.00	$335,941.26	$2.30	$27.93	8.22%	(6.43%) - 22.86%
Prescribed Drugs	8	8	2,914	$7,206.34	$18,403,103.15	$1.49	$1,096.16	0.14%	0.00% - 0.27%
Personal Support Services	6	6	220	$1,543.43	$82,520.86	$0.97	$42.54	2.27%	(0.73%) - 5.27%
Home Health Services	2	1	68	$734.23	$40,299.15	$0.70	$25.24	2.76%	(2.59%) - 8.11%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Inpatient Hospital Services	2	2	1,101	$9,274.34	$29,448,191.96	$0.33	$504.94	0.07%	(0.03%) - 0.16%
Capitated Care/Fixed Payments	0	0	692	$0.00	$538,266.60	$0.00	$383.34	0.00%	0.00% - 0.00%
Crossover Claims	0	0	36	$0.00	$1,522.20	$0.00	$0.45	0.00%	0.00% - 0.00%
Denied Claims	0	0	600	$0.00	$111.23	$0.00	$0.88	0.00%	0.00% - 0.00%
Hospice Services	0	0	9	$0.00	$28,455.11	$0.00	$3.70	0.00%	0.00% - 0.00%
ICF for ICF/IID and ICF/Group Homes	0	0	11	$0.00	$129,747.91	$0.00	$5.05	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or ICF	0	0	2	$0.00	$11,954.35	$0.00	$0.13	0.00%	0.00% - 0.00%
Total	**296**	**292**	**15,970**	**$196,560.65**	**$55,553,322.80**	**$89.82**	**$5,164.98**	**1.74%**	**1.32% - 2.16%**

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

Table T11. Summary of CHIP FFS Data Processing Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/Enrollment Error (DP10)	819	$253,968.29	$140.17	$123.37	$156.96
Non-Covered Service/Beneficiary Eligibility/MMIS System Error (DP2)	141	$610,282.74	$28.98	$13.99	$43.98
Pricing Error (DP5)	50	$395,550.51	$7.48	$4.04	$10.92
Administrative/Other Error (DP12)	2	$416.07	$0.85	-$0.56	$2.26
Third-Party Liability Error (DP4)	8	$1,142.58	$0.55	-$0.09	$1.20
Data Processing Technical Deficiency (DTD)	4	$0.00	$0.00	$0.00	$0.00
Total	**1,024**	**$1,261,360.19**	**$178.03**	**$155.26**	**$200.81**

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

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table T12. Summary of CHIP FFS Data Processing Overpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Provider Information/ Enrollment Error (DP10)	819	$253,968.29	$140.17	$123.37	$156.96
Non-Covered Service/ Beneficiary Eligibility/MMIS System Error (DP2)	141	$610,282.74	$28.98	$13.99	$43.98
Pricing Error (DP5)	31	$287,424.16	$4.01	$1.45	$6.57
Administrative/Other Error (DP12)	2	$416.07	$0.85	-$0.56	$2.26
Third-Party Liability Error (DP4)	8	$1,142.58	$0.55	-$0.09	$1.20
Data Processing Technical Deficiency (DTD)	4	$0.00	$0.00	$0.00	$0.00
Total	**1,005**	**$1,153,233.84**	**$174.56**	**$151.90**	**$197.22**

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

*Deficiencies were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table T13. Summary of CHIP FFS Data Processing Underpayments

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Pricing Error (DP5)	19	$108,126.35	$3.47	$1.14	$5.80
Total	**19**	**$108,126.35**	**$3.47**	**$1.14**	**$5.80**

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 T14. CHIP FFS Specific Causes of Provider Information/Enrollment Error (DP10)

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	406	$87,050.89	$62.25	$55.32	$69.18
National Provider Identifier (NPI)	290	$68,304.70	$47.45	$37.86	$57.04
Attending or rendering provider NPI required, but not listed on claim	68	$13,438.21	$10.98	$7.74	$14.21
Provider Enrollment	23	$73,397.82	$15.18	$3.39	$26.98
Other missing provider information	24	$5,297.78	$3.12	$1.61	$4.64
Provider License/Certification	8	$6,478.89	$1.18	$0.18	$2.19
Total	**819**	**$253,968.29**	**$140.17**	**$123.37**	**$156.96**

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

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

Provider Type Missing NPI	Sub-Cause of Error	Number of Errors
Attending	No NPI on the claim	7
	Wrong NPI on the claim	1
Billing	No NPI on the claim	2
	Wrong NPI on the claim	5
ORP	No NPI on the claim	268
	Wrong NPI on the claim	9
Rendering	No NPI on the claim	66

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

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

Breakdown	Additional Detail	Number of Errors
Provider Enrollment Status	Newly Enrolled	406
Provider Risk Level	Limited	325
	High	81
Provider Type	Rendering	251
	Billing	124
	ORP	29
	Attending	2
Screening Elements Not Completed	LEIE not checked	164
	DMF not checked	152
	NPPES not checked	145
	SAM/EPLS not checked	42
	FCBC not conducted	16
	On-site not conducted	13
	No required databases checked	9

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. Revalidations, including Risk-based screenings, were paused due to covid flexibilities afforded to states. No revalidated providers were reviewed during the PHE for screening requirements.

Table T17. DP10 CHIP Errors: Provider Not Enrolled Breakdown

Provider Type Not Enrolled	Number of Errors
ORP	21
Attending	2

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

CHIP FFS Data Processing Errors by Service Type

Table T18. CHIP FFS Data Processing Errors by Service Type

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Psychiatric, Mental Health, and Behavioral Health Services	505	388	2,408	$95,765.34	$2,751,705.15	$60.39	$741.84	8.14%	7.11% - 9.18%
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	225	221	1,448	$22,024.89	$494,822.72	$27.30	$400.47	6.82%	4.88% - 8.75%
Prescribed Drugs	50	47	2,914	$189,240.66	$18,403,103.15	$18.76	$1,096.16	1.71%	0.37% - 3.05%
Outpatient Hospital Services	44	43	1,384	$31,954.34	$2,012,333.95	$9.06	$394.61	2.30%	0.19% - 4.40%
Inpatient Hospital Services	38	37	1,101	$815,901.75	$29,448,191.96	$8.23	$504.94	1.63%	0.98% - 2.28%
Dental and Oral Surgery Services	36	33	1,925	$6,688.23	$405,185.50	$7.29	$551.88	1.32%	0.65% - 1.99%
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	26	25	309	$1,053.18	$23,078.84	$6.59	$86.65	7.61%	2.87% - 12.34%
Clinic Services	32	32	1,286	$15,873.38	$381,330.78	$4.53	$463.46	0.98%	0.03% - 1.92%
Home Health Services	14	10	68	$20,832.05	$40,299.15	$4.29	$25.24	16.99%	4.02% - 29.96%
Physicians and Other Licensed Practitioner Services (includes APN, PA, Nurse Midwife and Midwife)	12	11	961	$2,429.64	$277,950.40	$4.16	$314.77	1.32%	(0.74%) - 3.38%
DME and Supplies, Prosthetic/ Orthopedic Devices, and Environmental Modifications	10	10	161	$2,538.92	$139,357.09	$2.32	$56.34	4.12%	0.28% - 7.95%
Capitated Care/Fixed Payments	7	7	692	$416.40	$538,266.60	$1.99	$383.34	0.52%	(0.03%) - 1.07%

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
Personal Support Services	9	8	220	$3,333.83	$82,520.86	$0.99	$42.54	2.33%	0.50% - 4.15%
Laboratory, X-ray and Imaging Services	6	6	206	$9,377.25	$47,444.59	$0.73	$64.60	1.13%	0.07% - 2.19%
Transportation and Accommodations	4	4	229	$1,237.11	$335,941.26	$0.26	$27.93	0.93%	(0.24%) - 2.10%
ICF for ICF/IID and ICF/Group Homes	2	2	11	$12,806.67	$129,747.91	$0.20	$5.05	3.97%	(3.52%) - 11.46%
Crossover Claims	4	4	36	$422.49	$1,522.20	$0.00	$0.45	0.19%	(0.06%) - 0.45%
Denied Claims	0	0	600	$0.00	$111.23	$0.00	$0.88	0.00%	0.00% - 0.00%
Hospice Services	0	0	9	$0.00	$28,455.11	$0.00	$3.70	0.00%	0.00% - 0.00%
Nursing Facility, Chronic Care Services or ICF	0	0	2	$0.00	$11,954.35	$0.00	$0.13	0.00%	0.00% - 0.00%
Total	**1,024**	**888**	**15,970**	**$1,231,896.13**	**$55,553,322.80**	**$157.10**	**$5,164.98**	**3.04%**	**2.63% - 3.45%**

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

CHIP Managed Care Errors by Type of Error

Table T19. Summary of CHIP Managed Care Data Processing Projected Federal Dollars by Type of Error

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Non-Covered Service/Beneficiary Eligibility/MMIS System Error (DP2)	16	$2,174.21	$141.59	-$1.56	$284.73
Pricing Error (DP5)	1	$0.69	$0.05	N/A	N/A
Total	**17**	**$2,174.89**	**$141.64**	**-$1.51**	**$284.79**

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

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

Table T20. CHIP Managed Care Specific Causes of Non-Covered Service/Beneficiary Eligibility/ MMIS System 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)
Eligibility in source system and MMIS match, but claim should not have paid under CHIP	12	$1,850.16	$124.79	-$16.98	$266.56
Capitation payment was made for beneficiary not enrolled in a managed care organization (MCO)	1	$122.78	$7.96	N/A	N/A
Medicaid/CHIP eligibility in source system does not match eligibility in MMIS for beneficiary on the claim DOS	1	$122.78	$7.96	N/A	N/A
Other	2	$78.48	$0.87	-$0.34	$2.08
Total	**16**	**$2,174.21**	**$141.59**	**-$1.56**	**$284.73**

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

CHIP Eligibility Review Errors by Eligibility Category

Table T21. CHIP ELG Eligibility Review Errors by Eligibility Category

Category	Number of Errors	Number of Claims in Error	Number of Claims Sampled	Sample Federal Improper Payments	Sample Federal Paid Amount	Projected Federal Improper Payments (millions)	Projected Federal Paid Amount (millions)	Federal Improper Payment Rate	95% Confidence Interval
MAGI - Medicaid CHIP Expansion	536	489	7,887	$1,063,724.42	$15,660,698.90	$666.15	$13,212.12	5.04%	4.14% - 5.95%
MAGI - CHIP	174	160	3,152	$246,701.09	$6,482,950.32	$226.30	$5,062.86	4.47%	3.24% - 5.69%
Unborn Child	112	111	745	$113,635.36	$1,302,225.72	$108.50	$767.79	14.13%	11.34% - 16.93%
Other	12	12	87	$2,103,257.25	$2,363,225.01	$14.86	$126.66	11.73%	3.49% - 19.98%
MAGI - Children under Age 19	3	2	65	$276.53	$237,378.74	$1.60	$158.11	1.01%	(0.41%) - 2.43%
TEFRA/Katie Beckett	1	1	2	$38.98	$1,139.21	$0.18	$1.26	14.22%	(19.59%) - 48.03%
1115 Waiver Programs	0	0	18	$0.00	$13,930.00	$0.00	$26.76	0.00%	0.00% - 0.00%
Aged, Blind, and Disabled - Mandatory and Optional Categorically Needy	0	0	1	$0.00	$39.50	$0.00	$0.17	0.00%	0.00% - 0.00%
Emergency Services (Including for Non-Citizens)	0	0	1	$0.00	$1,243.83	$0.00	$0.96	0.00%	0.00% - 0.00%
MAGI - CHIP Pregnant Women	0	0	38	$0.00	$82,942.07	$0.00	$74.75	0.00%	0.00% - 0.00%
MAGI - Medicaid Expansion - Newly Eligible	0	0	1	$0.00	$252.07	$0.00	$0.29	0.00%	0.00% - 0.00%
MAGI - Medicaid Expansion - Not Newly Eligible	0	0	1	$0.00	$4,842.43	$0.00	$0.13	0.00%	0.00% - 0.00%
Presumptive Eligibility	0	0	15	$0.00	$7,350.28	$0.00	$11.63	0.00%	0.00% - 0.00%
SSI Recipients	0	0	7	$0.00	$44,217.26	$0.00	$5.28	0.00%	0.00% - 0.00%
Total	**838**	**775**	**12,020**	**$3,527,633.63**	**$26,202,435.34**	**$1,017.58**	**$19,448.78**	**5.23%**	**4.66% - 5.81%**

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 T22. Summary of CHIP Eligibility Review Overall Errors

Error Type	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	288	$314,583.29	$405.80	$299.79	$511.81
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	207	$2,660,089.00	$218.37	$176.29	$260.45
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	106	$185,128.93	$156.51	$95.69	$217.33
Other Errors (ER10)	34	$6,134.34	$114.07	$52.44	$175.70
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	81	$59,627.95	$83.61	$63.41	$103.81
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	72	$272,978.87	$71.98	$50.66	$93.30
Not Eligible for Enrolled Program; Financial Issue (ER4)	39	$330,997.48	$41.61	$25.06	$58.16
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	3	$3,174.54	$18.51	-$4.19	$41.21
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	8	$0.00	$0.00	$0.00	$0.00
Total	**838**	**$3,832,714.40**	**$1,110.45**	**$964.58**	**$1,256.33**

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. 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.

*Deficiencies (ERTDs) were no longer cited beginning in the RY 2024 cycle. Any deficiencies included in this report are from prior cycle results in rolling data.

Table T23. 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	491	$1,438,851.83	$679.25	$550.23	$808.28
System	172	$2,254,719.43	$193.11	$160.95	$225.28
Policy	120	$117,670.14	$187.46	$124.45	$250.47
Multiple	54	$21,240.99	$50.49	$33.31	$67.67
Unable to Determine	1	$232.01	$0.13	N/A	N/A
Total	**838**	**$3,832,714.40**	**$1,110.45**	**$964.58**	**$1,256.33**

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 T24. 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	483	443	5,674	$466,600.64	$541.82	6.02%	5.15% - 6.90%
Application	207	184	1,378	$2,970,108.00	$279.32	14.86%	9.89% - 19.82%
Not Applicable	67	67	3,600	$31,526.81	$110.15	1.70%	1.16% - 2.24%
Change	77	77	1,364	$58,127.52	$79.28	3.82%	2.70% - 4.93%
Unknown	4	4	4	$1,270.66	$7.01	100.00%	100.00% - 100.00%
Total	**838**	**775**	**12,020**	**$3,527,633.63**	**$1,017.58**	**5.23%**	**4.66% - 5.81%**

Note: Details do not always sum to the total due to rounding. For case action categories with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report. Further explanation of case actions can be found in Section 4: Case Action Glossary, Table A5.

Table T25. 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	476	438	7,061	$126,685.46	$736.93	5.14%	4.31% - 5.97%
FFS	362	337	4,959	$3,400,948.17	$280.65	5.49%	4.19% - 6.80%
Total	**838**	**775**	**12,020**	**$3,527,633.63**	**$1,017.58**	**5.23%**	**4.66% - 5.81%**

Note: Details do not always sum to the total due to rounding. For claim types with fewer than two claims per sample stratum, a confidence interval is not calculated. Additionally, multiple errors on a claim are not counted separately in this table, except for the "Number of Errors" column. As a result, this table may not match other breakouts in the report.

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

Table T26. Specific Causes of Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility Error (ER2)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Income verification not on file/incomplete	219	$220,366.84	$311.12	$218.76	$403.48
TPL verification not on file/ incomplete	9	$7,646.11	$35.68	-$13.77	$85.14
Signature not obtained	29	$64,677.39	$30.22	$17.35	$43.09
Discrepant information not acted upon	19	$5,578.57	$13.92	$6.15	$21.69
Demographic verification not on file/incomplete	8	$15,769.13	$7.73	$2.33	$13.14
Other verification/other required forms not on file/incomplete	2	$288.62	$3.93	-$1.52	$9.37
Eligibility process(es) not followed	2	$256.63	$3.20	-$1.33	$7.72
Total	**288**	**$314,583.29**	**$405.80**	**$299.79**	**$511.81**

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

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

Table T27. Specific Causes of Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) Error (ER6)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Other non-financial error	48	$2,354,675.36	$43.60	$24.92	$62.28
Beneficiary had credible health insurance (CHIP only)	36	$24,434.99	$41.79	$17.95	$65.63
MAGI tax filer/tax dependent status incorrect	29	$18,532.16	$26.83	$13.93	$39.74
Income correctly calculated; below income limit	17	$32,676.07	$22.76	$10.71	$34.82
Information provided, not acted on as required	19	$40,077.74	$21.76	$6.69	$36.83
Pre-tax deduction incorrectly not applied	14	$16,016.94	$14.32	$5.16	$23.48
Income incorrectly calculated	14	$7,380.29	$13.52	$4.32	$22.71
MAGI non-filer/non-dependent status incorrect	7	$1,592.34	$8.86	$1.59	$16.12
Income incorrectly included	7	$136,860.25	$7.75	$1.17	$14.34
Data entry error	3	$674.83	$4.60	-$1.66	$10.86
Requirement not met	4	$18,463.66	$4.57	-$1.20	$10.33
MAGI tax dependent exception incorrect	3	$7,573.87	$4.12	-$0.56	$8.79
Income conversion factor incorrect	2	$374.67	$1.53	-$1.00	$4.06
Other financial error	2	$253.64	$1.21	-$0.52	$2.93
Exempt income incorrectly included	2	$502.19	$1.16	-$0.77	$3.09
Total	**207**	**$2,660,089.00**	**$218.37**	**$176.29**	**$260.45**

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

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

Table T28. Specific Causes of Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility Error (ER3)

Cause of Error	Number of Errors	Sample Federal Improper Payments	Projected Federal Improper Payments (millions)	Lower Confidence Limit (millions)	Upper Confidence Limit (millions)
Redetermination not conducted within 12 months before date of payment for services	87	$176,720.28	$130.32	$71.08	$189.56
Initial determination not conducted	9	$2,306.01	$16.15	$4.21	$28.09
Determination not conducted after underlying eligibility was terminated	10	$6,102.64	$10.04	$3.18	$16.90
Total	**106**	**$185,128.93**	**$156.51**	**$95.69**	**$217.33**

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.

Section 4: Error Codes/Glossaries

Table A1. Medical Review Error Codes

Error Code	Error	Definition
MR1	No Reviewable Documentation Received 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 or the provider did not send any documentation related to the sampled payment (i.e., wrong date of service, wrong beneficiary).
MR2	Document(s) Absent from Record Error	The submitted medical documentation is missing required documents, 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.
MR3	Procedure Coding Error	The medical service, treatment, and/or equipment was medically necessary and was provided at the proper level of care, but was billed and paid based on a wrong procedure code.
MR4	Diagnosis Coding/DRG Error	According to the medical record, the principal diagnosis code was incorrect or the payer paid for an incorrect DRG, resulting in a payment error.
MR5	Unbundling Error	A set of medical services was provided and billed as separate services when a CMS regulation, policy, or local practice dictates that the services should have been billed as a set.
MR6	Number of Unit(s) Error	The number of units billed by the provider were not supported in the record documentation.
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.
MR8	Policy Violation Error	The billed service or procedure did not comply with a documented policy that applied to the service or procedure at the time it was performed and/or billed.
MR9	Improperly Completed Documentation Error	The required forms and documents are present in the record, but are inadequately completed to verify that the services were provided in accordance with applicable policy or regulation.
MR10	Administrative/Other Error	MR determined a payment error, but the error does not fit into one of the other MR error categories.
*MTD**	*Medical Technical Deficiency*	*An identified instance of noncompliance with state policy during a case review that does not result in a difference between the amount paid and the amount that should have been paid (i.e., an improper payment).*

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

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 Eligibility/MMIS System Error	The state's policy indicates that the service billed on the sampled claim is not payable by the Medicaid or CHIP programs and/or the beneficiary eligibility status is not consistent between the eligibility source system and MMIS for the coverage category for the service.
DP3	FFS Payment for a Managed Care Service Error	The beneficiary is enrolled in a 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 MC 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 MC 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	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*	*An RBS provider enrollment deficiency was found during data processing review that did not result in a payment error.*

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

Table A3. Eligibility Error Codes

Error Code	Error	Definition
ER1	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicates that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.
ER2	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.
ER3	Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility	The state could not provide evidence that the state conducted an eligibility determination or completed a timely redetermination.
ER4	Not Eligible for Enrolled Program; Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the financial elements of the eligibility determination.
ER5	Not Eligible for Enrolled Program; Non-Financial Issue	The beneficiary is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) due to an incorrect caseworker or system action relating to the non-financial elements of the eligibility determination.
ER6	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP)	The beneficiary is not eligible for the enrolled program (i.e., Medicaid or CHIP) but is eligible for the other program.
ER7	Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect Federal Medical Assistance Percentage (FMAP) Assignment	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP) but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.
ER8	Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category, which results in the individual receiving services for which they were not eligible.
ER9	Federally-Facilitated Exchange-Determination (FFE-D) Error	Not applicable to states calculated error rate but applies to national error rate based upon Federal Exchange decisions; used for errors when the FFE incorrectly determined eligibility for the beneficiary.
ER10	Other Errors	The beneficiary is improperly denied or terminated, or the contribution to care calculation is incorrectly calculated, or the beneficiary is eligible for emergency services only.
*ERTD 1**	*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.*
*ERTD 2**	*Finding Noted With Case, But Did Not Affect Case Determination or Payment*	*The state completed an eligibility determination that was not in accordance with timeliness standards, but was completed before the claim date of payment, or an "other" finding was noted that does not impact claims payment.*

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

Table A4. Eligibility Root Cause Glossary

Root Cause	Definition
Caseworker	The determination under review had some elements that were completed by a caseworker and the finding related to the caseworker's actions.
System	The determination under review had some elements that were completed by a system and the finding related to a system action or indicator.
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 a process that was directly affected by more than one cause in the combination.
Policy	The state policy/process around the finding was not in compliance with Federal Regulation or other regulatory guidance; however, in the determination under review, the system actions were completed as expected and/or the caseworker followed all state policies/processes correctly.
Unable to Determine	The ERC was unable to identify the root cause of what led to this error.

Table A5. Eligibility Case Action Glossary

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

Table A6. Acronym Glossary

Acronym	Definition
APN	Advanced Practice Nurse
ASC	Accredited Standards Committee
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CI	Confidence Interval
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
DME	Durable Medical Equipment
DMF	Social Security Death Master File
DOS	Date Of Service
DP	Data Processing
DR	Difference Resolution
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
ER	Eligibility Review
ERC	Eligibility Review Contractor
FBDE	Full Benefit Dual Eligible
FCBC	Fingerprint-based Criminal Background Check
FEFR	Final Errors for Recovery
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Reviews
H&P	History and Physical
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICF	Intermediate Care Facility
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IID	Individuals With Intellectual Disabilities
IPP	Individual Program Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
IV	Independent Verification
LEIE	List of Excluded Individuals/Entities
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MAR	Medication Administration Record
MC	Managed Care

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

For more information on the PERM methodology and findings please visit www.cms.gov/perm and the 2025 HHS AFR.