U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

RY 2022 Pennsylvania Children's Health Insurance Program (CHIP)

Payment Error Rate Measurement (PERM) Cycle 1 Summary Report

November 15, 2022

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 Payment Integrity Information Act (PIIA) of 2019.

PIIA requires 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 (MC) 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) 2022.

This report provides an overview of the RY 2022 findings and presents data analyses of payment errors found in Pennsylvania CHIP. 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 CHIP FFS claims, MC capitation payments, and eligibility determinations (using claims from the FFS and MC 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 CHIP FFS, MC, and eligibility.[1] For CHIP FFS and MC, additional analysis from the Review Contractor is included to address CHIP FFS medical review and data processing

[1] PERM combines components (FFS and MC) 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.

errors, as well as MC data processing errors. For CHIP eligibility, additional analysis from the Eligibility Review Contractor is included to address CHIP 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.[2] 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.

[2] For additional information on PERM and PERM calculation methodologies please visit - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/PERM

B. PERM National Rolling CHIP Findings

In RY 2022, the combined national CHIP estimated federal improper payment rate is **26.75%**. The estimated national component federal improper payment rates are as follows.

- **National CHIP FFS - 11.23%**
- **National CHIP managed care - 0.62%**
- **National CHIP eligibility - 24.01%**

C. PERM 17-State Cycle 1 CHIP Findings

In RY 2022, the combined Cycle 1 CHIP estimated federal improper payment rate is **11.49%**. The estimated cycle component federal improper payment rates are as follows.

- **Cycle 1 CHIP FFS - 2.44%**
- **Cycle 1 CHIP managed care - 0.68%**
- **Cycle 1 CHIP eligibility - 10.46%**

D. Pennsylvania's CHIP Findings

In RY 2022, Pennsylvania's CHIP estimated federal improper payment rate is **5.58%**. Pennsylvania's estimated component federal improper payment rates are as follows.

- **There is no CHIP FFS program in Pennsylvania**
- **Pennsylvania CHIP managed care - 2.50%**
- **Pennsylvania CHIP eligibility - 3.16%**

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

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

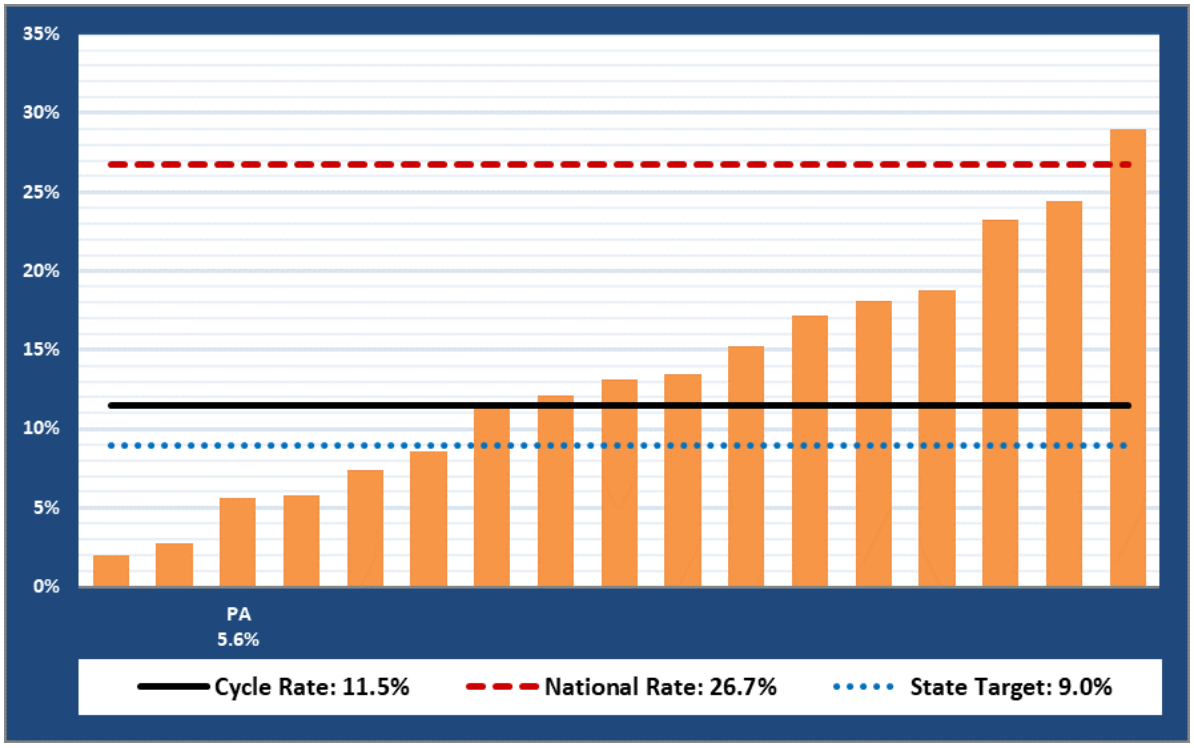
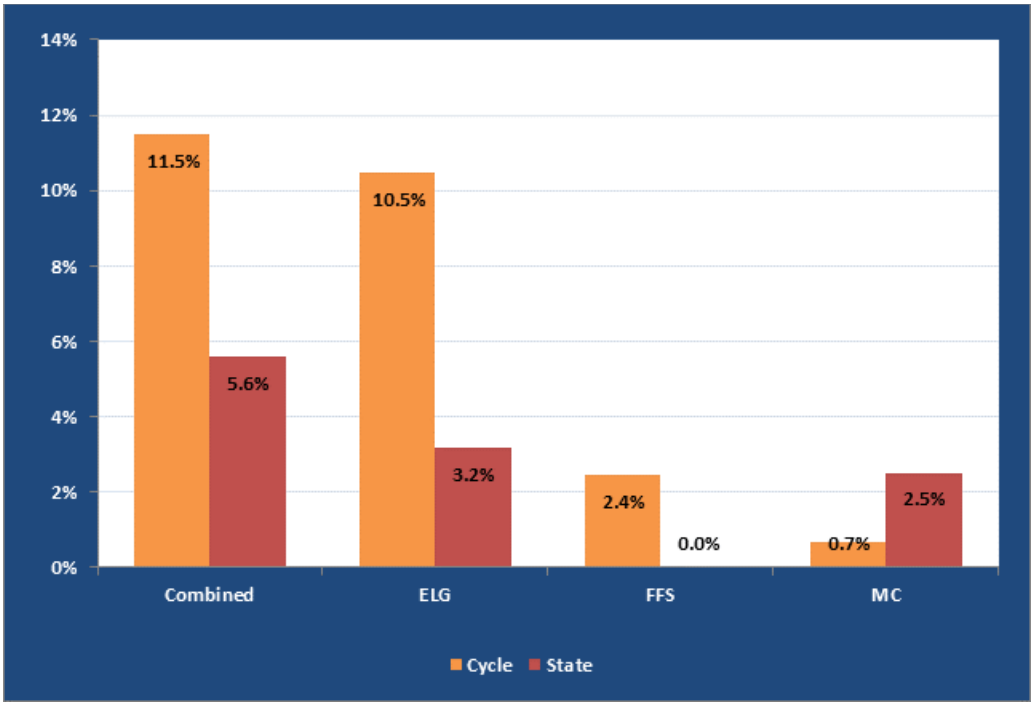


Figure 2 compares Cycle 1 and Pennsylvania on the combined CHIP federal improper payment rate and the component CHIP federal improper payment rates.

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



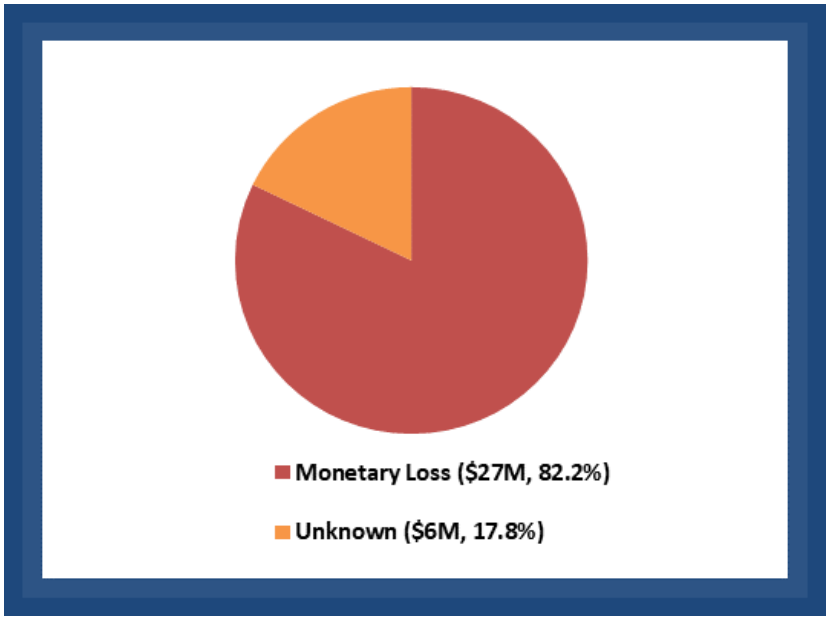
Please note that the PERM FFS review includes payments made to individual providers, while the MC review only looks at capitated payments made by states to MC organizations, not payments made by MC organizations to providers. Therefore, the MC measurement does not include some errors observed in the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

In addition, please note that improper payments do not necessarily represent expenses that should not have occurred. Improper payments also include instances where there is insufficient or no documentation to support the payment as proper. For example, on a national level, the majority of CHIP improper payments was comprised of instances where information required for payment was missing from the claim or state systems and/or states did not follow the appropriate process for enrolling and screening providers and/or determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or beneficiaries. If the missing information had been on the claim and/or had the state complied with the enrollment or redetermination requirements, then the claims may have been payable. On the national level, a smaller proportion of improper payments are considered a known monetary loss to the program, which are claims where CMS determines that the CHIP payment should not have been made or should have been made in a different amount (e.g., not medically necessary, made for a non-covered service, incorrectly coded, duplicate, incorrectly processed, with pricing mistakes, paid to a provider not enrolled in the program or on behalf of a beneficiary ineligible for the program or service).

See Figure 3 below, which presents the proportion of Pennsylvania's CHIP 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 (e.g., claims where information was missing 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[3]: CHIP Percentage of Projected Dollars in Error (in Millions) by Monetary Loss



[3] If a claim has only underpayment errors, then the claim is classified as an underpayment. However, if a claim has at least one monetary loss error, then the entire claim is classified as Monetary Loss. If a claim is neither classified as an Underpayment or Monetary Loss, then the claim is classified as Unknown. Additionally, multiple errors on a claim are not counted separately in this figure and may not match other tables in the report.

E. Sample CHIP 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, medical, and eligibility review. As services are not billed individually on MC claims and therefore cannot be evaluated for appropriateness, only CHIP 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 CHIP FFS claims and universe of MC 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 CHIP in proportion to the rate and amount observed in the sample.

Table 1 summarizes the CHIP 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: CHIP Component by State and Cycle Sample Error Payments

CHIP 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
CHIP FFS	N/A	N/A	N/A	**N/A**	N/A	5,568	223	$242,514	**$23**	5.65%
CHIP Managed Care	43	1	$150	**$14,674,293**	44.16%	552	2	$166	**$18**	4.29%
CHIP Eligibility	189	6	$1,025	**$18,554,064**	55.84%	4,056	477	$1,899,967	**$367**	90.06%

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 not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted. 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 the 17 Cycle 1 states by error type for CHIP MC.

Pennsylvania Table 2: CHIP MC Cycle and State Number of Findings and Federal Dollars in Error by Type of Error

	# of Sample Findings		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
MC Data Processing Errors						
Non-covered Service/Beneficiary Error (DP2)	1	2	$150	$166	**$14,674,293**	**$18**
Total	1	2	$150	$166	**$14,674,293**	**$18**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample findings counts in this table. Deficiencies are, by definition, discrepancies found in the review of the claim or of the medical record that did not result in a payment error. Therefore, deficiencies have $0 in error and are reported as N/A in this table. 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 CHIP.

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

	# of Sample Findings		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; Unable to Determine Beneficiary Eligibility (ER1)	1	94	$158	$112,396	**$3,113,381**	**$50**
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	1	168	$217	$258,451	**$2,801,794**	**$98**
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	0	127	$0	$489,406	**$0**	**$117**
Not Eligible for Enrolled Program; Financial Issue (ER4)	0	19	$0	$59,006	**$0**	**$9**
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	1	30	$150	$19,124	**$2,946,736**	**$20**
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	3	89	$500	$1,030,913	**$9,692,153**	**$103**
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	0	20	N/A	N/A	**N/A**	**N/A**
Total	6	547	$1,025	$1,969,294	**$18,554,064**	**$398**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample findings counts in this table. Deficiencies are, by definition, discrepancies found in the review of the claim or of the medical record that did not result in a payment error. Therefore, deficiencies have $0 in error and are reported as N/A in this table. 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.

F. CHIP Medical Review and Data Processing Findings

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

There is no FFS program in Pennsylvania; therefore, there are no FFS findings.

2. CHIP Managed Care Data Analyses

Table 4 shows the number of CHIP managed care errors and dollars in error by overpayments, underpayments, and percentage of total managed care errors.

Pennsylvania Table 4: CHIP Managed Care Data Processing Review Error Type by Percentage of Data Processing Errors

Error Type	Overpayments			Percentage of Total MC Data Processing Review Errors		
	# of Sample Findings	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Findings	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Non-covered Service/Beneficiary Error (DP2)	1	$150	**$14,674,293**	100.00%	100.00%	**100.00%**
Total	1	$150	**$14,674,293**	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 findings counts in this table. Dollars in error for deficiencies are reported as N/A in this table, as applicable, since deficiencies, by definition, do not result in a payment error. 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 5 lists the CHIP managed care data processing errors by their more specific cause 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 5 is hyperlinked to this list. In addition, the CAP template includes further details on each claim.

Pennsylvania Table 5: CHIP Managed Care Data Processing Error by Error Type

Error Type and Cause of Error	# of Sample Findings
Non-covered Service/Beneficiary Error (DP2)	
Beneficiary was ineligible for the applicable program on the DOS	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. Also, deficiencies are included in the number of sample findings counts in this table.

Managed Care Data Processing Error Descriptions by Error Type

Non-covered Service/Beneficiary Error (DP2)

Beneficiary was ineligible for the applicable program on the DOS

One error was cited because the beneficiary was ineligible for the applicable program on the date of service (DOS). The beneficiary under review was not eligible for CHIP enrollment as they were covered by a third-party liability comprehensive service plan on the DOS. According to 42 CFR 447.45 (f)(1)(i), the beneficiary must be eligible under the applicable program on the date of service to allow services to be furnished.
For even more detailed information on any findings and specific policy citations, please refer to the SMERF website.

3. Types of Payment Errors

This section analyzes Pennsylvania CHIP payment errors for RY 2022, separating them into state errors (data processing errors) versus provider errors (medical review errors).

Table 6 shows how the errors aggregate into state and provider payment errors.

Pennsylvania Table 6: CHIP 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
Data Processing Errors	State	1	100.00%	$150	100.00%	**$14,674,293**	100.00%

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 not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted.

G. CHIP Eligibility Review Findings

1. CHIP Eligibility Data Analyses

This section describes the types of CHIP eligibility payment errors. Table 7 compares Pennsylvania's CHIP eligibility review errors to the cycle CHIP 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 7: Cycle and State CHIP Eligibility Number of Errors and Federal Dollars in Error by Eligibility Category

Eligibility Category	# of Sample Claims		# of Sample Claims in Error		Sample Federal Dollars in Error		Projected Federal Dollars in Error		Federal Improper Payment Rate	
	State	Cycle	State	Cycle	State	Cycle	State (in Millions)	Cycle (in Millions)	State	Cycle
MAGI - CHIP	97	1,572	1	208	$217	$622,200	**$3**	**$134**	0.93%	10.59%
MAGI - Medicaid CHIP Expansion	92	2,092	5	229	$808	$1,214,805	**$16**	**$221**	5.50%	10.69%
Total	189	3,664	6	437	$1,025	$1,837,005	**$19**	**$355**	3.16%	10.65%

Note: Details do not always sum to the total due to rounding. Also, deficiencies are not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted. 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. CHIP Eligibility Review – Error Type Analysis

Figure 4 shows the percentage of CHIP eligibility review projected federal dollars in error by error type.

Pennsylvania Figure 4: CHIP Eligibility Review Percentage of Projected Federal Dollars in Error by Error Type

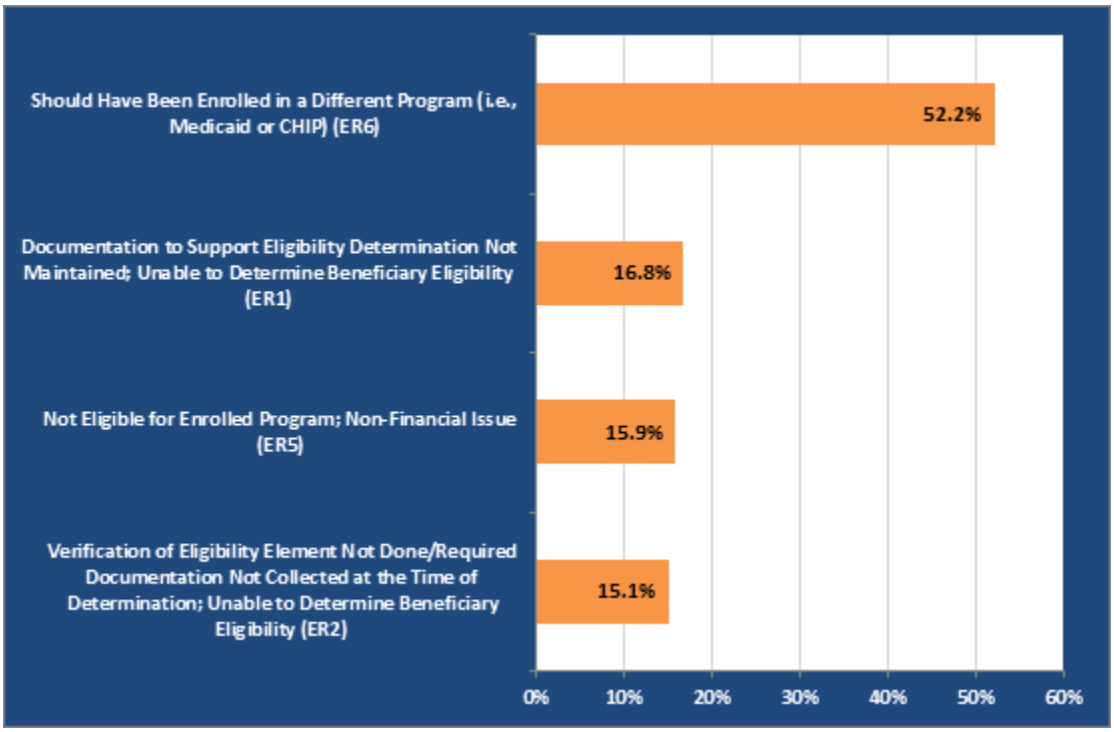


Table 8 contains information on the number of CHIP eligibility review errors and federal dollars in error for error types and percentage of total CHIP eligibility review errors.

Pennsylvania Table 8: CHIP Eligibility Review Error Type by Overpayments and Percentage of Eligibility Review Errors

Error Type	Overpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Findings	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Findings	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	1	$158	**$3,113,381**	16.67%	15.41%	**16.78%**
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	1	$217	**$2,801,794**	16.67%	21.21%	**15.10%**
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	1	$150	**$2,946,736**	16.67%	14.64%	**15.88%**
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	3	$500	**$9,692,153**	50.00%	48.74%	**52.24%**

Error Type	Overpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Findings	Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Total # of Sample Findings	% of Total Sample Federal Dollars in Error	% of Total Projected Federal Dollars in Error
Total	6	$1,025	**$18,554,064**	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 findings counts in this table. Dollars in error for deficiencies are reported as N/A in this table, as applicable, since deficiencies, by definition, do not result in a payment error. In this table, deficiencies are included in the overpayment number of sample findings. 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. These notes also apply to Figure 4, above.

Table 9 lists the CHIP 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 9: CHIP Eligibility Review Error Causes by Error Type

Error Type and Cause of Error	# of Sample Findings
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	
Signature not on file	1
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	
Signature not obtained	1
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	
Beneficiary had credible health insurance (CHIP only)	1
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
Beneficiary had credible health insurance (CHIP only)	2
Data entry error	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. Also, deficiencies are included in the number of sample findings counts in this table.

Eligibility Review Error Descriptions by Error Type[4]

Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)

Signature not on file

One error was cited because there was indication in the case record that signature under penalty of perjury was recorded during the state's determination, but sufficient documentation was not maintained to complete review of this element. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

[4] For additional information relating to identified root causes, please refer to Appendix Table 4.

- Renewal (1)
    - Caseworker (1)

Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)

Signature not obtained

One error was cited because there was no indication in the case record that the beneficiary's signature under penalty of perjury was recorded during the state's determination. The state did not identify the beneficiary's signature as missing. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

- Application (1)
    - Caseworker (1)

Not Eligible for Enrolled Program; Non-Financial Issue (ER5)

Beneficiary had credible health insurance (CHIP only)

One error was cited because the beneficiary had comprehensive health insurance coverage. Therefore, the beneficiary is not eligible for CHIP.

- TPL - Comprehensive Health Care Coverage (CHIP) (1)
    - Caseworker (1)

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

Beneficiary had credible health insurance (CHIP only)

Two errors were cited because the beneficiaries had comprehensive health insurance coverage. The beneficiaries should have been enrolled in Medicaid, and therefore, should not have been enrolled in CHIP. The errors were in the following area:

- TPL - Comprehensive Health Care Coverage (CHIP) (2)
    - Caseworker (2)

Data entry error

One error was cited because there was a data entry error when determining if the beneficiary met the eligibility requirements. The beneficiary should have been enrolled in Medicaid, and therefore, should not have been enrolled in CHIP. The error was in the following area:

- Income - Wages (1)
    - Caseworker (1)

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

b. CHIP Eligibility Review – Eligibility Category Analysis

Figure 5 shows the percentage of CHIP eligibility review projected federal dollars in error by eligibility category.

Pennsylvania Figure 5: CHIP Eligibility Review Percentage of Projected Federal Dollars in Error by Eligibility Category

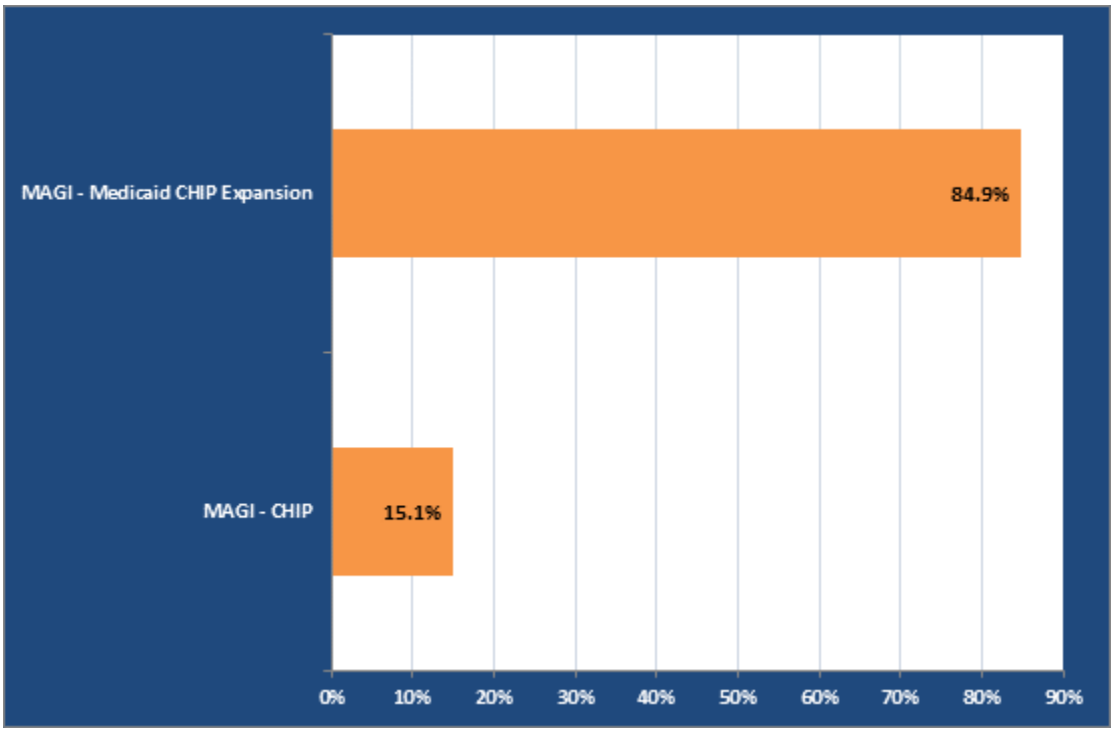


Table 10 contains information on the number of CHIP eligibility review errors and federal dollars in error by eligibility category.

Pennsylvania Table 10: CHIP Eligibility Review Errors by Eligibility Category

Eligibility Category	# of Sample Claims	Overpayments			Federal Improper Payment Rate	Percentage of Total Eligibility 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
MAGI - CHIP	97	1	$217	**$2,801,794**	0.93%	16.67%	21.21%	**15.10%**
MAGI - Medicaid CHIP Expansion	92	5	$808	**$15,752,270**	5.50%	83.33%	78.79%	**84.90%**
Total	189	6	$1,025	**$18,554,064**	3.16%	100.00%	100.00%	**100.00%**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted. 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. There were no underpayments cited, so only overpayments are reported in this table. These notes also apply to Figure 5, above.

Table 11 shows eligibility review errors by eligibility category for CHIP eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 11: CHIP Eligibility Category by Eligibility Review Error Type in Projected Federal Dollars

Eligibility Category	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)		Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)		Not Eligible for Enrolled Program; Non-Financial Issue (ER5)		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
MAGI - CHIP	0	**$0**	1	**$2,801,794**	0	**$0**	0	**$0**
MAGI - Medicaid CHIP Expansion	1	**$3,113,381**	0	**$0**	1	**$2,946,736**	3	**$9,692,153**
Total	1	**$3,113,381**	1	**$2,801,794**	1	**$2,946,736**	3	**$9,692,153**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample findings counts in this table. Dollars in error for deficiencies are reported as N/A in this table, as applicable. 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 12 lists the CHIP eligibility review payment errors by eligibility category.

Pennsylvania Table 12: CHIP Eligibility Review Error Type and Error Causes by Eligibility Category

Eligibility Category and Error Type	# of Sample Findings
MAGI - CHIP	
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	
Signature not obtained	1
MAGI - Medicaid CHIP Expansion	
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	
Signature not on file	1
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	
Beneficiary had credible health insurance (CHIP only)	1
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	
Beneficiary had credible health insurance (CHIP only)	2
Data entry error	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. Also, deficiencies are included in the number of sample findings counts in this table.	

Eligibility Review Error Descriptions by Eligibility Category[5]

MAGI - CHIP

ER2 - Signature not obtained

One error was cited because there was no indication in the case record that the beneficiary's signature under penalty of perjury was recorded during the state's determination. The state did not identify the beneficiary's signature as missing. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

- Application (1)
    - Caseworker (1)

MAGI - Medicaid CHIP Expansion

ER1 - Signature not on file

One error was cited because there was indication in the case record that signature under penalty of perjury was recorded during the state's determination, but sufficient documentation was not maintained to complete review of this element. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

- Renewal (1)
    - Caseworker (1)

[5] For additional information relating to identified root causes, please refer to Appendix Table 4.

ER5 - Beneficiary had credible health insurance (CHIP only)

One error was cited because the beneficiary had comprehensive health insurance coverage. Therefore, the beneficiary is not eligible for CHIP. The error was in the following area:

- TPL - Comprehensive Health Care Coverage (CHIP) (1)
    - Caseworker (1)

ER6 - Beneficiary had credible health insurance (CHIP only)

Two errors were cited because the beneficiaries had comprehensive health insurance coverage. The beneficiaries should have been enrolled in Medicaid, and therefore, should not have been enrolled in CHIP. The errors were in the following area:

- TPL - Comprehensive Health Care Coverage (CHIP) (2)
    - Caseworker (2)

ER6 - Data entry error

One error was cited because there was a data entry error when determining if the beneficiary met the eligibility requirements. The beneficiary should have been enrolled in Medicaid, and therefore, should not have been enrolled in CHIP. The error was in the following area:

- Income - Wages (1)
    - Caseworker (1)

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

2. Types of Payment Errors

a. CHIP Eligibility Review – MAGI Analysis

This section analyzes Pennsylvania CHIP payment errors for RY 2022 MAGI errors versus Non-MAGI errors.

Table 13 shows how the errors aggregate into MAGI and Non-MAGI payment errors.

Pennsylvania Table 13: CHIP 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	Federal Improper Payment Rate
MAGI	6	100.00%	$1,025	100.00%	**$18,554,064**	100.00%	3.16%

Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. Also, deficiencies are not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted.

Table 14 shows how the MAGI errors aggregate into system and caseworker errors[6].

Pennsylvania Table 14: CHIP Eligibility MAGI Errors by System versus Caseworker

Classification	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
Caseworker	6	$1,025	**$18,554,064**
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 not included in the number of sample errors throughout this report, unless otherwise noted. Additionally, the distribution of all payments that were made between caseworker and system is not known since this classification is only collected if there is a finding.			

b. CHIP Eligibility Review – Claim Type Analysis

This section analyzes Pennsylvania CHIP payment errors for RY 2022 FFS errors versus managed care errors.

Table 15 shows how the errors aggregate into FFS and managed care payment errors.

Pennsylvania Table 15: CHIP 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	Federal Improper Payment Rate
Managed Care	6	100.00%	$1,025	100.00%	**$18,554,064**	100.00%	3.16%
Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. Also, deficiencies are not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted. Additionally, please note that the eligibility reviews of FFS and managed care claims are identical, unlike for medical and data processing reviews.							

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

c. CHIP Eligibility Review – Case Action Analysis

This section analyzes Pennsylvania CHIP payment errors for RY 2022 case action errors.

Figure 6 shows the percentage of CHIP case action errors by projected federal dollars in error. In Pennsylvania, Change errors account for 48.28% of projected federal dollars in error, while Redetermination errors comprise 36.62% and Application errors comprise 15.10%.

Pennsylvania Figure 6: CHIP Eligibility Case Action Errors

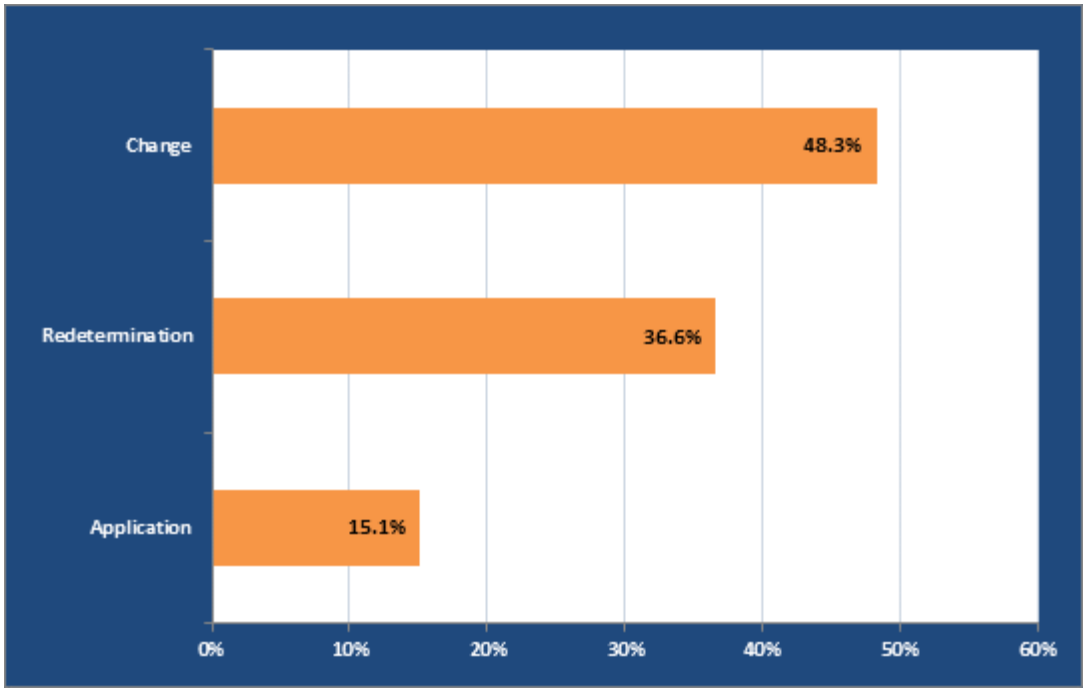


Table 16 shows how the errors aggregate into case action payment errors.

Pennsylvania Table 16: CHIP Eligibility Case Action Errors

Case Action Error[7]	# 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	Federal Improper Payment Rate
Application	1	16.67%	$217	21.21%	**$2,801,794**	15.10%	4.00%
Change	3	50.00%	$456	44.51%	**$8,958,620**	48.28%	8.33%
Redetermination	2	33.33%	$352	34.28%	**$6,793,650**	36.62%	1.89%
Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. Also, deficiencies are not included in the number of sample errors and number of sample claims in error counts throughout this report, unless otherwise noted. 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. These notes also apply to Figure 6, above.							

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

Table 17 shows eligibility review errors by case action for CHIP eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 17: CHIP Eligibility Case Action by Eligibility Review Error Type in Projected Federal Dollars

Case Action	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)		Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)		Not Eligible for Enrolled Program; Non-Financial Issue (ER5)		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
Application	0	**$0**	1	**$2,801,794**	0	**$0**	0	**$0**
Change	1	**$3,113,381**	0	**$0**	1	**$2,946,736**	1	**$2,898,504**
Redetermination	0	**$0**	0	**$0**	0	**$0**	2	**$6,793,650**
Total	1	**$3,113,381**	1	**$2,801,794**	1	**$2,946,736**	3	**$9,692,153**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample findings counts in this table. Dollars in error for deficiencies are reported as N/A in this table, as applicable. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors.

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 Error	Claim errors are placed into this category when the submitted medical documentation is missing required information, making the record insufficient to support payment for the services billed. The provider submitted some documentation, but the documentation is inconclusive to support the billed service. Based on the medical records provided, the reviewer could not conclude that some of the allowed services were provided at the level billed and/or medically necessary. Additional documentation was not submitted.
MR3	Coding Error	The reviewer determines that the medical service, treatment, and/or equipment was medically necessary and was provided at a proper level of care, but billed and paid based on a wrong procedure code.
MR4	Diagnosis Coding/DRG Error	According to the medical record, the principal diagnosis code was incorrect or the DRG paid was incorrect and resulted in a payment error.
MR5	Unbundling Error	Unbundling includes instances where a set of medical services was provided and billed as separate services when a CMS regulation or policy or local practice dictates that they should have been billed as a set rather than as individual services.
MR6	Number of Unit(s) Error	An incorrect number of units was billed.
MR7	Medically Unnecessary Service Error	There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary. There is affirmative evidence that shows there was an improper diagnosis or deficient treatment plan reasonably connected to the provision of unnecessary medical services or treatment plan for an illness/injury not applicable to improving a patient's condition.
MR8	Policy Violation Error	A policy is in place regarding the service or procedure performed, and medical review indicates that the service or procedure in the record is inconsistent with the documented policy.
MR9	Improperly Completed Documentation Error	Required forms and documents are present, but are inadequately completed to verify that the services were provided in accordance with policy or regulation.
MR10	Administrative/Other Error	Medical review determined a payment error, but does not fit into one of the other medical review error categories.
MTD	Medical Technical Deficiency	Medical review determined a deficiency that did not result in a payment error.

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

Pennsylvania Appendix Table 3: Eligibility Review Error Codes

Error Code	Error	Definition
ER1	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. Evidence within the eligibility case file or eligibility system indicated that the state verified the eligibility element using an appropriate verification source during the state's eligibility determination, but the documentation of the verification source was not maintained. The beneficiary under review may be financially and categorically eligible but eligibility cannot be confirmed without the documentation.
ER2	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility	The state cannot provide documentation obtained during the state's eligibility determination. In addition, the state cannot provide evidence the state obtained documentation from an appropriate verification source during the state's eligibility determination. The beneficiary under review may be financially and categorically eligible, but eligibility cannot be confirmed without the documentation.
ER3	Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility	The state could not provide evidence 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; Resulting in Incorrect FMAP Assignment	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category within the program, which results in an incorrect FMAP assignment for the beneficiary.
ER8	Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided	The beneficiary is assigned to the correct program (i.e., Medicaid or CHIP), but is enrolled in an incorrect eligibility category, which results in the individual receiving services for which they were not eligible.
ER9	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	There was an issue with the determination that would have resulted in an ER1 – ER10, but no payment was made for the claim.
ERTD2	Finding Noted With Case, But Did Not Affect Case 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: Eligibility Root Cause Glossary

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

Pennsylvania Appendix Table 5: Acronym Glossary

Acronym	Definition
APN	Advance Practice Nurse
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
DMF	Social Security Death Master File
DOS	Date Of Service
DP	Data Processing
DR	Difference Resolution
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
ER	Eligibility Review
ERC	Eligibility Review Contractor
FCBC	Fingerprint-based Criminal Background Check
FEFR	Final Errors for Recovery
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage

Acronym	Definition
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	Physician Assistant
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Measurement
POC	Plan Of Care
QMB	Qualified Medicare Beneficiary
RBS	Risk-Based Screening
RC	Review Contractor
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 6: CHIP Managed Care Data Processing Error by Error Type

PERM ID	Error Type	Qualifier
PAC2203M027	Non-covered Service/Beneficiary Error (DP2)	Beneficiary was ineligible for the applicable program on the DOS

Return to CHIP Medical Review and Data Processing Findings

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

PERM ID	Error Type	Qualifier	Eligibility Category
PAC2202M016	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Signature not on file	MAGI - Medicaid CHIP Expansion
PAC2201M003	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	Signature not obtained	MAGI - CHIP
PAC2203M027	Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	Beneficiary had credible health insurance (CHIP only)	MAGI - Medicaid CHIP Expansion
PAC2201M021	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	Beneficiary had credible health insurance (CHIP only)	MAGI - Medicaid CHIP Expansion
PAC2202M015	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	Beneficiary had credible health insurance (CHIP only)	MAGI - Medicaid CHIP Expansion
PAC2202M027	Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	Data entry error	MAGI - Medicaid CHIP Expansion

Return to CHIP 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 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 MC. States can find a comprehensive list of these overpayments in the RY 2022 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 or state submits documentation after the cycle ended, or the provider successfully appealed a decision to the state. These exceptions are listed in Section XIII of the CMS PERM Manual, located at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/PERM/PERM-Manual.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.

States should work with their designated CMS Division of Financial Operations (DFO) contact to ensure the appropriate federal share is returned timely. Your CMS PERM recoveries contact is your CMS PERM state liaison, Anita Moore, who can be reached at Anita.Moore@cms.hhs.gov.

D. Next Steps

A 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.

As a possible recommendation, your corrective action process should begin by establishing a corrective action oversight team. The team would consist of persons within your organization who have decision-making authority that affects policy and procedural change. The oversight team would be responsible for reviewing Pennsylvania's PERM findings each cycle, identifying programmatic causes of errors, determining the root causes for each error, and developing a CAP using the CMS provided CAP template to address the major causes of these errors.

Your CAP should include:

1. An implementation schedule that identifies major tasks, targeted implementation dates, and milestones.
2. A clear demonstration of how your CAP will be monitored to ensure complete implementation.

3. Measures you will take to evaluate that the identified corrective action is achieving the desired outcomes.

CMS appreciates the cooperation extended by Pennsylvania during the RY 2022 measurement and the commitment to safeguarding taxpayers' dollars by ensuring that CHIP services are rendered and reimbursed accurately. We look forward to continuing our partnership. Our aim is to work closely with you to ensure timely submission and implementation of your corrective action plan. If you have any questions or concerns about the CAP process, please email PERMCAPS@cms.hhs.gov or visit the CAP Process Tab of the PERM website for detailed information and instructions on how to develop a CAP.

For any other PERM findings questions or concerns, contact your CMS PERM state liaison, Anita Moore, at the email address listed in the above recoveries section.