U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

RY 2019 Pennsylvania Medicaid

Payment Error Rate Measurement (PERM) Cycle 1 Summary Report

November 26, 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

A. Program and Report Overview

This report gives an analysis and breakdown of Pennsylvania's federal improper payment rate through the Payment Error Rate Measurement (PERM) program. The purpose of the PERM program is to produce a national-level improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

IPERIA is one of three Acts that require federal agencies to review their programs to:

- Identify programs at risk of improper payments;
- Estimate the amount of improper payments;
- Give those estimates to Congress; and
- Report on the actions taken to reduce the improper payments.

The Medicaid program and CHIP have been identified as programs at high risk of improper payments. The Centers for Medicare & Medicaid Services (CMS) measures these improper payments annually through the PERM program. The PERM program reviews three components: 1) Fee-For-Service (FFS) claims, 2) managed care capitation payments, and 3) eligibility determinations and resulting payments.

The PERM program requires a joint effort between CMS and the states to calculate the Medicaid and CHIP improper payment rates. To meet this objective, the PERM program uses a 17-state, three-year rotation cycle to measure improper payments. Each cycle, CMS measures a third of the states and all states are reviewed once every three years. Pennsylvania is a Cycle 1 state evaluated in Reporting Year (RY) 2019.

This report provides an overview of the RY 2019 findings and presents data analyses of payment errors found in the Pennsylvania Medicaid program. These findings, including the projected federal dollars in error, are meant to support the state during the corrective action process.

Reducing improper payments is a high priority for CMS, and states are critical partners in the corrective action phase of the PERM cycle. States' systems, claims payment methods, provider billing errors, and provider compliance with record requests all contribute to the cycle improper payment rates in various ways. PERM identifies and classifies different types of errors, but states must conduct root cause analyses to understand why the errors occurred and determine how to take corrective action.

During the PERM cycle, CMS and its contractors reviewed Medicaid FFS claims, managed care capitation payments, and eligibility determinations (using claims from the FFS and managed care universes). The first two sections of this report include the estimated 17-state cycle rates and state improper payment rates based on the results of the reviewed samples. The remaining sections include sample payments in error along with the projected federal improper payments for Pennsylvania, broken out by Medicaid FFS, managed care, and eligibility.[1] For Medicaid FFS and managed care, additional analysis from the Review Contractor is included to address Medicaid FFS medical review and data processing errors, as well as managed care data processing errors.

[1] PERM combines components (FFS and managed care) into a single universe when a given component accounts for less than 2% of total expenditures included in the PERM universe for that state and program.

For Medicaid eligibility, additional analysis from the Eligibility Review Contractor is included to address Medicaid eligibility review errors.

Note that much of the analysis provided in the document is focused on projected federal dollars in error, which are an estimate for how much the state may have paid incorrectly. The projected federal dollars in error are estimated by multiplying the sampled federal improper payments by the appropriate weight based on the universe size from which the sample was selected with respect to the known expenditures, as reported in the Medicaid and CHIP CMS 64/21 reports. The projected paid amount is the sum of all expenditures listed on the Medicaid and CHIP CMS 64/21 reports.

States are encouraged to use the projected federal dollars in error figures, which include both overpayments and underpayments, in the cycle summary reports for purposes of identifying which factors (e.g., error types, provider types) had the biggest contribution to a state's federal improper payment rate. The number provides a good indication of an improper payment's impact on a state's federal improper payment rate and can be used to appropriately target corrective actions. However, states are cautioned from taking the projected federal dollars in error for certain levels of analysis (for example, by error type per provider type) to be an exact reflection of the actual federal dollars in error because they are estimates using the PERM sample and sometimes have wide confidence intervals.

B. PERM 17-State Cycle 1 Medicaid Findings

In RY 2019, the combined Cycle 1 Medicaid estimated federal improper payment rate is **26.18%**. The estimated cycle component federal improper payment rates are as follows.

- **Medicaid FFS - 15.12%**
- **Medicaid managed care - 0.00%**
- **Medicaid eligibility - 20.60%**

C. Pennsylvania's Medicaid Findings

In RY 2019, Pennsylvania's Medicaid estimated federal improper payment rate is **14.24%**. Pennsylvania's sample review findings by component are as follows.

- **Pennsylvania's Medicaid FFS estimated federal improper payment rate is 8.74%**
- **Pennsylvania's Medicaid managed care does not have any sampled errors**
- **Pennsylvania's Medicaid eligibility estimated federal improper payment rate is 11.36%**

Figure 1 shows Pennsylvania's Medicaid federal improper payment rate compared to the Cycle 1 combined Medicaid federal improper payment rate and other Cycle 1 states' Medicaid federal improper payment rates.

Pennsylvania Figure 1: State Medicaid Federal Improper Payment Rate Relative to Other States and the Combined Cycle Medicaid Federal Improper Payment Rate

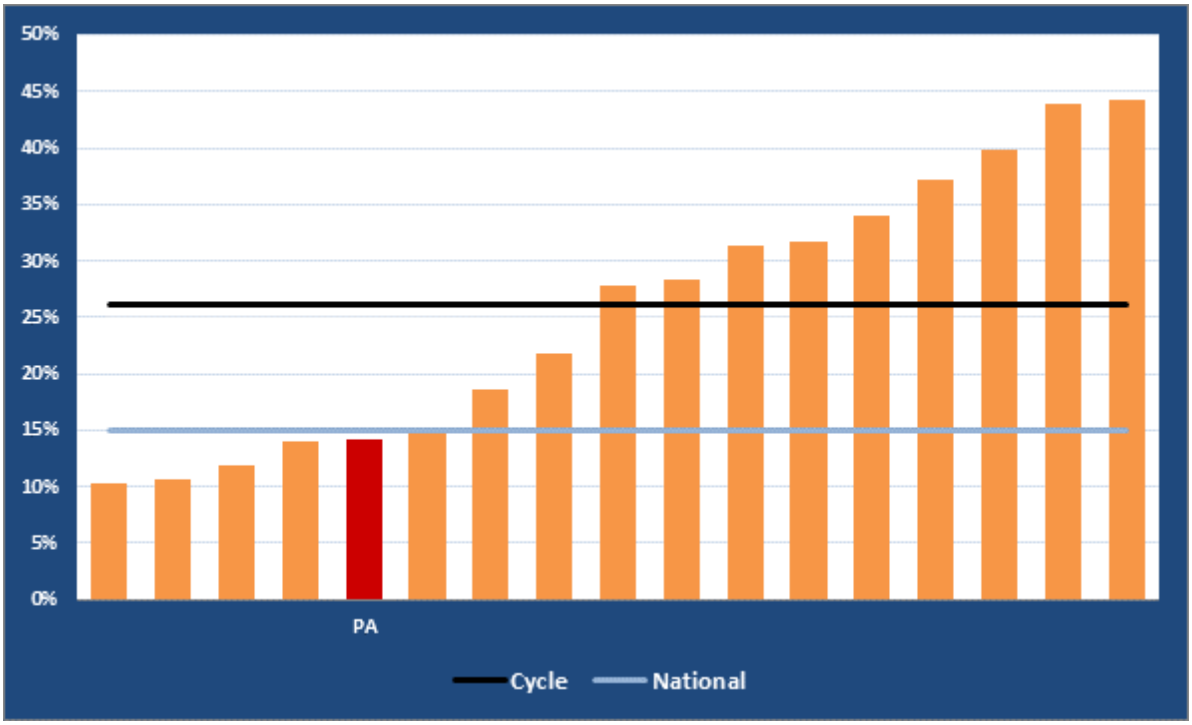
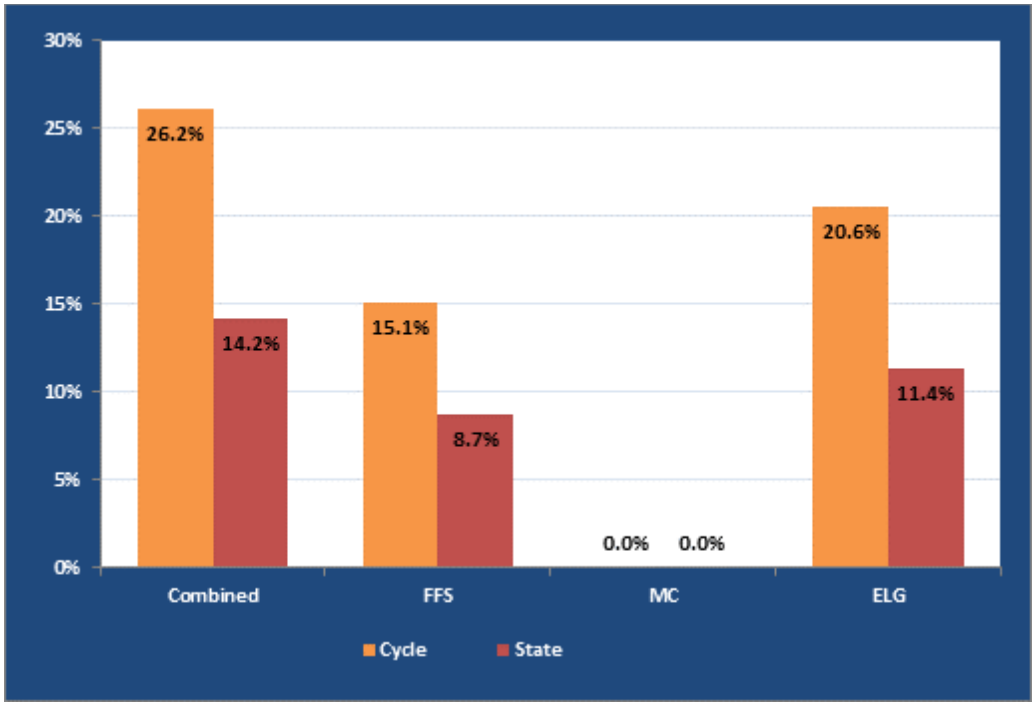


Figure 2 compares Cycle 1 and Pennsylvania on the combined Medicaid federal improper payment rate and the component Medicaid federal improper payment rates.

Pennsylvania Figure 2: Cycle and State Medicaid Combined and Component Federal Improper Payment Rates



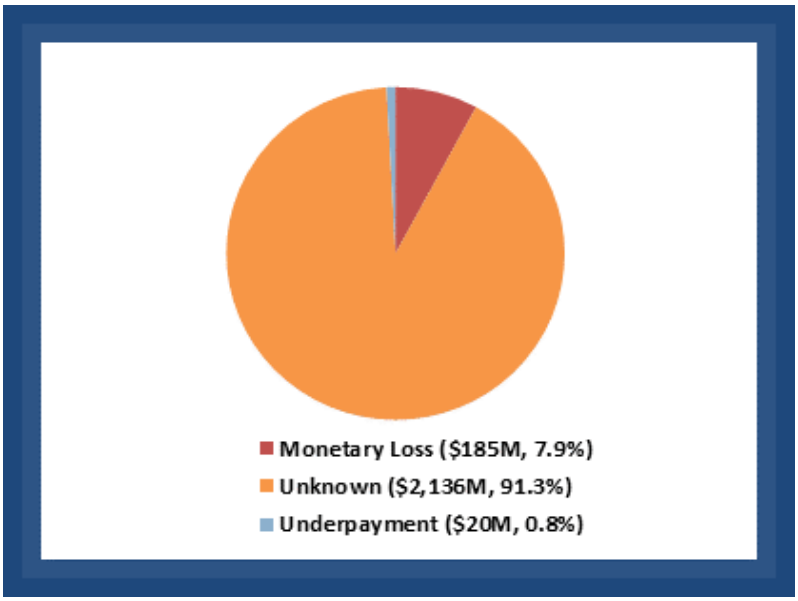
Please note that the PERM FFS review includes payments made to individual providers, while the managed care review only looks at capitated payments made by states to managed care organizations, not payments made by managed care organizations to providers. Therefore, the managed care measurement does not include some errors observed in the FFS component.

In addition, please note that improper payments do not necessarily represent expenses that should not have occurred. For example, on a national level, the majority of Medicaid improper payments were due to instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers. However, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable. Additionally, some improper payments are due to provider documentation errors where CMS could not determine whether the billed services were actually provided, were correctly billed, and/or were medically necessary. However, if the documentation had been submitted or providers had complete and sufficient documentation, then the claims may have been payable. On the national level, a smaller proportion of improper payments are claims where CMS determines that the Medicaid payment should not have been made or should have been made in a different amount and are considered a known monetary loss to the program (i.e., not medically necessary, made for a non-covered service, paid to a provider not enrolled in the program).

See Figure 3 below, which presents the proportion of Pennsylvania's Medicaid federal improper payments that are considered a known monetary loss to the program. In the figure, the "Unknown" represents payments where there is no or insufficient documentation to support the payment as

proper or a known monetary loss. For example, it represents claims where necessary information was missing from the claim or states did not follow appropriate processes. These are payments where more information is needed to determine if the claims were payable or if they should be considered monetary losses to the program. The Corrective Action Plan (CAP) template includes further details on each of these claims.

Pennsylvania Figure 3: Medicaid Percentage of Projected Dollars in Error (in Millions) by Monetary Loss



D. Sample Medicaid Findings and Projected Federal Dollars in Error

The analyses in this section are for sample federal dollars in error and projected federal dollars in error. The sample federal dollars in error are the improper payments found through data processing and medical review. Only Medicaid FFS claims are eligible for medical review. The projected federal dollars in error are the claim-weighted error amounts that are used to form the numerators for each state's component federal improper payment rates. The weights for each sampled claim are based on the universe size from which the sample was selected (i.e., universe of Medicaid FFS claims and universe of managed care payments). The projected federal dollars in error is an estimate of the total federal dollars that may have been paid incorrectly across the program during the year. The projection assumes that the errors may be generalized to the Medicaid program in proportion to the rate and amount observed in the sample.

Table 1 summarizes the Medicaid number of errors and associated dollars for Pennsylvania and the cycle by component. Please note that, because each of the component samples is weighted, the proportion of sample federal dollars in error will be different than the proportion of the projected federal dollars in error.

Pennsylvania Table 1: Medicaid Program Component by State and Cycle Sample Error Payments

Medicaid Program Component	State					Cycle				
	# of Sample Claims	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total Projected Federal Dollars in Error	# of Sample Claims	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error (in Millions)	% of Total Projected Federal Dollars in Error
Medicaid FFS	761	75	$90,548	**$519,992,086**	22.21%	8,917	1,680	$2,394,232	**$7,242**	25.45%
Medicaid Managed Care	40	0	$0	**$0**	0.00%	1,015	0	$0	**$0**	0.00%
Medicaid Eligibility	677	201	$96,160	**$1,821,156,133**	77.79%	6,003	1,888	$1,851,951	**$21,218**	74.55%

Note: States are cautioned from making direct comparisons to the cycle data throughout this report, as each state program is unique and can vary greatly from the overall cycle composition. Also, deficiencies (discrepancies found in the review of the claim or of the medical record that did not result in a payment error) are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are not counted separately in this table and may not match other tables in the report.

Table 2 compares Pennsylvania's number of errors, sample federal dollars in error, and projected federal dollars in error to those found in Cycle 1 by error type for Medicaid FFS.

Pennsylvania Table 2: Medicaid FFS Cycle and State Number of Errors and Federal Dollars in Error by Type of Error

	# of Sample Errors		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
FFS Medical Review Errors						
No Documentation Error (MR1)	1	59	$30	$75,892	**$12,458,829**	**$249**
Document(s) Absent from Record (MR2)	7	118	$13,246	$158,077	**$56,459,901**	**$586**
Procedure Coding Error (MR3)	0	5	$0	$4,460	**$0**	**$12**
Number of Unit(s) Error (MR6)	4	19	$201	$21,150	**$31,649,192**	**$100**
Policy Violation Error (MR8)	0	2	$0	$6,038	**$0**	**$14**
Improperly Completed Documentation (MR9)	1	31	$1,980	$62,453	**$12,399,770**	**$177**
Administrative/Other Error (MR10)	0	3	$0	$6,326	**$0**	**$9**
Medical Technical Deficiency (MTD)	0	13	$0	$0	**$0**	**$0**
Total	13	250	$15,457	$334,396	**$112,967,691**	**$1,147**
FFS Data Processing Errors						
Duplicate Claim Error (DP1)	0	46	$0	$6,568	**$0**	**$276**
Non-covered Service/Beneficiary Error (DP2)	0	24	$0	$33,452	**$0**	**$184**
Third-Party Liability Error (DP4)	0	3	$0	$5,639	**$0**	**$31**
Pricing Error (DP5)	0	41	$0	$8,932	**$0**	**$35**
Managed Care Rate Cell Error (DP8)	0	1	$0	$0	**$0**	**$0**
Managed Care Payment Error (DP9)	0	2	$0	$227	**$0**	**$91**
Provider Information/Enrollment Error (DP10)	51	1,386	$78,761	$2,234,471	**$436,258,386**	**$6,118**
Claim Filed Untimely Error (DP11)	0	1	$0	$3,319	**$0**	**$1**
Administrative/Other Error (DP12)	0	25	$0	$8,684	**$0**	**$494**

	# of Sample Errors		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
Data Processing Technical Deficiency (DTD)	14	154	$0	$0	**$0**	**$0**
Total	65	1,683	$78,761	$2,301,293	**$436,258,386**	**$7,229**
Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. 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 explanations of error types can be found in Appendix A Error Type Definitions.						

Table 3 compares Pennsylvania's number of errors, sample federal dollars in error, and projected federal dollars in error to those found in Cycle 1 by error type for Medicaid.

Pennsylvania Table 3: Medicaid Eligibility Cycle and State Number of Errors and Federal Dollars in Error by Type of Error

	# of Sample Errors		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
Eligibility Review Errors						
Documentation to Support Eligibility Determination Not Maintained (ER1)	32	395	$64,921	$558,924	**$725,847,319**	**$8,541**
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	28	365	$20,536	$598,014	**$873,706,245**	**$7,351**
Determination Not Conducted as Required (ER3)	18	317	$8,307	$688,835	**$359,865,102**	**$5,353**
Not Eligible for Enrolled Program - Financial Issue (ER4)	3	36	$5,815	$45,302	**$72,905,122**	**$484**
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	0	10	$0	$12,094	**$0**	**$197**
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	2	18	$75	$2,786	**$31,481,799**	**$316**
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	2	14	$623	$13,203	**$38,557,379**	**$220**

	# of Sample Errors		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	7	$366	$6,801	**$28,789,812**	**$139**
Other Errors (ER10)	4	50	$449	$3,377	**$3,156,655**	**$28**
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	3	74	$0	$0	**$0**	**$0**
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	151	923	$0	$0	**$0**	**$0**
Total	244	2,209	$101,093	$1,929,335	**$2,134,309,433**	**$22,630**

Note: Details do not always sum to the total due to rounding. Also, deficiencies (discrepancies found in the review of the claim or of the medical record that did not result in a payment error) are included in the number of sample errors and number of sample claims in error counts throughout this report. 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 explanations of error types can be found in Appendix A Error Type Definitions.

E. Medicaid Medical Review and Data Processing Findings

1. Medicaid Fee-For-Service (FFS) Data Analyses

This section describes the types of Medicaid FFS payment errors. Table 4 compares Pennsylvania's Medicaid FFS errors to the cycle Medicaid FFS errors by service type.

Pennsylvania Table 4: Cycle and State Medicaid FFS Number of Claims in Error and Federal Dollars in Error by Service Type

Service Type	# of Sample Claims in Error		Sample Federal Dollars in Error		Projected Federal Dollars in Error		Federal Improper Payment Rate	
	State	Cycle	State	Cycle	State (in Millions)	Cycle (in Millions)	State	Cycle
Capitated Care/Fixed Payments	0	41	$0	$1,143	**$0**	**$550**	0.00%	10.51%
Crossover Claims	0	3	$0	$3	**$0**	**$1**	0.00%	0.16%
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	49	581	$30,187	$583,991	**$406**	**$2,385**	12.98%	23.00%
Denied Claims	0	0	$0	$0	**$0**	**$0**	N/A	N/A
Dental/Oral Surgery Services	0	59	$0	$11,992	**$0**	**$256**	0.00%	48.88%
Durable Medical Equipment (DME)/Supplies/Prosthetic/Orthopedic Devices/Environmental Modifications	0	9	$0	$10,507	**$0**	**$34**	0.00%	8.43%
Inpatient Hospital Services	0	13	$0	$139,738	**$0**	**$74**	0.00%	1.84%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes	8	90	$48,488	$497,584	**$64**	**$376**	23.02%	20.45%
Laboratory/X-ray/Imaging Services	0	9	$0	$175	**$0**	**$11**	0.00%	4.24%
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	15	313	$11,807	$666,234	**$29**	**$1,013**	1.93%	13.20%
Outpatient Hospital Services	0	12	$0	$31,849	**$0**	**$42**	0.00%	2.03%
Personal Support Services	0	168	$0	$30,886	**$0**	**$1,127**	0.00%	47.51%
Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment	1	30	$66	$1,305	**$21**	**$139**	100.00%	46.39%

Service Type	# of Sample Claims in Error		Sample Federal Dollars in Error		Projected Federal Dollars in Error		Federal Improper Payment Rate	
	State	Cycle	State	Cycle	State (in Millions)	Cycle (in Millions)	State	Cycle
Physicians/Other Licensed Practitioner Services (includes APN/PA/Nurse Midwife/Midwife)	0	24	$0	$7,163	**$0**	**$58**	0.00%	3.68%
Prescribed Drugs	2	203	$0	$248,276	**$0**	**$589**	0.00%	10.28%
Psychiatric/Mental Health/Behavioral Health Services	0	89	$0	$129,907	**$0**	**$369**	0.00%	13.09%
Total	75	1,644	$90,548	$2,360,753	**$520**	**$7,023**	8.74%	15.30%

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are not counted separately in this table (since claims are not sampled by service type, counting separately may have artificially inflated the results of a service type with claims that have multiple errors) and may not match other tables in the report.

a. Medicaid FFS Medical Review – Error Type Analysis

Figure 4 shows the percentage of Medicaid FFS medical review projected federal dollars in error by error type.

Pennsylvania Figure 4: Medicaid FFS Medical Review Percentage of Projected Federal Dollars in Error by Error Type

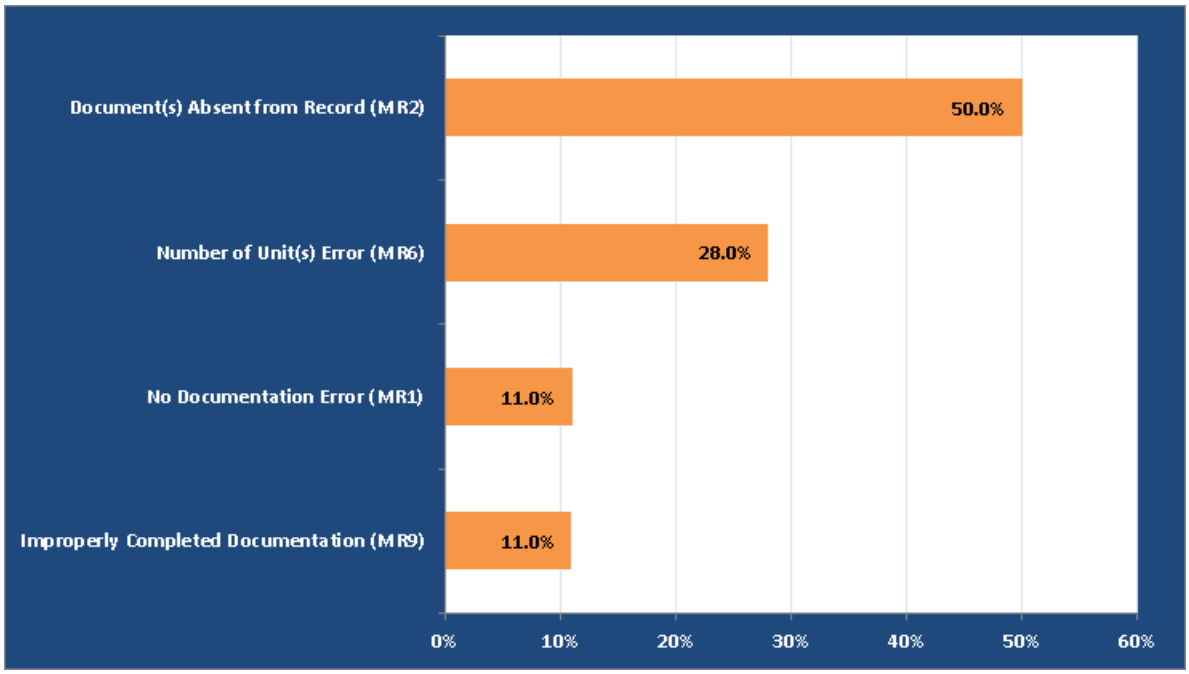


Table 5 contains information on the number of Medicaid FFS medical review errors and federal dollars in error by error type and percentage of total medical review errors.

Pennsylvania Table 5: Medicaid FFS Medical Review Error Type by Percentage of Medical Review Errors

Error Type	Overpayments			Percentage of Total Medical Review Errors		
	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Errors	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
No Documentation Error (MR1)	1	$30	**$12,458,829**	7.69%	0.19%	**11.03%**
Document(s) Absent from Record (MR2)	7	$13,246	**$56,459,901**	53.85%	85.69%	**49.98%**
Number of Unit(s) Error (MR6)	4	$201	**$31,649,192**	30.77%	1.30%	**28.02%**
Improperly Completed Documentation (MR9)	1	$1,980	**$12,399,770**	7.69%	12.81%	**10.98%**

Error Type	Overpayments			Percentage of Total Medical Review Errors		
	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Errors	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Total	13	$15,457	**$112,967,691**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. This also applies to Figure 4, above. There were no underpayments cited, so only overpayments are reported in this table.

Table 6 lists the Medicaid FFS medical review errors by their more specific causes of error. The error causes are more detailed descriptions of why PERM deemed a claim to be in error. The sections following the table describe each error. This report provides a full list of PERM IDs associated with each error in Section H. The title of Table 6 is hyperlinked to this list. In addition, the CAP template includes further details on each claim.

Pennsylvania Table 6: Medicaid FFS Medical Review Error Causes by Error Type

Error Type and Cause of Error	# of Sample Errors
No Documentation Error (MR1)	
Provider responded that he or she did not have the beneficiary on file or in the system	1
Document(s) Absent from Record (MR2)	
One or more documents are missing from the record that are required to support payment	7
Number of Unit(s) Error (MR6)	
Number of units billed not supported by number of units documented	4
Improperly Completed Documentation (MR9)	
Required provider signature and/or credentials are not present	1

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

FFS Medical Review Error Descriptions by Error Type

No Documentation Error (MR1)

Provider responded that he or she did not have the beneficiary on file or in the system

- One error was cited because the provider did not submit the requested records and responded that the beneficiary was neither on file nor in the system.

Document(s) Absent from Record Error (MR2)

One or more documents are missing from the record that are required to support payment

- One error was cited because the Plan of Care (POC) present was not applicable to the sampled DOS and the provider did not submit the required prior authorization for personal assistance services (Procedure code W1793) billed. The provider submitted service logs; a POC dated two years before the sampled dates; and a client care policy stating all POCs will be updated as the needs of the beneficiary change. However, these documents were not sufficient to demonstrate a required POC in effect for the sampled DOS or that the services were authorized, in accordance with state policy.
- Two errors were cited because the providers did not submit timesheets with daily documentation of specific tasks performed on the sampled dates of service for additional individual staffing (Procedure code W7085) and personal assistance services (Procedure code W1792) as required.
- One error was cited because the provider did not submit records with daily documentation of specific tasks performed on the sampled dates of service and the ISP for personal assistance services (Procedure code W1793) as required. The provider submitted clinical documentation for other dates of service and an ISP that did not have personal assistance services listed in the service details.
- One error was cited because the provider did not submit the ISP, physician's order or prescription, and personal care assistant daily log in support of personal care services (Procedure code T1019) for the sampled dates of service as required.
- One error was cited because the provider did not submit physician visit progress notes written within 60 days prior to or during the sampled dates of service for all-inclusive room and board services (Revenue code 0100) as required. The provider submitted physician visit progress notes that were not applicable to the sampled dates of service.
- One error was cited because the record did not include a complete list of physician orders for all-inclusive room and board services (Revenue code 0100) as required for the sampled dates of service.

Number of Unit(s) Error (MR6)

Number of units billed not supported by number of units documented

- Four errors were cited because the providers billed for more units of service than were documented for homecare services (Procedure code W7201 [1 claim]) and personal assistance services (W1793 [3 claims]).
    - For homecare services, the provider billed for 15 units, but documentation only supported eight units. Therefore, seven units were not represented in the submitted records.
    - For personal assistance services:

- The first provider billed for 101 units, but documentation only supported 68 units. Therefore, 33 units were not represented in the submitted records.
- The second provider billed for 102 units, but documentation only supported 86 units. Therefore, 16 units were not represented in the submitted records.
- The third provider billed for 252 units, but documentation only supported 248 units. Therefore, four units were not supported.

Improperly Completed Documentation Error (MR9)

Required provider signature and/or credentials are not present

- One error was cited because the provider submitted a medication review report that was not signed by the physician for all-inclusive room and board services (Revenue code 0100) and for leave of absence (Revenue code 0185) as required for the sampled dates of service.

For even more detailed information on any findings and specific policy citations, please refer to the State Medicaid Error Rate Findings (SMERF) website.

b. Medicaid FFS Medical Review – Service Type Analysis

Figure 5 displays the Medicaid FFS percentages of medical review projected federal dollars in error by service type.

Pennsylvania Figure 5: Medicaid FFS Medical Review Percentage of Projected Federal Dollars in Error by Service Type

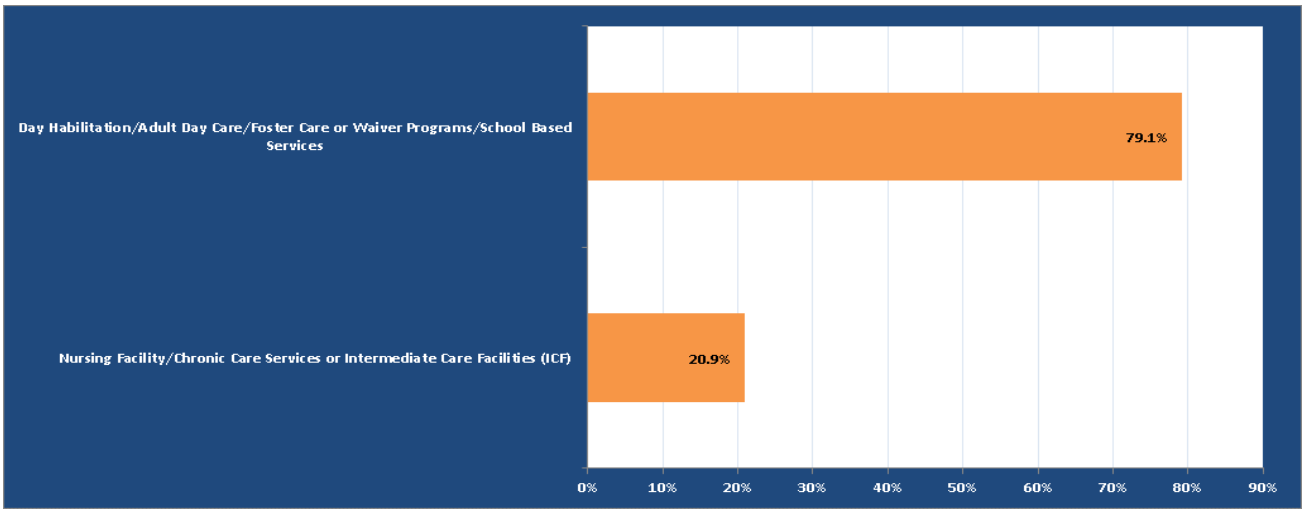


Table 7 provides information on the number of Medicaid FFS medical review errors and federal dollars in error for service type by percentage of total medical review errors.

Pennsylvania Table 7: Medicaid FFS Medical Review Claims in Error by Service Type

Service Type	Overpayments			Percentage of Total Medical Review Errors		
	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Claims in Error	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	10	$7,443	**$89,370,354**	76.92%	48.15%	**79.11%**
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	3	$8,014	**$23,597,337**	23.08%	51.85%	**20.89%**
Total	13	$15,457	**$112,967,691**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are not counted separately in this table (since claims are not sampled by service type, counting separately may have artificially inflated the results of a service type with claims that have multiple errors) and may not match other tables in the report. This also applies to Figure 5, above. There were no underpayments cited, so only overpayments are reported in this table.

Table 8 shows medical review error type by service type for Medicaid FFS, including count of errors and projected federal dollars in error.

Pennsylvania Table 8: Medicaid FFS Service Type by Medical Review Error Type in Projected Federal Dollars

Service Type	No Documentation Error (MR1)		Document(s) Absent from Record (MR2)		Number of Unit(s) Error (MR6)		Improperly Completed Documentation (MR9)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	1	**$12,458,829**	5	**$45,262,333**	4	**$31,649,192**	0	**$0**
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	0	**$0**	2	**$11,197,568**	0	**$0**	1	**$12,399,770**
Total	1	**$12,458,829**	7	**$56,459,901**	4	**$31,649,192**	1	**$12,399,770**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

Table 9 lists the Medicaid FFS medical review errors by service type. The sections following the table provide a more detailed explanation of the relationship between the service rendered and the error. This report supplies a full list of PERM IDs associated with each error in Section H. The title of Table 9 is hyperlinked to this list.

Pennsylvania Table 9: Medicaid FFS Medical Review Error Causes by Service Type

Service Type and Error Type	# of Sample Errors
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	
No Documentation Error (MR1)	
Provider responded that he or she did not have the beneficiary on file or in the system	1
Document(s) Absent from Record (MR2)	
One or more documents are missing from the record that are required to support payment	5
Number of Unit(s) Error (MR6)	
Number of units billed not supported by number of units documented	4
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	
Document(s) Absent from Record (MR2)	
One or more documents are missing from the record that are required to support payment	2
Improperly Completed Documentation (MR9)	
Required provider signature and/or credentials are not present	1

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

FFS Medical Review Error Descriptions by Service Type

Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services

Ten errors were cited for this service type:

- One No Documentation Error (MR1) was cited because the provider did not submit the requested records and responded that the beneficiary was neither on file nor in the system.
- One Document(s) Absent from Record Error (MR2) was cited because the POC submitted was not applicable to the sampled dates of service and the provider did not submit the prior authorization for personal assistance services (Procedure code W1793) billed. The provider submitted a POC dated two years before the sampled dates of service and a client care policy stating all POCs will be updated as the needs of the beneficiary change. However, these documents were not sufficient to demonstrate a required POC in effect for the sampled dates of service or that the services were authorized as required.
- Two Document(s) Absent from Record Errors (MR2) were cited because the providers did not submit timesheets with daily documentation of specific tasks performed on the

sampled dates of service for additional individual staffing (Procedure code W7085) and personal assistance services (Procedure code W1792) as required.

- One Document(s) Absent from Record Error (MR2) was cited because the Plan of Care (POC) present was not applicable to the sampled DOS and the provider did not submit the required prior authorization for personal assistance services (Procedure code W1793) billed. The provider submitted service logs; a POC dated two years before the sampled dates; and a client care policy stating all POCs will be updated as the needs of the beneficiary change. However, these documents were not sufficient to demonstrate a required POC in effect for the sampled DOS or that the services were authorized, in accordance with state policy.
- One Document(s) Absent from Record Error (MR2) was cited because the provider did not submit the ISP, physician's order or prescription, and personal care assistant daily log in support of personal care services (Procedure code T1019) for the sampled dates of service as required.
- Four Number of Unit(s) Errors (MR6) were cited because the providers billed for more units of service than were documented for homecare services (Procedure code W7201 [1 claim]) and personal assistance services (W1793 [3 claims]).
  - For homecare services, the provider billed for 15 units, but documentation only supported eight units. Therefore, seven units were not represented in the submitted records.
  - For personal assistance services:
    - The first provider billed for 101 units, but documentation only supported 68 units. Therefore, 33 units were not represented in the submitted records.
    - The second provider billed for 102 units, but documentation only supported 86 units. Therefore, 16 units were not represented in the submitted records.
    - The third provider billed for 252 units, but documentation only supported 248 units. Therefore, four units were not represented in the submitted records.

Nursing Facility/ Chronic Care Services or Intermediate Care Facilities (ICF)

Three errors were cited for this service type:

- One Document(s) Absent from Record Error (MR2) was cited because the provider did not submit physician visit progress notes written within 60 days prior to or during the sampled dates of service for all-inclusive room and board services (Revenue code 0100) as required. The provider submitted physician visit progress notes that were not applicable to the sampled dates of service.
- One Document(s) Absent from Record Error (MR2) was cited because the provider did not submit a complete list of physician orders for all-inclusive room and board services (Revenue code 0100) as required for the sampled dates of service.

- One Improperly Completed Documentation Error (MR9) was cited because the provider submitted a medication review report that was not signed by the physician for all-inclusive room and board services (Revenue code 0100) and for leave of absence (Revenue code 0185) as required for the sampled dates of service.

For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

c. Medicaid FFS Data Processing Review – Error Type Analysis

Table 10 contains information on the number of Medicaid FFS data processing review errors and federal dollars in error for error types by percentage of total Medicaid FFS data processing review errors.

Pennsylvania Table 10: Medicaid FFS Data Processing Review Error Type by Percentage of Data Processing Errors

Error Type	Overpayments			Percentage of Total FFS Data Processing Review Errors		
	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Errors	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Provider Information/Enrollment Error (DP10)	51	$78,761	**$436,258,386**	78.46%	100.00%	**100.00%**
Data Processing Technical Deficiency (DTD)	14	$0	**$0**	21.54%	0.00%	**0.00%**
Total	65	$78,761	**$436,258,386**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. There were no underpayments cited, so only overpayments are reported in this table.

Table 11 lists the Medicaid FFS data processing errors by their more specific causes of error. The error causes are more detailed descriptions of why PERM deemed a claim to be in error. The sections following the table describe each error. This report provides a full list of PERM IDs associated with each error in Section H. The title of Table 11 is hyperlinked to this list. In addition, the CAP template includes further details on each claim.

Pennsylvania Table 11: Medicaid FFS Data Processing Error Causes by Error Type

Error Type and Cause of Error	# of Sample Errors
Provider Information/Enrollment Error (DP10)	
Attending provider NPI required, but not submitted on institutional claim	3
Missing provider license information	1
Missing provider risk-based screening information	5
ORP Type 1 NPI required, but not listed on the claim	1
Provider not screened using risk based criteria prior to claim payment date	41

Error Type and Cause of Error	# of Sample Errors
Data Processing Technical Deficiency (DTD)	
Provider not screened prior to enrollment determination date but screened prior to claim payment date	14

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

FFS Data Processing Error Descriptions by Error Type

Provider Information/Enrollment Error (DP10)

Attending provider NPI required, but not submitted on institutional claim

- Three errors were cited because the attending provider NPI required, but not submitted on the institutional claim as required by the data content and data condition requirements of the ASC X12 Version 5010 HIPAA transaction standards.

Missing provider license information

- One error was cited because of the missing provider license information. As required by 42 CFR 447.203 (a) and 42 CFR 431.970 the state must be able to furnish documentation upon request. The billing provider was required to be licensed on the DOS, however, the state was unable to furnish documentation to show that the provider had an active license.

Missing provider risk-based screening information

- Five errors were cited because of insufficient or missing provider RBS information. As required by 42 CFR 447.203 (a) and 42 CFR 431.970 the state must be able to furnish documentation upon request. In addition, 42 CFR 455.436 requires newly enrolled providers to be screened prior to enrollment and prior to claim paid date. 42 CFR 455.414 requires a provider to be revalidated every five years.

ORP Type 1 NPI required, but not listed on the claim

- One error was cited because the ORP Type 1 NPI was required, but not listed on the claim. The service provided was for therapy and as required by 42 CFR 455.440, a referring provider NPI must be submitted on the claim.

Provider not screened using risk based criteria prior to claim payment date

- Forty-one errors were cited because the provider was not screened using RBS prior to claim payment date as required by 42 CFR 455.436 and 42 CFR 455.414. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.
    - Twenty-two errors were cited for revalidated providers. 42 CFR 455.436 and 42 CFR 455.414 require RBS within five years prior to the claim payment dates.
    - Nineteen errors were cited for newly enrolled providers. 42 CFR 455.450 and 42 CFR 455.436 require RBS for newly enrolled providers prior to enrollment determination and claim payment dates.

Data Processing Technical Deficiency (DTD)

Provider not screened prior to enrollment determination date but screened prior to claim payment date

- Fourteen DTDs were cited because as required by 42 CFR 455.436 and 42 CFR 455.450, RBS criteria was not completed on the newly enrolled providers prior to enrollment determination date but was completed prior to claim payment date.

Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Table 12 lists the Medicaid FFS DP10 errors related to risk-based screening, describing their more specific causes of error.

For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

Pennsylvania Table 12: Medicaid FFS Risk Based Screening Database Checks and Risk Level Activities

	Required Databases Not Checked					Risk Level Activities Not Completed	
# of Errors	**All Four**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
41	34	0	0	1	3	4	0
# of Deficiencies	**All Four**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
14	10	1	3	4	0	0	0

Note: Details do not always sum to the total since there may be multiple databases not checked per error. Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. For more information on which databases were not checked, states can refer to the CAP templates.
*Applicable for moderate or high risk providers only
**Applicable for high risk providers only

d. Medicaid FFS Data Processing Review – Service Type Analysis

In the following section, Medicaid FFS data processing errors are analyzed by service type. Figure 6 shows the percentage of data processing review projected federal dollars in error by service type.

Pennsylvania Figure 6: Medicaid FFS Data Processing Review Percentage of Projected Federal Dollars in Error by Service Type

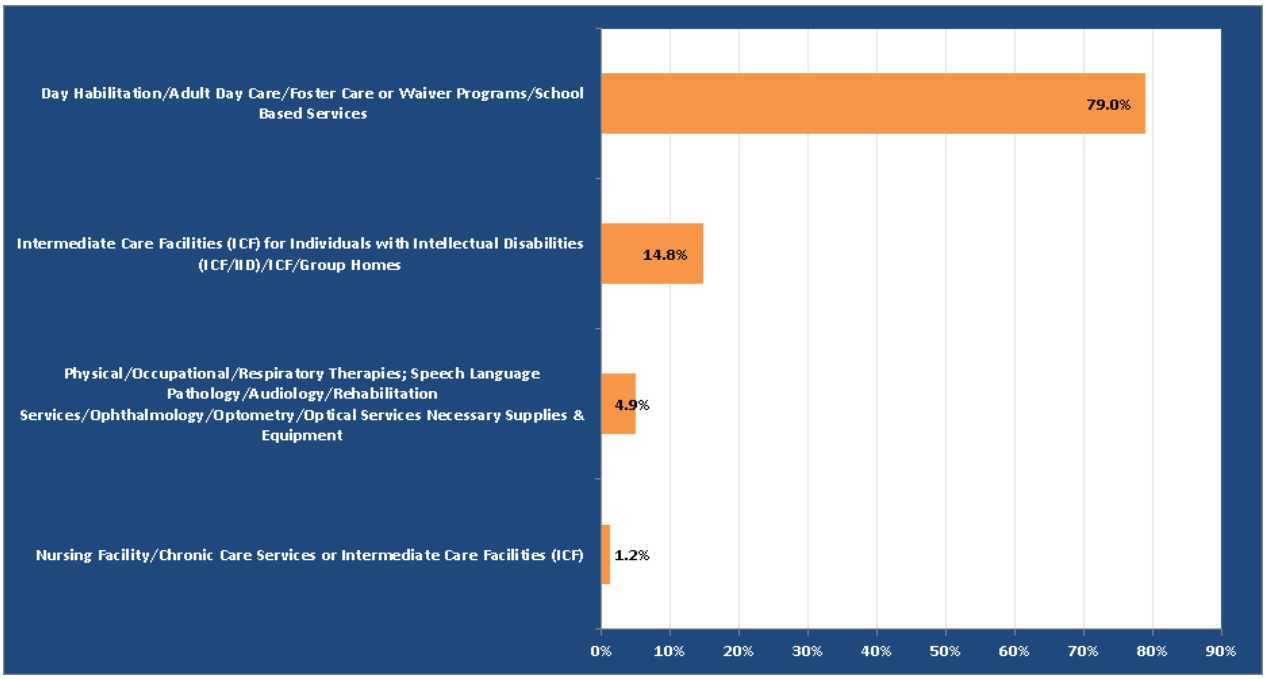


Table 13 includes information on the number of Medicaid FFS data processing review errors and federal dollars in error for service type by percentage of total data processing review errors.

Pennsylvania Table 13: Medicaid FFS Data Processing Review Errors by Service Type

Service Type	Overpayments			Percentage of Total FFS Data Processing Review Errors		
	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Claims in Error	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	41	$23,265	**$341,401,588**	64.06%	30.77%	**79.04%**
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes	8	$48,488	**$63,986,173**	12.50%	64.13%	**14.81%**
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	12	$3,792	**$5,184,079**	18.75%	5.02%	**1.20%**
Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment	1	$66	**$21,381,477**	1.56%	0.09%	**4.95%**
Prescribed Drugs	2	$0	**$0**	3.13%	0.00%	**0.00%**
Total	64	$75,611	**$431,953,317**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are not counted separately in this table (since claims are not sampled by service type, counting separately may have artificially inflated the results of a service type with claims that have multiple errors) and may not match other tables in the report. This also applies to Figure 6, above. There were no underpayments cited, so only overpayments are reported in this table.

Table 14 shows data processing errors by service type for Medicaid FFS, including count of errors and projected federal dollars in error.

Pennsylvania Table 14: Medicaid FFS Service Type by Data Processing Review Error Type in Projected Federal Dollars

Service Type	Provider Information/Enrollment Error (DP10)		Data Processing Technical Deficiency (DTD)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	40	**$341,401,588**	1	**$0**
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes	9	**$68,291,242**	0	**$0**
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	1	**$5,184,079**	11	**$0**
Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment	1	**$21,381,477**	0	**$0**
Prescribed Drugs	0	**$0**	2	**$0**
Total	51	**$436,258,386**	14	**$0**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

Table 15 lists the Medicaid FFS data processing errors by service type. The following table gives a more detailed explanation of the relationship between the service rendered and the error. This report provides a full list of PERM IDs associated with each error in Section H. The title of Table 15 is hyperlinked to this list.

Pennsylvania Table 15: Medicaid FFS Data Processing Error Causes by Service Type

Service Type and Error Type	# of Sample Errors
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	
Provider Information/Enrollment Error (DP10)	
Missing provider license information	1
Missing provider risk-based screening information	3
Provider not screened using risk based criteria prior to claim payment date	36
Data Processing Technical Deficiency (DTD)	
Provider not screened prior to enrollment determination date but screened prior to claim payment date	1
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes	
Provider Information/Enrollment Error (DP10)	
Attending provider NPI required, but not submitted on institutional claim	3
Missing provider risk-based screening information	2
Provider not screened using risk based criteria prior to claim payment date	4
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	
Provider Information/Enrollment Error (DP10)	
Provider not screened using risk based criteria prior to claim payment date	1
Data Processing Technical Deficiency (DTD)	
Provider not screened prior to enrollment determination date but screened prior to claim payment date	11
Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment	
Provider Information/Enrollment Error (DP10)	
ORP Type 1 NPI required, but not listed on the claim	1
Prescribed Drugs	
Data Processing Technical Deficiency (DTD)	
Provider not screened prior to enrollment determination date but screened prior to claim payment date	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.

FFS Data Processing Error Descriptions by Service Type

Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services

Forty errors were cited for this service type:

- One provider information/enrollment (DP10) error was cited because of missing provider license information. As required by 42 CFR 447.203 (a) and 42 CFR 431.970 the state must be able to furnish documentation upon request. The billing provider was required to be licensed on the DOS, however, the state was unable to furnish documentation to show that the provider had an active license.

- Three provider information/enrollment (DP10) errors were cited because of insufficient or missing provider RBS information. As required by 42 CFR 447.203 (a) and 42 CFR 431.970 the state must be able to furnish documentation upon request. In addition, 42 CFR 455.436 requires newly enrolled providers to be screened prior to enrollment and prior to claim paid date. 42 CFR 455.414 requires a provider to be revalidated every five years.
- Sixteen provider information/enrollment (DP10) errors were cited because as required by 42 CFR 455.450 and 42 CFR 455.436 the newly enrolled providers were not screened using RBS criteria prior to enrollment and prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

  Twenty provider information/enrollment (DP10) errors were cited because as required by 42 CFR 455.436 and 42 CFR 455.414, RBS criteria was not completed for the revalidated providers within five years prior to the claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

One deficiency was cited for this service type:

- One DTD was cited because as required by 42 CFR 455.436 and 42 CFR 455.450, RBS criteria was not completed on the newly enrolled providers prior to enrollment determination date but was completed prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes

Nine errors were cited for this service type:

- Three provider information/enrollment (DP10) errors were cited because attending provider NPIs were required, but not submitted on the institutional claims as required by the data content and data condition requirements of the ASC X 12 Version 5010 HIPAA transaction standards.
- Two provider information/enrollment (DP10) errors were cited because there was insufficient or missing provider RBS information. As required by 42 CFR 447.203 (a) and 42 CFR 431.970 the state must be able to furnish documentation upon request. In addition, 42 CFR 455.436 requires newly enrolled providers to be screened prior to enrollment and prior to claim paid date. 42 CFR 455.414 requires a provider to be revalidated every five years.
- Two provider information/enrollment (DP10) errors were cited because as required by 42 CFR 455.436 and 42 CFR 455.414, RBS criteria was not completed for the revalidated providers within five years prior to the claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

  Two provider information/enrollment (DP10) errors were cited because as required by 42 CFR 455.450 and 42 CFR 455.436 the newly enrolled providers were not screened using RBS criteria prior to enrollment and prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)

One error was cited for this service type:

- One provider information/enrollment (DP10) error was cited because as required by 42 CFR 455.450 and 42 CFR 455.436 the newly enrolled providers were not screened using RBS criteria prior to enrollment and prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Eleven deficiencies were cited for this service type:

- Eleven DTDs were cited because as required by 42 CFR 455.436 and 42 CFR 455.450, RBS criteria was not completed on the newly enrolled providers prior to enrollment determination date but was completed prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment

One error was cited for this service type:

- One provider information/enrollment (DP10) error was cited because ORP Type 1 NPI required, but not listed on the claim. The service provided was for therapy and as required by 42 CFR 455.440, a referring provider NPI must be submitted on the claim.

Prescribed Drugs

Two deficiencies were cited for this service type:

- Two DTDs were cited because as required by 42 CFR 455.436 and 42 CFR 455.450, RBS criteria was not completed on the newly enrolled providers prior to enrollment determination date but was completed prior to claim payment date. Additionally, PECOS did not show the provider in an active and approved status to satisfy the RBS requirement.

Table 16 lists the Medicaid DP10 errors related to risk-based screening, describing their more specific causes of error, broken down by service type.

For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

Pennsylvania Table 16: Medicaid FFS Risk Based Screening Database Checks and Risk Level Activities by Service Type

		Required Databases Not Checked					Risk Level Activities Not Completed	
Service Type	# of Errors	All Four	DMF	LEIE	SAM/EPLS	NPPES	On-site Visit*	FCBC**
Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)	1	1	0	0	0	0	0	0
Intermediate Care Facilities for Individuals with Intellectual	4	4	0	0	0	0	0	0

		Required Databases Not Checked					Risk Level Activities Not Completed	
Service Type	**# of Errors**	**All Four**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
Disabilities (ICF/IID) and ICF/Group Homes								
Day Habilitation, Adult Day Care, Foster Care, Waiver Programs, & School-based Services	36	29	0	0	1	3	4	0
Service Type	**# of Deficiencies**	**All Four**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
Nursing Facility, Chronic Care Services, or Intermediate Care Facilities (ICF)	11	9	0	2	2	0	0	0
Prescribed Drugs	2	1	1	0	1	0	0	0
Day Habilitation, Adult Day Care, Foster Care, Waiver Programs, & School-based Services	1	0	0	1	1	0	0	0

Note: Details do not always sum to the total since there may be multiple databases not checked per error. Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.
*Applicable for moderate or high risk providers only
**Applicable for high risk providers only

2. Medicaid Managed Care Data Analyses

There were no managed care processing review errors in Pennsylvania; therefore, there are no managed care processing review analyses.

3. Types of Payment Errors

This section analyzes Pennsylvania Medicaid payment errors for RY 2019, separating them into state errors (data processing errors) versus provider errors (medical review errors).

Figure 7 shows the Medicaid percentage of state versus provider errors by projected federal dollars in error. In Pennsylvania, state errors account for 79.43% of projected federal dollars in error, while provider errors comprise 20.57%.

Pennsylvania Figure 7: Medicaid Types of Payment Errors

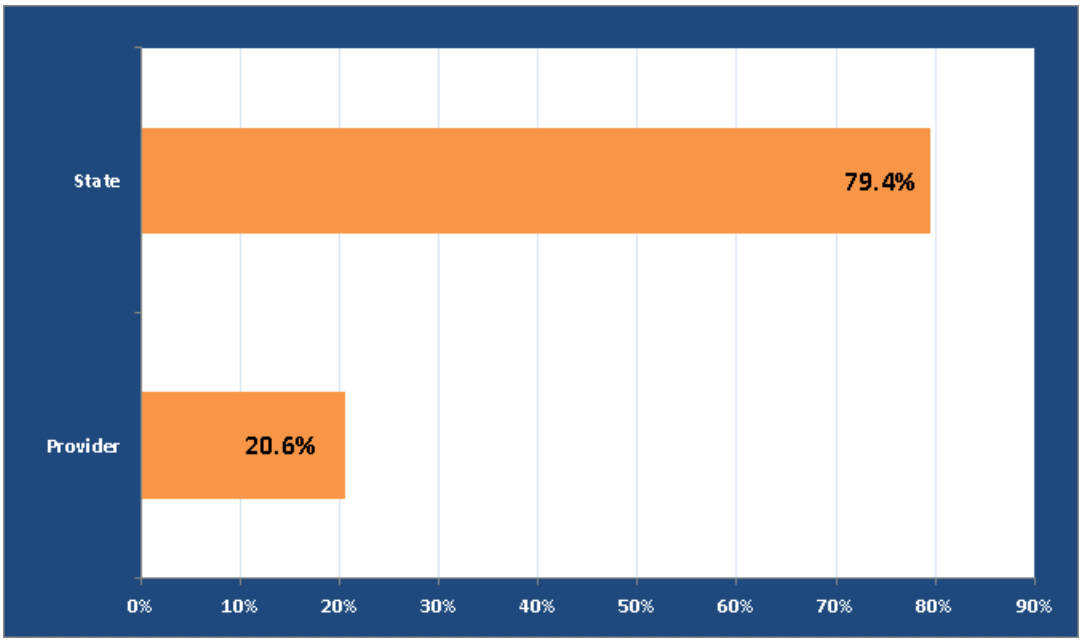


Table 17 shows how the errors aggregate into state and provider payment errors.

Pennsylvania Table 17: Medicaid Types of Payment Errors

Error Type	State or Provider Error	# of Sample Errors	% of Total # of Sample Errors	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
Medical Review Errors	Provider	13	16.67%	$15,457	16.41%	**$112,967,691**	20.57%
Data Processing Errors	State	65	83.33%	$78,761	83.59%	**$436,258,386**	79.43%

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. This also applies to Figure 7, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

4. Comparison of Medicaid FY 2015 and RY 2019

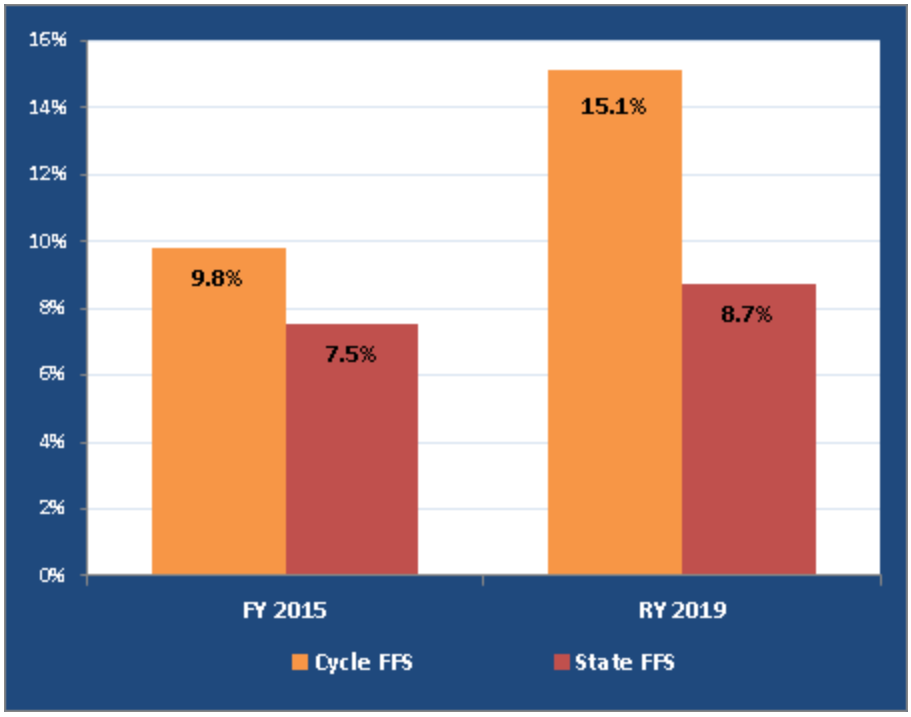
This section provides a brief comparison of the sample findings for Pennsylvania in FY 2015 and RY 2019 for Medicaid.

Due to changes in the type of error and service type descriptions, the type of error and service type categories from FY 2015 have been updated to match those in RY 2019 for the comparisons.

Pennsylvania's Medicaid FFS Findings

Figure 8 compares Cycle 1 and Pennsylvania for FY 2015 and RY 2019. Pennsylvania's Medicaid FFS federal improper payment rate was 7.55% in FY 2015 as compared to 8.74% for the RY 2019 measurement. In both measurement cycles, Pennsylvania's federal improper payment rate was below the national average.

Pennsylvania Figure 8: Cycle and State Medicaid FFS Federal Improper Payment Rates



Sample Medicaid FFS Comparisons

Table 18 summarizes the total number of claims in error found for Medicaid FFS in FY 2015 and RY 2019 for Pennsylvania.

Pennsylvania Table 18: Comparison of Medicaid FFS Number of Claims in Error

Fiscal Year	Number of Sample Errors	Number of Sample Claims in Error	Number of Sampled Claims
FY 2015	24	24	332
RY 2019	78	75	761

Note: In order to provide a more accurate comparison between cycles, multiple errors on a claim are not counted separately in the third column of this table and may not match other tables in the report. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, states are cautioned from making direct comparisons between the cycles, since review requirements and program structure may have changed.

Table 19 shows a comparison of the Medicaid service type where the errors occurred for the state's two fiscal years measured.

Pennsylvania Table 19: Medicaid FFS FY 2015 and RY 2019 Number of Claims in Error by Service Type

Service Type	FY 2015	RY 2019
Day Habilitation, Adult Day Care, Foster Care or Waiver Programs and School Based Services	19	49
Home Health Services	1	0
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID) and ICF/Group Homes	2	8
Nursing Facility, Chronic Care Services or Intermediate Care Facilities (ICF)	2	15
Physical, Occupational, Respiratory Therapies; Speech Language Pathology, Audiology and Rehabilitation Services, Ophthalmology and Optometry, Optical Services Necessary Supplies & Equipment	0	1
Prescribed Drugs	0	2
Total	24	75

Note: In order to provide a more accurate comparison between cycles, multiple errors on a claim are not counted separately in this table and may not match other tables in the report. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

Sample Medicaid Managed Care Comparisons

There were no managed care errors in Pennsylvania in either cycle; therefore, there are no managed care comparison analyses.

F. Medicaid Eligibility Review Findings

1. Medicaid Eligibility Data Analyses

This section describes the types of Medicaid eligibility payment errors. Table 20 compares Pennsylvania's Medicaid eligibility review errors to the cycle Medicaid eligibility review errors by eligibility category. For reporting purposes, these categories were established by mapping each state's eligibility categories to the matching federal eligibility category grouping.

Pennsylvania Table 20: Cycle and State Medicaid Eligibility Number of Errors and Federal Dollars in Error by Eligibility Category

Eligibility Category	# of Sample Claims in Error		Sample Federal Dollars in Error		Projected Federal Dollars in Error		Federal Improper Payment Rate	
	State	Cycle	State	Cycle	State (in Millions)	Cycle (in Millions)	State	Cycle
Aged, Blind, and Disabled - Mandatory Coverage	1	242	$73	$308,304	**$35**	**$1,800**	72.51%	20.41%
Aged, Blind, and Disabled - Optional Categorically Needy	20	141	$5,452	$142,602	**$305**	**$1,783**	27.51%	42.98%
Home and Community-Based Services	41	224	$19,640	$211,995	**$422**	**$1,795**	26.71%	21.68%
LTC/Nursing Home	45	218	$62,886	$414,065	**$414**	**$1,412**	24.52%	18.49%
MAGI - Children under Age 19	22	305	$418	$103,901	**$115**	**$3,149**	13.12%	29.92%
MAGI - Medicaid Expansion - Newly Eligible	38	265	$2,069	$317,330	**$170**	**$5,327**	3.66%	26.96%
MAGI - Medicaid Expansion - Not Newly Eligible	1	30	$0	$24,967	**$0**	**$562**	0.00%	30.86%
MAGI - Parent Caretaker	6	146	$34	$77,555	**$11**	**$1,858**	2.73%	25.27%
MAGI - Pregnant Woman	1	55	$0	$30,408	**$0**	**$127**	0.00%	8.35%
Newborn	0	10	$0	$2,248	**$0**	**$139**	0.00%	4.29%
Other (None of the Above)	9	16	$4,707	$9,939	**$178**	**$297**	67.05%	27.57%
Other Full Benefit Dual Eligible (FBDE)	10	73	$590	$104,095	**$105**	**$1,252**	40.30%	56.23%
Qualified Individuals	1	4	$0	$268	**$0**	**$180**	N/A	62.50%
SSI Recipients	0	35	$0	$69,853	**$0**	**$475**	0.00%	2.49%
Title IV-E	0	3	$0	$163	**$0**	**$16**	0.00%	2.29%
Transitional Medicaid	6	38	$291	$2,907	**$66**	**$509**	18.85%	32.80%
Women with Breast or Cervical Cancer	0	0	$0	$0	**$0**	**$0**	0.00%	0.00%
Total	201	1,805	$96,160	$1,820,600	**$1,821**	**$20,683**	11.36%	21.07%

Eligibility Category	# of Sample Claims in Error		Sample Federal Dollars in Error		Projected Federal Dollars in Error		Federal Improper Payment Rate	
	State	Cycle	State	Cycle	State (in Millions)	Cycle (in Millions)	State	Cycle
Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are not counted separately in this table (since claims are not sampled by eligibility category, counting separately may have artificially inflated the results of an eligibility category with claims that have multiple errors) and may not match other tables in the report.								

a. Medicaid Eligibility Review – Error Type Analysis

Figure 9 shows the percentage of Medicaid eligibility review projected federal dollars in error by error type.

Pennsylvania Figure 9: Medicaid Eligibility Review Percentage of Projected Federal Dollars in Error by Error Type

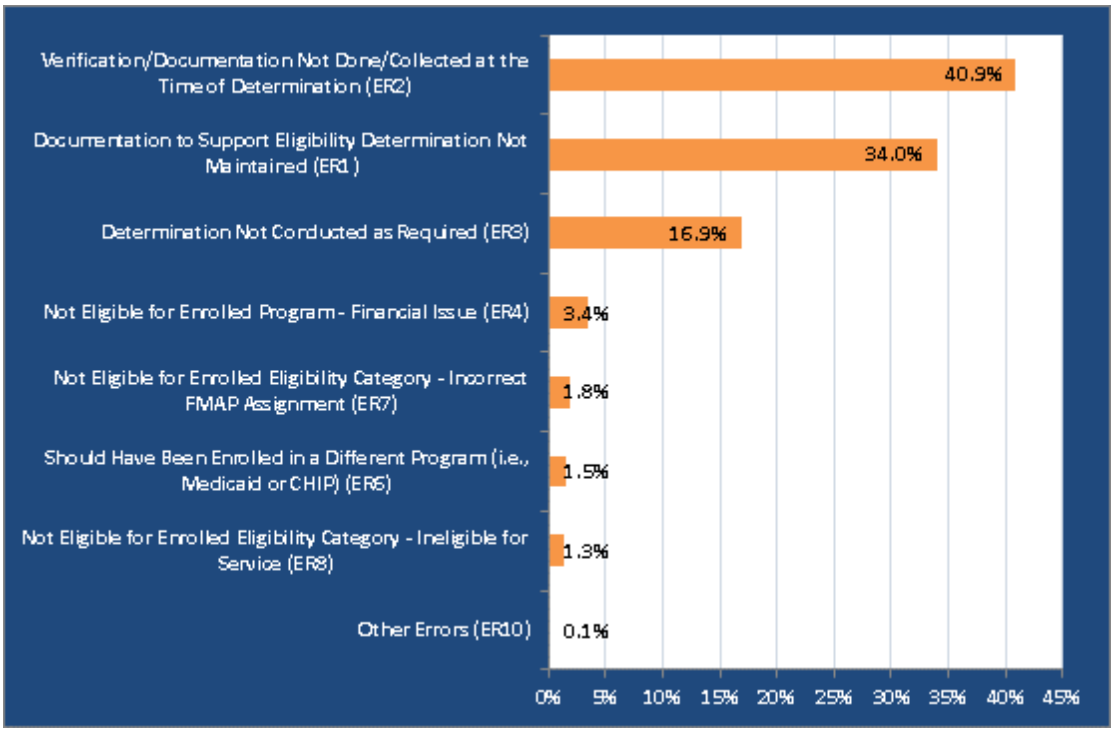


Table 21 contains information on the number of Medicaid eligibility review errors and federal dollars in error for error types by overpayments, underpayments, and percentage of total Medicaid eligibility review errors.

Pennsylvania Table 21: Medicaid Eligibility Review Error Type by Overpayments, Underpayments, and Percentage of Eligibility Review Errors

Error Type	Overpayments			Underpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Errors	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Documentation to Support Eligibility Determination Not Maintained (ER1)	32	$64,921	**$725,847,319**	0	$0	**$0**	13.11%	64.22%	**34.01%**
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	28	$20,536	**$873,706,245**	0	$0	**$0**	11.48%	20.31%	**40.94%**
Determination Not Conducted as Required (ER3)	18	$8,307	**$359,865,102**	0	$0	**$0**	7.38%	8.22%	**16.86%**

Error Type	Overpayments			Underpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Errors	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Not Eligible for Enrolled Program - Financial Issue (ER4)	3	$5,815	**$72,905,122**	0	$0	**$0**	1.23%	5.75%	**3.42%**
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	2	$75	**$31,481,799**	0	$0	**$0**	0.82%	0.07%	**1.48%**
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	1	$160	**$18,786,875**	1	$463	**$19,770,504**	0.82%	0.62%	**1.81%**
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	$366	**$28,789,812**	0	$0	**$0**	0.41%	0.36%	**1.35%**
Other Errors (ER10)	4	$449	**$3,156,655**	0	$0	**$0**	1.64%	0.44%	**0.15%**
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	3	$0	**$0**	0	$0	**$0**	1.23%	0.00%	**0.00%**
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	151	$0	**$0**	0	$0	**$0**	61.89%	0.00%	**0.00%**
Total	243	$100,629	**$2,114,538,929**	1	$463	**$19,770,504**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. In this table, deficiencies are included in the overpayment number of sample errors. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. This also applies to Figure 9, above.

Table 22 lists the Medicaid eligibility review errors by their more specific causes of error. The error causes are more detailed descriptions of why PERM deemed a claim to be in error.

Pennsylvania Table 22: Medicaid Eligibility Review Error Causes by Error Type

Error Type and Cause of Error	# of Sample Errors
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Blindness/disability determination documentation not on file/incomplete	6
Income verification not on file/incomplete	1
Level of care determination not on file/incomplete	10
Other required forms not on file/incomplete	1
Record of signature not on file - caseworker	4
Resource verification not on file/incomplete	10
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Income not verified - caseworker	1
Income not verified - system	1
Other element not verified - caseworker	2
Other eligibility process(es) not followed - caseworker	2

Error Type and Cause of Error	# of Sample Errors
Resources not verified - caseworker	6
Signature not recorded at initial application - caseworker	3
State did not do required disability/blindness determination - caseworker	1
When appropriate, signature not recorded at renewal - caseworker	12
Determination Not Conducted as Required (ER3)	
Initial determination not conducted	13
Redetermination was not conducted within 12 months before date of payment for services - caseworker	5
Not Eligible for Enrolled Program - Financial Issue (ER4)	
Resources incorrectly calculated - caseworker	2
Resources incorrectly included/excluded - caseworker	1
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
Countable income incorrectly excluded - system	1
Income incorrectly calculated; other - caseworker	1
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	
Household composition/tax filer unit or tax filer status incorrect - caseworker	1
Other non-financial error - caseworker	1
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	
Countable income incorrectly excluded - caseworker	1
Other Errors (ER10)	
Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker	2
Other error	2
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	2
Not eligible for enrolled program; financial issue	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Countable income incorrectly excluded; eligible for enrolled category - caseworker	9
Countable income incorrectly excluded; eligible for enrolled category - system	5
Exempt income incorrectly included; eligible for enrolled category - system	1
Exempt income incorrectly included; not eligible for enrolled category - caseworker	1
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	15
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	12
Income deduction incorrectly included/excluded; eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; eligible for enrolled category - caseworker	36

Error Type and Cause of Error	# of Sample Errors
Income incorrectly calculated; other; eligible for enrolled category - system	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	4
Other financial deficiency - caseworker	1
Other non-financial deficiency - caseworker	7
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	5
Resources incorrectly calculated; eligible for enrolled category - caseworker	43
Resources incorrectly included/excluded; eligible for enrolled category - caseworker	8

Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

Eligibility Review Error Descriptions by Error Type

Documentation to Support Eligibility Determination Not Maintained (ER1)

Blindness/disability determination documentation not on file/incomplete

- Six errors were cited because there was indication in the case record that the state completed a blindness/disability assessment, but sufficient documentation of the assessment was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

Income verification not on file/incomplete

- One error was cited because there was indication in the case record that income was verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

Level of care determination not on file/incomplete

- Ten errors were cited because there was indication in the case record that the state completed a level of care assessment, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

Other required forms not on file/incomplete

- One error was cited because there was indication in the case record that the state obtained required forms, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

Record of signature not on file - caseworker

- Four errors were cited because the application forms and/or renewal forms were not signed by the beneficiary. 42 CFR § 435.907(f) requires all initial applications to be signed and 42 CFR § 435.916(2)(ii) requires all renewal forms to be signed.

Resource verification not on file/incomplete

- Ten errors were cited because there was indication in the case record that resources were verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

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

Income not verified - caseworker

- One error was cited because there was no indication in the case record that income was verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Income not verified - system

- One error was cited because there was no indication in the case record that income was verified by the system during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Other element not verified – caseworker

- Two errors were cited because there was no indication in the case record that other elements were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Other eligibility process(es) not followed - caseworker

- Two errors were cited because there was no indication in the case record that other eligibility process(es) were followed by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Resources not verified – caseworker

- Six errors were cited because there was no indication in the case record that resources were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Signature not recorded at initial application - caseworker

- Three errors were cited because there was no indication in the case record that the beneficiary's signature was recorded during the initial application during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.907(f) requires all initial applications to be signed.

State did not do required disability/blindness determination - caseworker

- One error was cited because there was no indication in the case record that the state completed a blindness/disability assessment during the state's determination. The caseworker did not identify a blindness/disability assessment was needed. Therefore, eligibility could not be determined to support the state's decision.

When appropriate, signature not recorded at renewal - caseworker

- Twelve errors were cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.

Determination Not Conducted as Required (ER3)

Initial determination not conducted

- Thirteen errors were cited because there was no indication in the case record that an initial determination was conducted by the state. The state did not have case documentation or system processing records.

Redetermination was not conducted within 12 months before date of payment for services – caseworker

- Five errors were cited because the redetermination was not conducted by the caseworker within 12 months of the date of service as required by 42 CFR § 435.916(a).

Not Eligible for Enrolled Program - Financial Issue (ER4)

Resources incorrectly calculated - caseworker

- Two errors were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. The beneficiaries are not eligible for Medicaid.

Resources incorrectly included/excluded - caseworker

- One error was cited because the caseworker incorrectly included or excluded resources when determining if the beneficiary met the eligibility resource thresholds. The beneficiary is not eligible for Medicaid.

Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)

Countable income incorrectly excluded – system

- One error was cited because the system incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. The beneficiary should have been enrolled in CHIP and not Medicaid.

Income incorrectly calculated; other – caseworker

- One error was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. The beneficiary should have been enrolled in CHIP and not Medicaid.

Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)

Household composition/tax filer unit or tax filer status incorrect - caseworker

- One error was cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. The beneficiaries were incorrectly placed in an eligibility category with a different FMAP rate than the correct eligibility category.

Other non-financial error - caseworker

- One error was cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. The beneficiary was incorrectly placed in an eligibility category with a different FMAP rate than the correct eligibility category.

Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)

Countable income incorrectly excluded - caseworker

- One error was cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. The beneficiary was not eligible for the type of service that was received.

Other Errors (ER10)

Contribution to care calculated incorrectly resulting in a partial payment difference – caseworker

- Two errors were cited because the caseworker incorrectly calculated the contribution to care.

Other error

- Two errors were cited because a different error was made that impacted the beneficiary's eligibility. The errors were cited because spousal shelter expenses were not verified at the time of renewal.

Incorrect Case Determination, But There was No Payment on Claim (ERTD1)

Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility

- Two deficiencies were cited because there was indication the state obtained documentation to support the determination, but sufficient documentation was not maintained to complete a review of an eligibility element(s). An error would have been cited if a payment had been made on the sampled claim.

Not eligible for enrolled program; financial issue

- One deficiency was cited because the state did not correctly determine the financial factors of the beneficiary's eligibility. The beneficiary is not eligible for Medicaid. An error would have been cited if a payment had been made on the sampled claim.

Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)

Countable income incorrectly excluded; eligible for enrolled category - caseworker

- Nine deficiencies were cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

Countable income incorrectly excluded; eligible for enrolled category - system

- Five deficiencies were cited because the system incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

Exempt income incorrectly included; eligible for enrolled category - system

- One deficiency was cited because the system incorrectly included exempt income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.

Exempt income incorrectly included; not eligible for enrolled category - caseworker

- One deficiency was cited because the caseworker incorrectly included exempt income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker

- Fifteen deficiencies were cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiaries were still eligible for the enrolled category.

Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system

- One deficiency was cited because the system did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship

rules. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker

- Twelve deficiencies were cited because the caseworker incorrectly included or excluded MAGI income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

Income deduction incorrectly included/excluded; eligible for enrolled category - system

- One deficiency was cited because the system incorrectly included or excluded income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.

Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker

- One deficiency was cited because the caseworker incorrectly included or excluded MAGI income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

Income incorrectly calculated; other; eligible for enrolled category - caseworker

- Thirty-six deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

Income incorrectly calculated; other; eligible for enrolled category - system

- One deficiency was cited because the system incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.

Income incorrectly calculated; other; not eligible for enrolled category - caseworker

- Four deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were eligible for a different program category with the same service package and FMAP rate.

Other financial deficiency - caseworker

- One deficiency was cited because the caseworker made a financial error when determining if the beneficiary met the eligibility thresholds. However, the beneficiary was eligible for Medicaid.

Other non-financial deficiency - caseworker

- Seven deficiencies were cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiaries were eligible for Medicaid.

Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker

- Five deficiencies were cited because the redetermination was not conducted by the caseworker before the required 12-month renewal date as required by 42 CFR § 435.916(a). However, the redetermination was conducted before the date of payment; therefore, the finding did not have an eligibility/financial impact.

Resources incorrectly calculated; eligible for enrolled category - caseworker

- Forty-three deficiencies were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.

Resources incorrectly included/excluded; eligible for enrolled category - caseworker

- Eight deficiencies were cited because the caseworker incorrectly included or excluded resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.

For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

b. Medicaid Eligibility Review – Eligibility Category Analysis

Figure 10 shows the percentage of Medicaid eligibility review projected federal dollars in error by eligibility category.

Pennsylvania Figure 10: Medicaid Eligibility Review Percentage of Projected Federal Dollars in Error by Eligibility Category

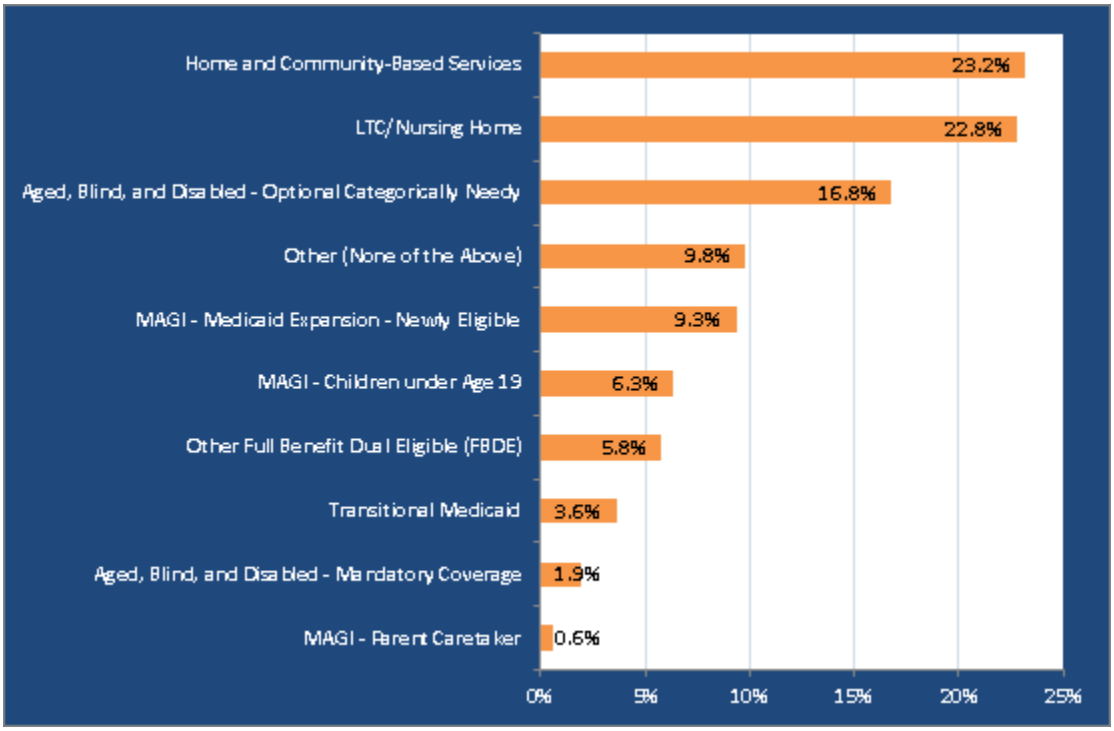


Table 23 contains information on the number of Medicaid eligibility review errors and federal dollars in error by eligibility category by overpayment, underpayments, and percentage of total eligibility review errors.

Pennsylvania Table 23: Medicaid Eligibility Review Errors by Eligibility Category

Eligibility Category	Overpayments			Underpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Claims in Error	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Aged, Blind, and Disabled - Mandatory Coverage	1	$73	**$35,331,527**	0	$0	**$0**	0.50%	0.08%	**1.94%**
Aged, Blind, and Disabled - Optional Categorically Needy	19	$4,988	**$285,374,429**	1	$463	**$19,770,504**	9.95%	5.67%	**16.76%**
Home and Community-Based Services	41	$19,640	**$421,904,856**	0	$0	**$0**	20.40%	20.42%	**23.17%**
LTC/Nursing Home	45	$62,886	**$414,440,177**	0	$0	**$0**	22.39%	65.40%	**22.76%**
MAGI - Children under Age 19	22	$418	**$115,022,475**	0	$0	**$0**	10.95%	0.43%	**6.32%**
MAGI - Medicaid Expansion - Newly Eligible	38	$2,069	**$170,176,249**	0	$0	**$0**	18.91%	2.15%	**9.34%**
MAGI - Medicaid Expansion - Not Newly Eligible	1	$0	**$0**	0	$0	**$0**	0.50%	0.00%	**0.00%**
MAGI - Parent Caretaker	6	$34	**$11,091,841**	0	$0	**$0**	2.99%	0.04%	**0.61%**
MAGI - Pregnant Woman	1	$0	**$0**	0	$0	**$0**	0.50%	0.00%	**0.00%**

Eligibility Category	Overpayments			Underpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# of Sample Claims in Error	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Claims in Error	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Other (None of the Above)	9	$4,707	**$177,627,130**	0	$0	**$0**	4.48%	4.89%	**9.75%**
Other Full Benefit Dual Eligible (FBDE)	10	$590	**$104,753,199**	0	$0	**$0**	4.98%	0.61%	**5.75%**
Qualified Individuals	1	$0	**$0**	0	$0	**$0**	0.50%	0.00%	**0.00%**
Transitional Medicaid	6	$291	**$65,663,746**	0	$0	**$0**	2.99%	0.30%	**3.61%**
Total	200	$95,696	**$1,801,385,629**	1	$463	**$19,770,504**	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. In this table, deficiencies are included in the overpayment number of sample errors. Additionally, multiple errors on a claim are not counted separately in this table (since claims are not sampled by eligibility category, counting separately may have artificially inflated the results of an eligibility category with claims that have multiple errors) and may not match other tables in the report. This also applies to Figure 10, above.

Table 24 shows eligibility review errors by eligibility category for Medicaid eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 24: Medicaid Eligibility Category by Eligibility Review Error Type in Projected Federal Dollars

Eligibility Category	Documentation to Support Eligibility Determination Not Maintained (ER1)		Verification/ Documentation Not Done/ Collected at the Time of Determination (ER2)		Determination Not Conducted as Required (ER3)		Not Eligible for Enrolled Program - Financial Issue (ER4)		Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Aged, Blind, and Disabled - Mandatory Coverage	0	**$0**	1	**$35,331,527**	0	**$0**	0	**$0**	0	**$0**
Aged, Blind, and Disabled - Optional Categorically Needy	8	**$189,798,498**	4	**$95,575,932**	0	**$0**	0	**$0**	0	**$0**
Home and Community-Based Services	12	**$293,856,856**	4	**$257,369,239**	4	**$95,101,415**	1	**$32,676,937**	0	**$0**
LTC/Nursing Home	10	**$221,492,057**	6	**$179,195,642**	1	**$12,264,399**	2	**$40,228,185**	0	**$0**
MAGI - Children under Age 19	1	**$14,156,947**	5	**$69,668,267**	1	**$13,872,408**	0	**$0**	2	**$31,481,799**
MAGI - Medicaid Expansion - Newly Eligible	0	**$0**	2	**$122,599,563**	0	**$0**	0	**$0**	0	**$0**
MAGI - Medicaid Expansion - Not Newly Eligible	0	**$0**	0	**$0**	0	**$0**	0	**$0**	0	**$0**
MAGI - Parent Caretaker	0	**$0**	1	**$11,091,841**	0	**$0**	0	**$0**	0	**$0**
MAGI - Pregnant Woman	0	**$0**	0	**$0**	0	**$0**	0	**$0**	0	**$0**
Other (None of the Above)	0	**$0**	1	**$14,923,744**	7	**$162,703,386**	0	**$0**	0	**$0**
Other Full Benefit Dual Eligible (FBDE)	1	**$6,542,961**	1	**$22,286,744**	5	**$75,923,494**	0	**$0**	0	**$0**

Eligibility Category	Documentation to Support Eligibility Determination Not Maintained (ER1)		Verification/ Documentation Not Done/ Collected at the Time of Determination (ER2)		Determination Not Conducted as Required (ER3)		Not Eligible for Enrolled Program - Financial Issue (ER4)		Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Qualified Individuals	0	**$0**	0	**$0**	0	**$0**	0	**$0**	0	**$0**
Transitional Medicaid	0	**$0**	3	**$65,663,746**	0	**$0**	0	**$0**	0	**$0**
Total	32	**$725,847,319**	28	**$873,706,245**	18	**$359,865,102**	3	**$72,905,122**	2	**$31,481,799**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

Eligibility Category	Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)		Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)		Other Errors (ER10)		Incorrect Case Determination, But There was No Payment on Claim (ERTD1)		Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Aged, Blind, and Disabled - Mandatory Coverage	0	**$0**	0	**$0**	0	**$0**	0	**$0**	0	**$0**
Aged, Blind, and Disabled - Optional Categorically Needy	1	**$19,770,504**	0	**$0**	0	**$0**	0	**$0**	8	**$0**
Home and Community-Based Services	0	**$0**	0	**$0**	0	**$0**	1	**$0**	34	**$0**
LTC/Nursing Home	0	**$0**	0	**$0**	4	**$3,156,655**	1	**$0**	34	**$0**
MAGI - Children under Age 19	0	**$0**	0	**$0**	0	**$0**	0	**$0**	15	**$0**
MAGI - Medicaid Expansion - Newly Eligible	1	**$18,786,875**	1	**$28,789,812**	0	**$0**	0	**$0**	43	**$0**
MAGI - Medicaid Expansion - Not Newly Eligible	0	**$0**	0	**$0**	0	**$0**	0	**$0**	1	**$0**
MAGI - Parent Caretaker	0	**$0**	0	**$0**	0	**$0**	0	**$0**	5	**$0**
MAGI - Pregnant Woman	0	**$0**	0	**$0**	0	**$0**	0	**$0**	2	**$0**
Other (None of the Above)	0	**$0**	0	**$0**	0	**$0**	0	**$0**	1	**$0**
Other Full Benefit Dual Eligible (FBDE)	0	**$0**	0	**$0**	0	**$0**	0	**$0**	3	**$0**
Qualified Individuals	0	**$0**	0	**$0**	0	**$0**	1	**$0**	0	**$0**
Transitional Medicaid	0	**$0**	0	**$0**	0	**$0**	0	**$0**	5	**$0**

Eligibility Category	Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)		Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)		Other Errors (ER10)		Incorrect Case Determination, But There was No Payment on Claim (ERTD1)		Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Total	2	**$38,557,379**	1	**$28,789,812**	4	**$3,156,655**	3	**$0**	151	**$0**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

Table 25 lists the Medicaid eligibility review payment errors by eligibility category.

Pennsylvania Table 25: Medicaid Eligibility Review Error Type and Error Causes by Eligibility Category

Eligibility Category and Error Type	# of Sample Errors
Aged, Blind, and Disabled - Mandatory Coverage	
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
State did not do required disability/blindness determination - caseworker	1
Aged, Blind, and Disabled - Optional Categorically Needy	
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Blindness/disability determination documentation not on file/incomplete	6
Resource verification not on file/incomplete	2
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Other element not verified - caseworker	2
Resources not verified - caseworker	1
Signature not recorded at initial application - caseworker	1
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	
Other non-financial error - caseworker	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Countable income incorrectly excluded; eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	1
Other financial deficiency - caseworker	1
Other non-financial deficiency - caseworker	2
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	1
Resources incorrectly calculated; eligible for enrolled category - caseworker	1
Home and Community-Based Services	
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Level of care determination not on file/incomplete	3
Record of signature not on file - caseworker	4
Resource verification not on file/incomplete	5
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Resources not verified - caseworker	2
When appropriate, signature not recorded at renewal - caseworker	2
Determination Not Conducted as Required (ER3)	
Redetermination was not conducted within 12 months before date of payment for services - caseworker	4
Not Eligible for Enrolled Program - Financial Issue (ER4)	
Resources incorrectly included/excluded - caseworker	1
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	

Eligibility Category and Error Type	# of Sample Errors
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Income incorrectly calculated; other; eligible for enrolled category - caseworker	7
Income incorrectly calculated; other; eligible for enrolled category - system	1
Other non-financial deficiency - caseworker	1
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	2
Resources incorrectly calculated; eligible for enrolled category - caseworker	21
Resources incorrectly included/excluded; eligible for enrolled category - caseworker	2
LTC/Nursing Home	
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Level of care determination not on file/incomplete	7
Other required forms not on file/incomplete	1
Resource verification not on file/incomplete	2
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Other eligibility process(es) not followed - caseworker	1
Resources not verified - caseworker	2
When appropriate, signature not recorded at renewal - caseworker	3
Determination Not Conducted as Required (ER3)	
Redetermination was not conducted within 12 months before date of payment for services - caseworker	1
Not Eligible for Enrolled Program - Financial Issue (ER4)	
Resources incorrectly calculated - caseworker	2
Other Errors (ER10)	
Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker	2
Other error	2
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Income incorrectly calculated; other; eligible for enrolled category - caseworker	7
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	2
Resources incorrectly calculated; eligible for enrolled category - caseworker	19
Resources incorrectly included/excluded; eligible for enrolled category - caseworker	6
MAGI - Children under Age 19	
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Income verification not on file/incomplete	1
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Signature not recorded at initial application - caseworker	1

Eligibility Category and Error Type	# of Sample Errors
When appropriate, signature not recorded at renewal - caseworker	4
Determination Not Conducted as Required (ER3)	
Initial determination not conducted	1
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
Countable income incorrectly excluded - system	1
Income incorrectly calculated; other - caseworker	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Countable income incorrectly excluded; eligible for enrolled category - caseworker	1
Exempt income incorrectly included; not eligible for enrolled category - caseworker	1
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	3
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	2
Income incorrectly calculated; other; eligible for enrolled category - caseworker	7
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	1
MAGI - Medicaid Expansion - Newly Eligible	
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
When appropriate, signature not recorded at renewal - caseworker	2
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	
Household composition/tax filer unit or tax filer status incorrect - caseworker	1
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	
Countable income incorrectly excluded - caseworker	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Countable income incorrectly excluded; eligible for enrolled category - caseworker	6
Countable income incorrectly excluded; eligible for enrolled category - system	5
Exempt income incorrectly included; eligible for enrolled category - system	1
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	6
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	10
Income deduction incorrectly included/excluded; eligible for enrolled category - system	1
Income incorrectly calculated; other; eligible for enrolled category - caseworker	14
MAGI - Medicaid Expansion - Not Newly Eligible	
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
MAGI - Parent Caretaker	
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
When appropriate, signature not recorded at renewal - caseworker	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Countable income incorrectly excluded; eligible for enrolled category - caseworker	1

Eligibility Category and Error Type	# of Sample Errors
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	4
MAGI - Pregnant Woman	
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	1
Other (None of the Above)	
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Signature not recorded at initial application - caseworker	1
Determination Not Conducted as Required (ER3)	
Initial determination not conducted	7
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Other non-financial deficiency - caseworker	1
Other Full Benefit Dual Eligible (FBDE)	
Documentation to Support Eligibility Determination Not Maintained (ER1)	
Resource verification not on file/incomplete	1
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Resources not verified - caseworker	1
Determination Not Conducted as Required (ER3)	
Initial determination not conducted	5
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Other non-financial deficiency - caseworker	1
Resources incorrectly calculated; eligible for enrolled category - caseworker	2
Qualified Individuals	
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
Not eligible for enrolled program; financial issue	1
Transitional Medicaid	
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	
Income not verified - caseworker	1
Income not verified - system	1
Other eligibility process(es) not followed - caseworker	1
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	1
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	1
Other non-financial deficiency - caseworker	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.

Eligibility Review Error Descriptions by Eligibility Category

Aged, Blind, and Disabled - Mandatory Coverage

One error was cited for this eligibility category:

- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that the state completed a blindness/disability assessment during the state's determination. The caseworker did not identify a blindness/disability assessment was needed. Therefore, eligibility could not be determined to support the state's decision.

Aged, Blind, and Disabled - Optional Categorically Needy

Thirteen errors were cited for this eligibility category:

- Six "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that the state completed a blindness/disability assessment, but sufficient documentation of the assessment was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- Two "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that resources were verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- Two "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that other elements were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that resources were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that the beneficiary's signature was recorded during the initial application during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.907(f) requires all initial applications to be signed.
- One "Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)" error was cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. The beneficiary was incorrectly placed in an eligibility category with a different FMAP rate than the correct eligibility category.

Eight deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker made a financial error when determining if the beneficiary met the eligibility thresholds. However, the beneficiary was eligible for Medicaid.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiaries were eligible for Medicaid.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the redetermination was not conducted by the caseworker before the required 12-month renewal date as required by 42 CFR § 435.916(a). However, the redetermination was conducted before the date of payment; therefore, the finding did not have an eligibility/financial impact.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiary was still eligible for the enrolled category.

Home and Community-Based Services

Twenty-one errors were cited for this eligibility category:

- Three "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that the state completed a level of care assessment, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- Four "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because the application forms and/or renewal forms were not signed by the beneficiary. 42 CFR § 435.907(f) requires all initial applications to be signed and 42 CFR § 435.916(2)(ii) requires all renewal forms to be signed.
- Five "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that resources were verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- Two "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that resources were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- Two "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.

- Four "Determination Not Conducted as Required (ER3)" errors were cited because the redetermination was not conducted by the caseworker within 12 months of the date of service as required by 42 CFR § 435.916(a).
- One "Not Eligible for Enrolled Program - Financial Issue (ER4)" error was cited because the caseworker incorrectly included or excluded resources when determining if the beneficiary met the eligibility resource thresholds. The beneficiary is not eligible for Medicaid.

Thirty-five deficiencies were cited for this eligibility category:

- One "Incorrect Case Determination, But There was No Payment on Claim (ERTD1)" deficiency was cited because there was indication the state obtained documentation to support the determination, but sufficient documentation was not maintained to complete a review of an eligibility element. An error would have been cited if a payment had been made on the sampled claim.
- Seven "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the system incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiary was eligible for Medicaid.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the redetermination was not conducted by the caseworker before the required 12-month renewal date as required by 42 CFR § 435.916(a). However, the redetermination was conducted before the date of payment; therefore, the finding did not have an eligibility/financial impact.
- Twenty-one "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly included or excluded resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.

LTC/Nursing Home

Twenty-three errors were cited for this eligibility category:

- Seven "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that the state completed a level of care assessment, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- One "Documentation to Support Eligibility Determination Not Maintained (ER1)" error was cited because there was indication in the case record that the state obtained

required forms, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.

- Two "Documentation to Support Eligibility Determination Not Maintained (ER1)" errors were cited because there was indication in the case record that resources were verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that other eligibility process(es) were followed by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- Two "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that resources were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- Three "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.
- One "Determination Not Conducted as Required (ER3)" error was cited because the redetermination was not conducted by the caseworker within 12 months of the date of service as required by 42 CFR § 435.916(a).
- Two "Not Eligible for Enrolled Program - Financial Issue (ER4)" errors were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. The beneficiaries are not eligible for Medicaid.
- Two "Other Errors (ER10)" errors were cited because the caseworker incorrectly calculated the contribution to care.
- Two "Other Errors (ER10)" errors were cited because a different error was made that impacted the beneficiary's eligibility. The errors were cited because spousal shelter expenses were not verified at the time of renewal.

Thirty-five deficiencies were cited for this eligibility category:

- One "Incorrect Case Determination, But There was No Payment on Claim (ERTD1)" deficiency was cited because there was indication the state obtained documentation to support the determination, but sufficient documentation was not maintained to complete a review of an eligibility element. An error would have been cited if a payment had been made on the sampled claim.
- Seven "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the redetermination was not conducted by the caseworker before the required 12-month renewal date as required by 42 CFR §

435.916(a). However, the redetermination was conducted before the date of payment; therefore, the finding did not have an eligibility/financial impact.

- Nineteen "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.
- Six "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly included or excluded resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.

MAGI - Children under Age 19

Nine errors were cited for this eligibility category:

- One "Documentation to Support Eligibility Determination Not Maintained (ER1)" error was cited because there was indication in the case record that income was verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that the beneficiary's signature was recorded during the initial application during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.907(f) requires all initial applications to be signed.
- Four "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.
- One "Determination Not Conducted as Required (ER3)" error was cited because there was no indication in the case record that an initial determination was conducted by the state. The state did not have case documentation or system processing records.
- One "Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)" error was cited because the system incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. The beneficiary should have been enrolled in CHIP and not Medicaid.
- One "Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)" error was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. The beneficiary should have been enrolled in CHIP and not Medicaid.

Fifteen deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly included exempt income when determining if the beneficiary met the eligibility income thresholds.

However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

- Three "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiaries were still eligible for the enrolled category.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly included or excluded MAGI income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- Seven "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

MAGI - Medicaid Expansion - Newly Eligible

Four errors were cited for this eligibility category:

- Two "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" errors were cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.
- One "Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)" error was cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. The beneficiaries were incorrectly placed in an eligibility category with a different FMAP rate than the correct eligibility category.
- One "Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)" error was cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. The beneficiary was not eligible for the type of service that was received.

Forty-three deficiencies were cited for this eligibility category:

- Six "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- Five "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the system incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the system incorrectly included exempt income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- Six "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiaries were still eligible for the enrolled category.
- Ten "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" errors were cited because the caseworker incorrectly included or excluded MAGI income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the system incorrectly included or excluded income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- Fourteen "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiaries were still eligible for the enrolled category.

MAGI - Medicaid Expansion - Not Newly Eligible

One deficiency was cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the system did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

MAGI - Parent Caretaker

One error was cited for this eligibility category:

- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that the beneficiary's signature was recorded at renewal during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.916(a)(3)(i)(B) requires all renewal forms to be signed.

Five deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly excluded countable income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was still eligible for the enrolled category.
- Four "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiaries were still eligible for the enrolled category.

MAGI - Pregnant Woman

Two deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiary was still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.

Other (None of the Above)

Eight errors were cited for this eligibility category:

- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that the beneficiary's signature was recorded during the initial application during the state's determination. The caseworker did not identify the beneficiary's signature as missing. 42 CFR § 435.907(f) requires all initial applications to be signed.
- Seven "Determination Not Conducted as Required (ER3)" errors were cited because there was no indication in the case record that an initial determination was conducted by the state. The state did not have case documentation or system processing records.

One deficiency was cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiary was eligible for Medicaid.

Other Full Benefit Dual Eligible (FBDE)

Seven errors were cited for this eligibility category:

- One "Documentation to Support Eligibility Determination Not Maintained (ER1)" error was cited because there was indication in the case record that resources were verified during the state's determination, but sufficient documentation was not maintained to complete a review of this element. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that resources were verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- Five "Determination Not Conducted as Required (ER3)" errors were cited because there was no indication in the case record that an initial determination was conducted by the state. The state did not have case documentation or system processing records.

Three deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiary was eligible for Medicaid.

- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker incorrectly calculated resources when determining if the beneficiary met the eligibility resource thresholds. However, the beneficiaries were still eligible for the enrolled category.

Qualified Individuals

One deficiency was cited for this eligibility category:

- One "Incorrect Case Determination, But There was No Payment on Claim (ERTD1)" deficiency was cited because the state did not correctly determine the financial factors of the beneficiary's eligibility. The beneficiary is not eligible for Medicaid. An error would have been cited if a payment had been made on the sampled claim.

Transitional Medicaid

Three errors were cited for this eligibility category:

- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that income was verified by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that income was verified by the system during the state's determination. Therefore, eligibility could not be determined to support the state's decision.
- One "Verification/Documentation Not Done/Collected at the Time of Determination (ER2)" error was cited because there was no indication in the case record that other eligibility process(es) were followed by the caseworker during the state's determination. Therefore, eligibility could not be determined to support the state's decision.

Five deficiencies were cited for this eligibility category:

- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker did not construct the household size correctly based upon the appropriate tax filer rules, non-tax filer rules, or relationship rules. However, the beneficiary was still eligible for the enrolled category.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly included or excluded MAGI income deductions when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.
- One "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiency was cited because the caseworker incorrectly calculated the household income when determining if the beneficiary met the eligibility income thresholds. However, the beneficiary was eligible for a different program category with the same service package and FMAP rate.
- Two "Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)" deficiencies were cited because the caseworker made a non-financial error when determining the beneficiary's eligibility. However, the beneficiaries were eligible for Medicaid.

For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

2. Types of Payment Errors

a. Medicaid Eligibility Review – MAGI Analysis

This section analyzes Pennsylvania Medicaid payment errors for RY 2019 MAGI errors versus Non-MAGI errors.

Figure 11 shows the percentage of Medicaid MAGI versus Non-MAGI errors by projected federal dollars in error. In Pennsylvania, MAGI errors account for 16.27% of projected federal dollars in error, while Non-MAGI errors comprise 83.73%.

Pennsylvania Figure 11: Medicaid Eligibility MAGI versus Non-MAGI Errors

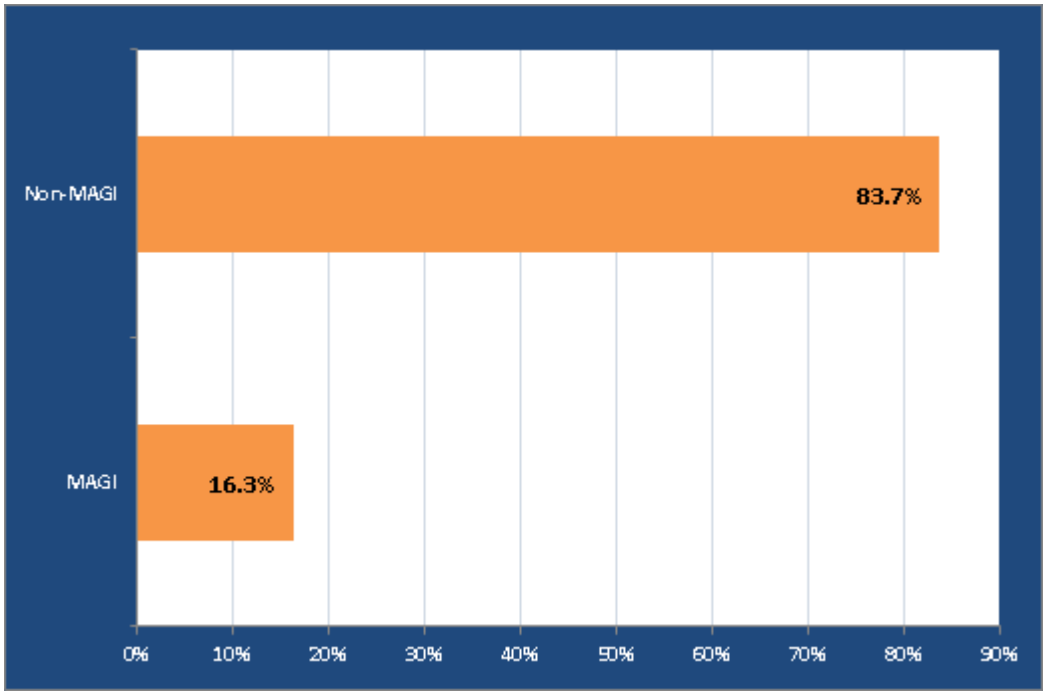


Table 26 shows how the errors aggregate into MAGI and Non-MAGI payment errors.

Pennsylvania Table 26: Medicaid Eligibility MAGI versus Non-MAGI Errors

MAGI or Non-MAGI Error	# of Sample Claims in Error	% of Total # of Sample Claims in Error	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
MAGI	68	33.83%	$2,521	2.62%	**$296,290,565**	16.27%
Non-MAGI	133	66.17%	$93,639	97.38%	**$1,524,865,569**	83.73%

Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. This also applies to Figure 11, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

Table 27 and Table 28 show how the MAGI and Non-MAGI errors aggregate into system and caseworker errors[2].

Pennsylvania Table 27: Medicaid Eligibility MAGI Errors by System versus Caseworker

Classification[3]	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
Caseworker	69	$2,391	**$265,771,936**
System	9	$40	**$16,646,220**
Unknown	2	$130	**$28,029,355**
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.			

Pennsylvania Table 28: Medicaid Eligibility Non-MAGI Errors by System versus Caseworker

Classification	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
Caseworker	118	$35,535	**$938,454,366**
System	2	$43	**$14,002,189**
Unknown	44	$62,954	**$871,405,366**
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.			

[2] Not all cases are touched by both a system and a caseworker.

[3] Some errors are not attributed to either system or caseworker, mostly where there is not enough documentation to determine an assignment. Additionally, some errors attributed to caseworker could stem from an underlying system issue. States will need to perform a deeper analysis to determine the true root cause and establish appropriate corrective actions.

b. Medicaid Eligibility Review – Claim Type Analysis

This section analyzes Pennsylvania Medicaid payment errors for RY 2019 FFS errors versus managed care errors.

Figure 12 shows the percentage of Medicaid FFS versus managed care errors by projected federal dollars in error. In Pennsylvania, FFS errors account for 47.57% of projected federal dollars in error, while managed care errors comprise 52.43%.

Pennsylvania Figure 12: Medicaid Eligibility Errors by Claim Type

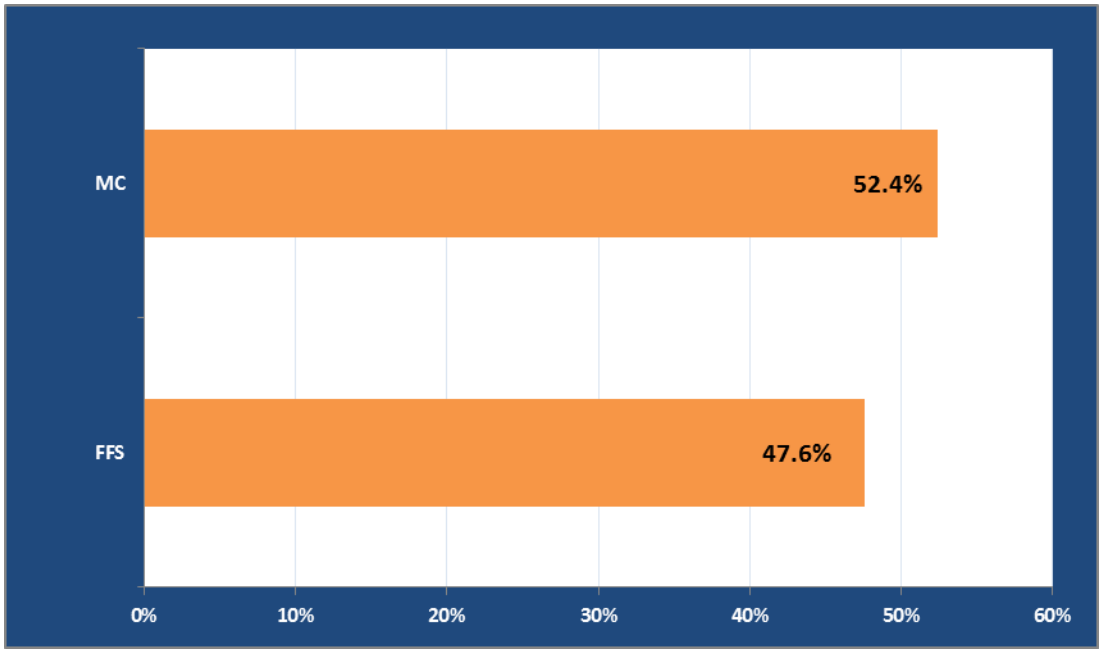


Table 29 shows how the errors aggregate into FFS and managed care payment errors.

Pennsylvania Table 29: Medicaid Eligibility Errors by Claim Type

Claim Type	# of Sample Claims in Error	% of Total # of Sample Claims in Error	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
FFS	90	44.78%	$86,824	90.29%	**$866,398,929**	47.57%
Managed Care	111	55.22%	$9,336	9.71%	**$954,757,204**	52.43%

Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. This also applies to Figure 12, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, please note that the eligibility reviews of FFS and managed care claims are identical, unlike for medical and data processing reviews.

c. Medicaid Eligibility Review – Case Action Analysis

This section analyzes Pennsylvania Medicaid payment errors for RY 2019 case action errors. Figure 13 shows the percentage of Medicaid case action errors by projected federal dollars in error.

In Pennsylvania, application errors account for 6.01% of projected federal dollars in error, while redetermination errors comprise 74.07%.

Pennsylvania Figure 13: Medicaid Eligibility Case Action Errors

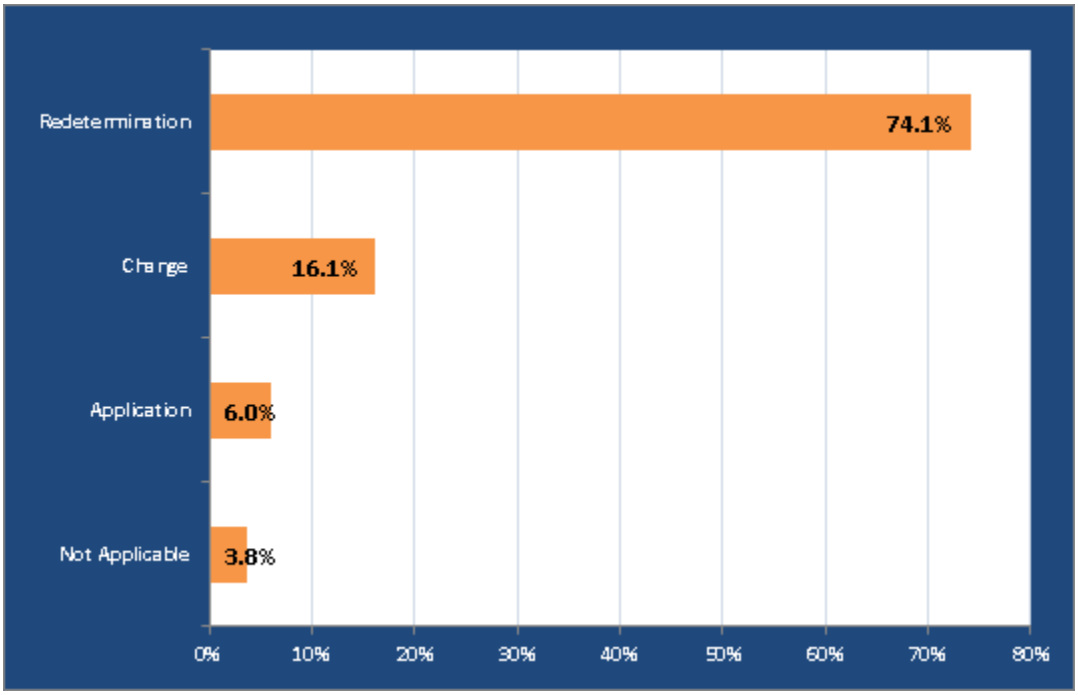


Table 30 shows how the errors aggregate into case action payment errors.

Pennsylvania Table 30: Medicaid Eligibility Case Action Errors

Case Action Error[4]	# of Sample Claims in Error	% of Total # of Sample Claims in Error	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
Application	23	11.44%	$9,766	10.16%	**$109,462,022**	6.01%
Change	48	23.88%	$14,867	15.46%	**$293,915,905**	16.14%
Not Applicable	3	1.49%	$923	0.96%	**$68,785,016**	3.78%
Redetermination	127	63.18%	$70,603	73.42%	**$1,348,993,190**	74.07%

Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. This also applies to Figure 13, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. A case action of "Not Applicable" applies to cases where eligibility happens automatically. Examples include Title IV-E cases and SSI cases in 1634 states. A case action of "Unknown" applies to cases where the type of action is not able to be determined. An example includes where an application or renewal is missing completely from the case file.

[4] Not all claims considered redetermination were cited errors for redetermination not conducted timely; other errors were cited on some of these claims.

Table 31 shows eligibility review errors by case action for Medicaid eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 31: Medicaid Eligibility Case Action by Eligibility Review Error Type in Projected Federal Dollars

Case Action	Documentation to Support Eligibility Determination Not Maintained (ER1)		Verification/ Documentation Not Done/ Collected at the Time of Determination (ER2)		Determination Not Conducted as Required (ER3)		Not Eligible for Enrolled Program - Financial Issue (ER4)		Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Application	3	**$54,126,053**	2	**$39,127,685**	2	**$15,592,717**	1	**$24,534,279**	0	**$0**
Change	3	**$79,672,177**	7	**$120,556,188**	1	**$13,872,408**	0	**$0**	2	**$31,481,799**
Not Applicable	0	**$0**	0	**$0**	2	**$68,785,016**	0	**$0**	0	**$0**
Redetermination	26	**$592,049,089**	19	**$714,022,371**	13	**$261,614,961**	2	**$48,370,843**	0	**$0**
Total	32	**$725,847,319**	28	**$873,706,245**	18	**$359,865,102**	3	**$72,905,122**	2	**$31,481,799**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

Case Action	Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)		Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)		Other Errors (ER10)		Incorrect Case Determination, But There was No Payment on Claim (ERTD1)		Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error
Application	0	**$0**	0	**$0**	1	**$615,567**	0	**$0**	19	**$0**
Change	1	**$18,786,875**	1	**$28,789,812**	1	**$756,647**	0	**$0**	44	**$0**
Not Applicable	0	**$0**	0	**$0**	0	**$0**	0	**$0**	1	**$0**
Redetermination	1	**$19,770,504**	0	**$0**	2	**$1,784,442**	3	**$0**	87	**$0**
Total	2	**$38,557,379**	1	**$28,789,812**	4	**$3,156,655**	3	**$0**	151	**$0**

Note: Details do not always sum to the total due to rounding. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.

3. Comparison of Medicaid FY 2015 and RY 2019

This section provides a brief comparison of the sample findings for Pennsylvania in FY 2015 and RY 2019 for Medicaid.

Sample Medicaid Eligibility Comparisons

There was no eligibility measurement in Pennsylvania in the previous cycle; therefore, there are no eligibility comparison analyses.

Appendix

A. Error Type Definitions

The following tables list error type definitions for medical review error codes, data processing error codes, and eligibility error codes, as well as an overall acronym glossary.

Pennsylvania Appendix Table 1: Medical Review Error Codes

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

Error Code	Error	Definition
MTD	Medical Technical Deficiency	Medical review determined a deficiency that did not result in a payment error. DOS billing errors are included as deficiencies when the date of service on the record is less than 7 days prior to or after the DOS on the claim.

Pennsylvania Appendix Table 2: Data Processing Error Codes

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

Pennsylvania Appendix Table 3: Eligibility Review Error Codes

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

Error Code	Error	Definition
ERTD2	Finding Noted with Case, But Did Not Affect Determination or Payment	The state incorrectly applied federal or state regulations; federal policy or procedure; or made an error during the eligibility determination; however, the beneficiary remains eligible for the enrolled program or category.

Pennsylvania Appendix Table 4: Acronym Glossary

Acronym	Definition
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
DMF	Death Master File
DOS	Date Of Service
DP	Data Processing
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
ER	Eligibility Review
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
HIPAA	Health Insurance Portability and Accountability Act
ICF	Intermediate Care Facility
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MR	Medical Review
NADAC	National Average Drug Acquisition Cost
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization

Acronym	Definition
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Measurement
POC	Plan Of Care
QMB	Qualified Medicare Beneficiary
RBS	Risk-Based Screening
SAM/EPLS	System for Award Management/Excluded Parties List System
SLMB	Specified Low - Income Medicare Beneficiary
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TD	Technical Deficiency
TPL	Third-Party Liability

B. List of PERM IDs

The following tables list the medical review errors, data processing errors, and eligibility errors by PERM ID.

Pennsylvania Appendix Table 5: Medicaid FFS Medical Review Error by Error Type

PERM ID	Error Type	Qualifier	Service Type
PAM1904F158	No Documentation Error (MR1)	Provider responded that he or she did not have the beneficiary on file or in the system	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F055	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1902F004	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F035	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1903F131	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F167	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1904F077	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1904F128	Document(s) Absent from Record (MR2)	One or more documents are missing from the record that are required to support payment	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F115	Number of Unit(s) Error (MR6)	Number of units billed not supported by number of units documented	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services

PERM ID	Error Type	Qualifier	Service Type
PAM1901F126	Number of Unit(s) Error (MR6)	Number of units billed not supported by number of units documented	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F095	Number of Unit(s) Error (MR6)	Number of units billed not supported by number of units documented	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1904F167	Number of Unit(s) Error (MR6)	Number of units billed not supported by number of units documented	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F074	Improperly Completed Documentation (MR9)	Required provider signature and/or credentials are not present	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)

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Pennsylvania Appendix Table 6: Medicaid FFS Data Processing Error by Error Type

PERM ID	Error Type	Qualifier	Service Type
PAM1901F006	Provider Information/Enrollment Error (DP10)	Attending provider NPI required, but not submitted on institutional claim	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1902F025	Provider Information/Enrollment Error (DP10)	Attending provider NPI required, but not submitted on institutional claim	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1903F019	Provider Information/Enrollment Error (DP10)	Attending provider NPI required, but not submitted on institutional claim	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1904F129	Provider Information/Enrollment Error (DP10)	Missing provider license information	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F119	Provider Information/Enrollment Error (DP10)	Missing provider risk-based screening information	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F160	Provider Information/Enrollment Error (DP10)	Missing provider risk-based screening information	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F016	Provider Information/Enrollment Error (DP10)	Missing provider risk-based screening information	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1904F026	Provider Information/Enrollment Error (DP10)	Missing provider risk-based screening information	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1904F079	Provider Information/Enrollment Error (DP10)	Missing provider risk-based screening information	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F168	Provider Information/Enrollment Error (DP10)	ORP Type 1 NPI required, but not listed on the claim	Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment
PAM1901F015	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes

PERM ID	Error Type	Qualifier	Service Type
PAM1901F092	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F093	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F096	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F107	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F110	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F120	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F130	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F139	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1901F169	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F007	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1902F076	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F082	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F086	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F092	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F119	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F127	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F129	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F133	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F135	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services

PERM ID	Error Type	Qualifier	Service Type
PAM1902F141	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F156	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F031	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1903F078	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F084	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F088	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F089	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F092	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F106	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F109	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F116	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F118	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F131	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F134	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F145	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F159	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1903F167	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1904F016	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1904F092	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services

PERM ID	Error Type	Qualifier	Service Type
PAM1904F102	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F025	Provider Information/Enrollment Error (DP10)	Provider not screened using risk based criteria prior to claim payment date	Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes
PAM1901F048	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1901F058	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1901F066	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1901F071	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1901F137	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services
PAM1902F058	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1902F102	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1902F148	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Prescribed Drugs
PAM1903F009	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1903F038	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1903F048	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1903F051	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)
PAM1903F064	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)

PERM ID	Error Type	Qualifier	Service Type
PAM1903F093	Data Processing Technical Deficiency (DTD)	Provider not screened prior to enrollment determination date but screened prior to claim payment date	Prescribed Drugs

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Pennsylvania Appendix Table 7: Medicaid Eligibility Review Error by Error Type

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1901M067	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M003	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M018	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M059	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903M045	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1904M043	Documentation to Support Eligibility Determination Not Maintained (ER1)	Blindness/disability determination documentation not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M081	Documentation to Support Eligibility Determination Not Maintained (ER1)	Income verification not on file/incomplete	MAGI - Children under Age 19
PAM1901F109	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	Home and Community-Based Services
PAM1901F156	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	Home and Community-Based Services
PAM1902F015	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1902F028	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1902F058	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1903F042	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1904F026	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1904F031	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1904F040	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	LTC/Nursing Home
PAM1904F127	Documentation to Support Eligibility Determination Not Maintained (ER1)	Level of care determination not on file/incomplete	Home and Community-Based Services
PAM1901F015	Documentation to Support Eligibility Determination Not Maintained (ER1)	Other required forms not on file/incomplete	LTC/Nursing Home
PAM1902F099	Documentation to Support Eligibility Determination Not Maintained (ER1)	Record of signature not on file - caseworker	Home and Community-Based Services

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1903F093	Documentation to Support Eligibility Determination Not Maintained (ER1)	Record of signature not on file - caseworker	Home and Community-Based Services
PAM1903F119	Documentation to Support Eligibility Determination Not Maintained (ER1)	Record of signature not on file - caseworker	Home and Community-Based Services
PAM1904F127	Documentation to Support Eligibility Determination Not Maintained (ER1)	Record of signature not on file - caseworker	Home and Community-Based Services
PAM1902F005	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Home and Community-Based Services
PAM1902F033	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Home and Community-Based Services
PAM1902F086	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Home and Community-Based Services
PAM1902F089	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	LTC/Nursing Home
PAM1902F116	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Home and Community-Based Services
PAM1902M074	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903F103	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Home and Community-Based Services
PAM1904F070	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	LTC/Nursing Home
PAM1904F160	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Other Full Benefit Dual Eligible (FBDE)
PAM1904M049	Documentation to Support Eligibility Determination Not Maintained (ER1)	Resource verification not on file/incomplete	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903M070	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Income not verified - caseworker	Transitional Medicaid
PAM1904M082	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Income not verified - system	Transitional Medicaid
PAM1901M021	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Other element not verified - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M004	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Other element not verified - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1903M092	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Other eligibility process(es) not followed - caseworker	Transitional Medicaid
PAM1904F090	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Other eligibility process(es) not followed - caseworker	LTC/Nursing Home
PAM1901F044	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	LTC/Nursing Home
PAM1901F112	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	Home and Community-Based Services
PAM1903M079	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	Other Full Benefit Dual Eligible (FBDE)
PAM1904M047	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1901F156	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	Home and Community-Based Services
PAM1902F058	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Resources not verified - caseworker	LTC/Nursing Home
PAM1903F008	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Signature not recorded at initial application - caseworker	Other (None of the Above)
PAM1903M073	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Signature not recorded at initial application - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1904M075	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	Signature not recorded at initial application - caseworker	MAGI - Children under Age 19
PAM1901M086	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	State did not do required disability/blindness determination - caseworker	Aged, Blind, and Disabled - Mandatory Coverage
PAM1901F069	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	LTC/Nursing Home
PAM1901F178	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Children under Age 19

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902F053	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	LTC/Nursing Home
PAM1902M077	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Children under Age 19
PAM1902M082	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Children under Age 19
PAM1903M039	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M051	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904F157	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	LTC/Nursing Home
PAM1904M084	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Parent Caretaker
PAM1901F109	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	Home and Community-Based Services
PAM1902M081	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	MAGI - Children under Age 19
PAM1901F156	Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	When appropriate, signature not recorded at renewal - caseworker	Home and Community-Based Services
PAM1901F170	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901M075	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901M081	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901M085	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901M088	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901M093	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other Full Benefit Dual Eligible (FBDE)

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902M063	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other Full Benefit Dual Eligible (FBDE)
PAM1903M062	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other Full Benefit Dual Eligible (FBDE)
PAM1903M063	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other Full Benefit Dual Eligible (FBDE)
PAM1903M076	Determination Not Conducted as Required (ER3)	Initial determination not conducted	MAGI - Children under Age 19
PAM1903M089	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1904M046	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other Full Benefit Dual Eligible (FBDE)
PAM1904M086	Determination Not Conducted as Required (ER3)	Initial determination not conducted	Other (None of the Above)
PAM1901F030	Determination Not Conducted as Required (ER3)	Redetermination was not conducted within 12 months before date of payment for services - caseworker	LTC/Nursing Home
PAM1901F127	Determination Not Conducted as Required (ER3)	Redetermination was not conducted within 12 months before date of payment for services - caseworker	Home and Community-Based Services
PAM1903F060	Determination Not Conducted as Required (ER3)	Redetermination was not conducted within 12 months before date of payment for services - caseworker	Home and Community-Based Services
PAM1903F080	Determination Not Conducted as Required (ER3)	Redetermination was not conducted within 12 months before date of payment for services - caseworker	Home and Community-Based Services
PAM1903F155	Determination Not Conducted as Required (ER3)	Redetermination was not conducted within 12 months before date of payment for services - caseworker	Home and Community-Based Services
PAM1904F057	Not Eligible for Enrolled Program - Financial Issue (ER4)	Resources incorrectly calculated - caseworker	LTC/Nursing Home
PAM1902F089	Not Eligible for Enrolled Program - Financial Issue (ER4)	Resources incorrectly calculated - caseworker	LTC/Nursing Home
PAM1903F085	Not Eligible for Enrolled Program - Financial Issue (ER4)	Resources incorrectly included/excluded - caseworker	Home and Community-Based Services
PAM1903M094	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	Countable income incorrectly excluded - system	MAGI - Children under Age 19
PAM1903M088	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	Income incorrectly calculated; other - caseworker	MAGI - Children under Age 19

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1904M069	Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	Household composition/tax filer unit or tax filer status incorrect - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M033	Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	Other non-financial error - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902M044	Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	Countable income incorrectly excluded - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901F089	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker	LTC/Nursing Home
PAM1903F067	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker	LTC/Nursing Home
PAM1901F049	Other Errors (ER10)	Other error	LTC/Nursing Home
PAM1901F059	Other Errors (ER10)	Other error	LTC/Nursing Home
PAM1901F151	Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	Home and Community-Based Services
PAM1901F162	Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	LTC/Nursing Home
PAM1903F171	Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	Not eligible for enrolled program; financial issue	Qualified Individuals
PAM1901M007	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1901M014	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M060	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M054	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M088	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Children under Age 19

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1903M040	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M065	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904F187	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Parent Caretaker
PAM1904M069	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M073	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M044	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M054	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M056	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M040	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Countable income incorrectly excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M044	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Exempt income incorrectly included; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M084	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Exempt income incorrectly included; not eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1901M051	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M076	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1902M049	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Pregnant Woman

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902M087	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	Transitional Medicaid
PAM1903F021	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M046	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M058	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M060	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Parent Caretaker
PAM1904M014	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Parent Caretaker
PAM1904M042	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M056	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Parent Caretaker
PAM1904M058	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M088	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1904M091	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1904M095	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	MAGI - Parent Caretaker
PAM1903M042	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	MAGI - Medicaid Expansion - Not Newly Eligible
PAM1901M054	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902M051	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M064	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M070	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1902M093	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M032	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M045	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M077	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M078	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1903M054	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M058	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M042	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M046	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; eligible for enrolled category - system	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M090	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	Transitional Medicaid
PAM1901F022	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1901F025	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F054	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F079	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901F104	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901M031	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M041	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M046	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M055	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M058	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M064	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1901M070	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1901M080	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901M082	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1902F101	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902F192	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902M060	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1902M068	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903F075	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903M035	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903M053	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M069	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1903M081	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1904F033	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F085	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904M040	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M061	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1904M092	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1902M051	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1902M077	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1903F093	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F031	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F090	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904M045	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1903M058	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	MAGI - Medicaid Expansion - Newly Eligible
PAM1901F156	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901F107	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; eligible for enrolled category - system	Home and Community-Based Services
PAM1902M025	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; not eligible for enrolled category - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903M075	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; not eligible for enrolled category - caseworker	MAGI - Children under Age 19
PAM1902M049	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; not eligible for enrolled category - caseworker	MAGI - Pregnant Woman
PAM1903M090	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Income incorrectly calculated; other; not eligible for enrolled category - caseworker	Transitional Medicaid
PAM1903M002	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other financial deficiency - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1901M047	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Other Full Benefit Dual Eligible (FBDE)

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1901M065	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Other (None of the Above)
PAM1902M001	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Transitional Medicaid
PAM1902M023	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1904M039	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1903F075	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Home and Community-Based Services
PAM1903M090	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Other non-financial deficiency - caseworker	Transitional Medicaid
PAM1901F072	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	LTC/Nursing Home
PAM1904F065	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	LTC/Nursing Home
PAM1901M067	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902F086	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	Home and Community-Based Services
PAM1903F103	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	Home and Community-Based Services
PAM1901F005	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901F056	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1901F074	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F097	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F099	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F124	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901M023	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Aged, Blind, and Disabled - Optional Categorically Needy
PAM1902F055	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F068	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F096	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1902F111	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1902F166	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1902F174	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Other Full Benefit Dual Eligible (FBDE)
PAM1903F010	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F090	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F124	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Other Full Benefit Dual Eligible (FBDE)

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1903F144	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F173	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F008	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F062	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F111	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F116	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F121	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F129	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F171	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F192	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904M003	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904M004	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904M012	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904M013	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1904M015	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F025	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F089	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1901F162	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F015	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F111	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F067	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F033	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F070	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F085	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F111	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F075	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901F156	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly calculated; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1901F061	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home

PERM ID	Error Type	Qualifier	Eligibility Category
PAM1901F064	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F023	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F187	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1903F057	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1904F065	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home
PAM1902F111	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	Home and Community-Based Services
PAM1904F033	Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	Resources incorrectly included/excluded; eligible for enrolled category - caseworker	LTC/Nursing Home

Return to Medicaid Eligibility Review Findings

C. Recoveries

When a sampled unit is identified as an overpayment error, CMS recovers funds from the state for the federal share. Final Errors For Recovery (FEFR) reports are posted on the designated CMS Review Contractor's SMERF website, which lists all claims with an overpayment error and is the official notice sent to the states of recoveries due. An official letter of notification from CMS is attached to the report notice sent to the states.

States have up to one year from the date of discovery of an overpayment (which is the date of the FEFR report) for Medicaid and CHIP to recover, or to attempt to recover, the overpayment before refunding the federal share. There are exceptions; please reference the State Medicaid Directors Letter (SMDL# 10-014) dated July 13, 2010 at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10014.pdf for more details.

CMS PERM recoveries are reported to the Department of Health & Human Services and Congress. States must return the federal share for overpayments identified in Medicaid and CHIP FFS and managed care. States can find a comprehensive list of these overpayments in the RY 2019 FEFR report. In addition, states may find a comprehensive list of Difference Resolutions (DRs) and Appeals filed throughout the cycle, as well as the outcomes of continued processing (which are not reflected in this report) on the SMERF website. Overpayments identified through the PERM

eligibility review follow the disallowance process outlined in the July 5, 2017 PERM Regulation (82 FR 31158) and 1903(u) of the Social Security Act.

There are circumstances in which exceptions to the requirement to return the federal share of a PERM overpayment may apply. Exceptions include instances where the state adjusted the payment to the correct amount after the 60 days allowed within PERM, the provider submitted documentation after the cycle ended, or the provider successfully appealed a decision to the state. These exceptions are listed in Section XII of the CMS PERM Manual, located at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf. States should alert CMS if they believe one of these exceptions applies to their state (note: exceptions will not result in a change in the state's officially cited errors or reported improper payment rate). Please note, the recoveries process is not an opportunity to disagree with error findings. States should complete the DR process within the designated timeframes throughout the PERM cycle, as the end of the cycle is not the time for a state to dispute findings.

States are to work with their designated CMS Regional Office PERM recoveries contact to ensure the appropriate federal share is returned timely. Your CMS Central Office PERM recoveries contact is your CMS PERM state liaison, Danielle Kochenour, who can be reached at 410-786-2999 or Danielle.Kochenour@cms.hhs.gov.

D. Next Steps

The corrective action process begins by establishing a corrective action panel consisting of persons within your organization who have decision-making responsibilities that affect policy and procedural change. This panel should review Pennsylvania's RY 2019 PERM findings, identify programmatic causes of the errors, determine the root causes for the errors, and develop a CAP using the CMS provided Pennsylvania CAP template to address the major causes of these errors.

The CAP should include an implementation schedule that identifies major tasks required to implement each corrective action and timelines, including target implementation dates and milestones. Monitoring and evaluation of the corrective action is also essential to ensure that the corrective action is meeting targets and goals and is achieving the desired results.

The CAP is due to CMS 90 calendar days after the date on which the state's improper payment rates are posted on the Review Contractor's website. A timely submission of the CAP is essential as it is the first step in making a good faith effort to address improper payments. Detailed information and instructions for submitting a CAP can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Corrective-Action-Plan-CAP-Process.html.

CMS appreciates the cooperation extended by Pennsylvania during the RY 2019 measurement and the commitment to safeguarding taxpayers' dollars by ensuring that Medicaid services are rendered and reimbursed accurately. CMS looks forward to continuing our partnership with Pennsylvania during the CAP process. Our aim is to work closely with Pennsylvania to ensure timely submission and implementation of Pennsylvania's corrective action plan. If you have any questions or concerns do not hesitate to contact your CMS PERM state liaison, Danielle Kochenour, at the number or email address listed in the above recoveries section.