U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

RY 2022 Pennsylvania Medicaid

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 Medicaid. 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, 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 Medicaid FFS, MC, and eligibility.[1] For Medicaid FFS and MC, additional analysis from the Review Contractor is included to address Medicaid FFS medical review and data processing errors, as well as MC data processing errors. For Medicaid eligibility, additional

[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.

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.[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 Medicaid Findings

In RY 2022, the combined national Medicaid estimated federal improper payment rate is **15.62%**. The estimated national component federal improper payment rates are as follows.

- **National Medicaid FFS - 10.42%**
- **National Medicaid managed care - 0.03%**
- **National Medicaid eligibility - 11.89%**

C. PERM 17-State Cycle 1 Medicaid Findings

In RY 2022, the combined Cycle 1 Medicaid estimated federal improper payment rate is **6.64%**. The estimated cycle component federal improper payment rates are as follows.

- **Cycle 1 Medicaid FFS - 3.72%**
- **Cycle 1 Medicaid managed care - 0.00%**
- **Cycle 1 Medicaid eligibility - 5.36%**

D. Pennsylvania's Medicaid Findings

In RY 2022, Pennsylvania's Medicaid estimated federal improper payment rate is **2.57%**. Pennsylvania's estimated component federal improper payment rates are as follows.

- **Pennsylvania Medicaid FFS - 1.23%**
- **Pennsylvania Medicaid managed care - 0.00%**
- **Pennsylvania Medicaid eligibility - 2.39%**

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

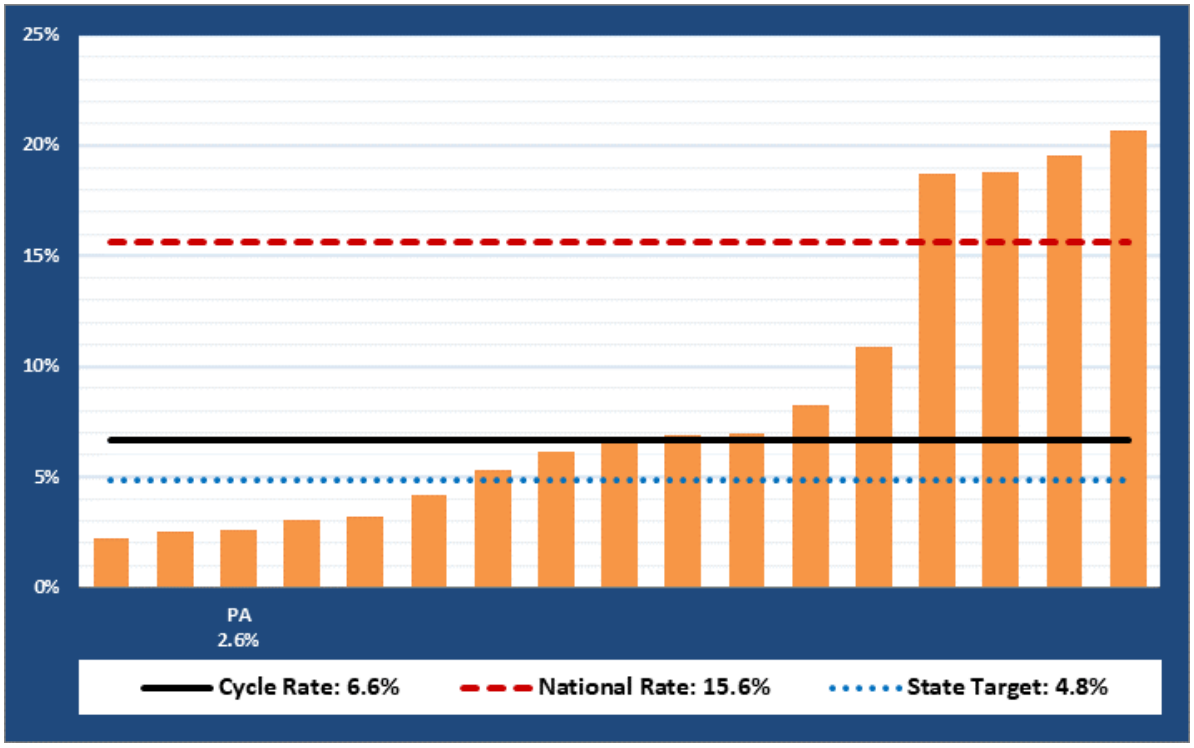
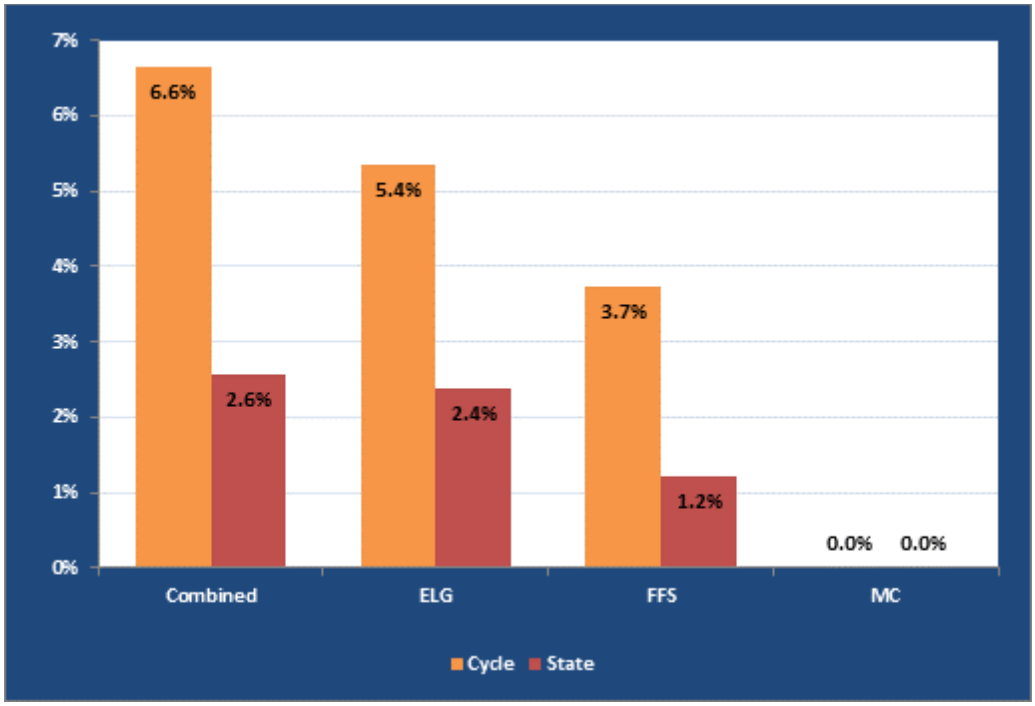


Figure 2 compares Cycle 1 and Pennsylvania on the combined Medicaid federal improper payment rate and the component Medicaid federal improper payment rates.

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



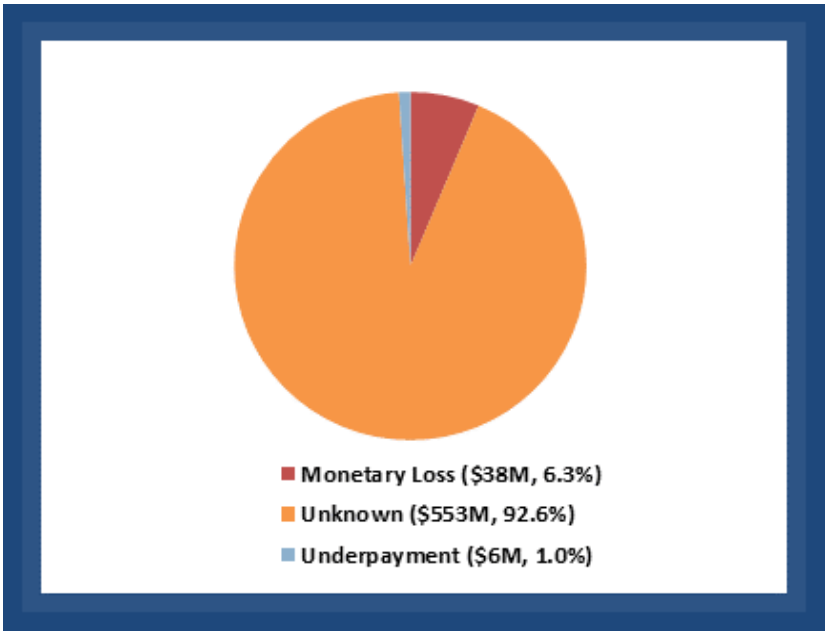
Please note that the PERM FFS review includes payments made to individual providers, while the MC review only looks at capitated payments made by states to MC organizations, not payments made by MC organizations to providers. Therefore, the MC measurement does not include some errors observed in the 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 Medicaid 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 Medicaid 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 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 (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]: Medicaid 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 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, medical, and eligibility review. As services are not billed individually on MC claims and therefore cannot be evaluated for appropriateness, 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 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 Medicaid 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 Component by State and Cycle Sample Error Payments

Medicaid 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	634	4	$20,754	**$41,563,488**	6.96%	8,996	431	$947,155	**$1,838**	20.15%
Medicaid Managed Care	77	0	$0	**$0**	0.00%	1,032	0	$0	**$0**	0.00%
Medicaid Eligibility	520	36	$17,751	**$555,936,082**	93.04%	6,103	448	$2,794,530	**$7,282**	79.85%

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 Cycle 1 by error type for Medicaid FFS.

Pennsylvania Table 2: Medicaid FFS 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)
FFS Medical Review Errors						
No Documentation Error (MR1)	0	86	$0	$252,457	**$0**	**$321**
Document(s) Absent from Record Error (MR2)	2	113	$2,740	$92,488	**$13,251,862**	**$436**
Coding Error (MR3)	0	3	$0	$469	**$0**	**$12**
Diagnosis Coding/DRG Error (MR4)	0	1	$0	$9,355	**$0**	**$1**
Number of Unit(s) Error (MR6)	0	16	$0	$7,699	**$0**	**$46**
Policy Violation Error (MR8)	0	8	$0	$9,820	**$0**	**$23**
Improperly Completed Documentation Error (MR9)	0	17	$0	$8,181	**$0**	**$48**
Total	2	244	$2,740	$380,469	**$13,251,862**	**$888**
FFS Data Processing Errors						
Duplicate Claim Error (DP1)	0	1	$0	$273	**$0**	**$4**
Non-covered Service/Beneficiary Error (DP2)	0	7	$0	$24,871	**$0**	**$36**
Pricing Error (DP5)	0	30	$0	$191,360	**$0**	**$39**
Provider Information/Enrollment Error (DP10)	2	175	$18,014	$365,618	**$28,311,627**	**$951**
Claim Filed Untimely Error (DP11)	0	1	$0	$196	**$0**	**$1**
Administrative/Other Error (DP12)	0	10	$0	$10,500	**$0**	**$45**
Data Processing Technical Deficiency (DTD)	1	63	N/A	N/A	**N/A**	**N/A**
Total	3	287	$18,014	$592,817	**$28,311,627**	**$1,076**

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 Medicaid.

Pennsylvania Table 3: Medicaid 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)	7	101	$7,422	$231,257	**$237,782,797**	**$1,879**
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	5	156	$4,376	$1,988,575	**$179,276,185**	**$2,941**
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	2	147	$3,592	$456,233	**$113,379,248**	**$2,114**
Not Eligible for Enrolled Program; Financial Issue (ER4)	1	17	$498	$128,186	**$4,659,741**	**$506**
Not Eligible for Enrolled Program; Non-Financial Issue (ER5)	0	3	$0	$3,606	**$0**	**$35**
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	0	2	$0	$16,626	**$0**	**$30**
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	1	3	$41	$528	**$33,278,855**	**$37**
Not Eligible for Enrolled Eligibility Category; Ineligible for Service Provided (ER8)	0	5	$0	$19,321	**$0**	**$47**
Other Errors (ER10)	23	54	$2,405	$14,160	**$6,980,329**	**$65**
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	1	30	N/A	N/A	**N/A**	**N/A**
Finding Noted With Case, But Did Not Affect Case Determination or Payment (ERTD2)	0	1	N/A	N/A	**N/A**	**N/A**
Total	40	519	$18,335	$2,858,491	**$575,357,154**	**$7,654**

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. 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		# 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
Capitated Care/Fixed Payments	62	665	0	5	$0	$425	**$0**	**$20**	0.00%	0.21%
Clinic Services	1	228	0	9	$0	$1,835	**$0**	**$25**	0.00%	2.63%
Crossover Claims	4	185	0	0	$0	$0	**$0**	**$0**	0.00%	0.00%
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	349	2,218	4	210	$20,754	$129,424	**$42**	**$879**	2.19%	8.19%
Denied Claims	34	412	0	0	$0	$0	**$0**	**$0**	N/A	0.00%
Durable Medical Equipment (DME)/Supplies/Prosthetic/Orthopedic Devices/Environmental Modifications	3	67	0	7	$0	$9,855	**$0**	**$33**	0.00%	9.95%
Inpatient Hospital Services	40	830	0	12	$0	$360,283	**$0**	**$64**	0.00%	1.45%
Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (ICF/IID)/ICF/Group Homes	50	257	0	26	$0	$236,282	**$0**	**$132**	0.00%	7.19%
Laboratory/X-ray/Imaging Services	2	56	0	6	$0	$323	**$0**	**$20**	0.00%	8.76%
Nursing Facility/Chronic Care Services or Intermediate Care Facilities (ICF)	62	1,080	0	41	$0	$78,514	**$0**	**$116**	0.00%	2.25%
Outpatient Hospital Services	2	387	0	8	$0	$10,188	**$0**	**$22**	0.00%	1.10%
Personal Support Services	5	358	0	25	$0	$4,840	**$0**	**$124**	0.00%	5.73%
Physical/Occupational/Respiratory Therapies; Speech Language Pathology/Audiology/Rehabilitation Services/Ophthalmology/Optometry/Optical Services Necessary Supplies & Equipment	3	73	0	12	$0	$621	**$0**	**$33**	0.00%	8.87%
Physicians/Other Licensed Practitioner Services (includes APN/PA/Nurse Midwife/Midwife)	1	305	0	14	$0	$5,594	**$0**	**$77**	0.00%	3.99%
Prescribed Drugs	11	1,314	0	18	$0	$93,594	**$0**	**$123**	0.00%	2.01%

Service Type	# 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
Psychiatric/Mental Health/Behavioral Health Services	5	317	0	29	$0	$5,209	**$0**	**$125**	0.00%	7.20%
Total	634	8,752	4	422	$20,754	$936,986	**$42**	**$1,795**	1.23%	3.73%

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 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. Improper payment rates for service types with zero dollars paid are reported as N/A in this table.

a. Medicaid FFS Medical Review – Error Type Analysis

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 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
Document(s) Absent from Record Error (MR2)	2	$2,740	**$13,251,862**	100.00%	100.00%	**100.00%**
Total	2	$2,740	**$13,251,862**	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 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 Findings
Document(s) Absent from Record Error (MR2)	
One or more documents are missing from the record that are required to support payment	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. Also, deficiencies are included in the number of sample findings counts in this table.	

FFS Medical Review Error Descriptions by Error Type

Document(s) Absent from Record (MR2)

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

Two errors were cited because one or more documents are missing from the record that are required to support payment. The document(s) missing from the record are summarized in the bulleted list below: (If a single error had multiple missing documents, each missing document is included in the summary, individually. Therefore, there may be more missing documents than errors cited).

- One *individual plan (ITP, ISP, IFSP, IEP, or POC) submitted, but not applicable to the*

sampled DOS instance was cited in accordance with Individual Support Plan (ISP) Manual for Individuals Receiving Targeted Support Management, Base-funded Services, Consolidated, Community Living or P/FDS Waiver Services or Who Reside in an ICF/ID, Section 10: Updating ISPs; Section 3.11: Responsibilities Regarding the Timeline for Annual ISPs; and 55 Pennsylvania (PA) Code §6100.225. Support coordination, base-funding support coordination and the Support Plan Manual, parts (a)(5) and (a)(8).

- One *provider did not submit required progress notes applicable to the sampled DOS* instance was cited in accordance with 55 PA Code §6100.221 Development of the individual plan, 55 PA Code §6100.225. Support coordination, base-funding support coordination and TSM, the Support Plan Manual Section 3.11 and Section 4.
- One *the signature page pertaining to ITP, ISP, IFSP, IEP or POC were not submitted* instance was cited in accordance with 55 PA Code §6100.221 Development of the individual plan, 55 PA Code §6100.225. Support coordination, base-funding support coordination and TSM, the Support Plan Manual Section 3.11 and Section 4.

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

The projected medical review dollars in error by service type can be attributed to Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services.

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	# of Sample Claims	Overpayments			Federal Improper Payment Rate	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	349	2	$2,740	**$13,251,862**	0.70%	100.00%	100.00%	**100.00%**
Total	634	2	$2,740	**$13,251,862**	0.39%	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 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. Since only service types with at least one claim in error appear in this table, the number of sample claims may not sum to the total. 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	Document(s) Absent from Record Error (MR2)	
	# of Sample Errors	Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	2	**$13,251,862**
Total	2	**$13,251,862**

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 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 Findings
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	
Document(s) Absent from Record Error (MR2)	
One or more documents are missing from the record that are required to support payment	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. Also, deficiencies are included in the number of sample findings counts in this table.	

FFS Medical Review Error Descriptions by Service Type

Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services (Category 13)

Two errors were cited for this service type:

Two "Document(s) Absent from Record (MR2)" errors were cited because one or more documents are missing from the record that are required to support payment. The document(s) missing from the record are summarized in the bulleted list below: (If a single error had multiple missing documents, each missing document is included in the summary, individually. Therefore, there may be more missing documents than errors cited).

- One *individual plan (ITP, ISP, IFSP, IEP, or POC) submitted, but not applicable to the sampled DOS* instance was cited in accordance with ISP Manual for Individuals Receiving Targeted Support Management, Base-funded Services, Consolidated, Community Living or P/FDS Waiver Services or Who Reside in an ICF/ID, Section 10: Updating ISPs; Section 3.11: Responsibilities Regarding the Timeline for Annual ISPs; and 55 PA Code §6100.225. Support coordination, base-funding support coordination and TSM, the Support Plan Manual, parts (a)(5) and (a)(8).
- One *provider did not submit required progress notes applicable to the sampled DOS* instance was cited in accordance with 55 PA Code §6100.221 Development of the individual plan, 55 PA Code §6100.225. Support coordination, base-funding support coordination and TSM, the Support Plan Manual Section 3.11 and Section 4.
- One *the signature page pertaining to ITP, ISP, IFSP, IEP or POC were not submitted* instance was cited in accordance with 55 PA Code §6100.221 Development of the individual plan, 55 PA Code §6100.225. Support coordination, base-funding support coordination and TSM, the Support Plan Manual Section 3.11 and Section 4.

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 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
Provider Information/Enrollment Error (DP10)	2	$18,014	**$28,311,627**	66.67%	100.00%	**100.00%**
Data Processing Technical Deficiency (DTD)	1	N/A	**N/A**	33.33%	N/A	**N/A**
Total	3	$18,014	**$28,311,627**	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 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 Findings
Provider Information/Enrollment Error (DP10)	
Provider not screened using risk-based criteria prior to claim payment date	2
Data Processing Technical Deficiency (DTD)	
Other	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.

FFS Data Processing Error Descriptions by Error Type

Provider Information/Enrollment (DP10)

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

Two errors were cited because the newly enrolled limited risk billing providers were not screened using risk-based criteria prior to the claim payment date as required by 42 CFR 455.450 and 42 CFR 455.436. No required databases were checked.

Data Processing Technical Deficiency (DTD)

Other

One deficiency was cited because the prescribing provider is required to be enrolled per 42 CFR 455.410(b) and 42 CFR 440.120. This claim had a pharmacy point of sale (POS) reversal/void to $0.00 payment within sixty days of its original payment. Therefore, it is not a payment accuracy error. The deficiency was cited because the claim could have resulted in a payment error if it had been paid.

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 Required**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
2	2	0	0	0	0	0	0
# of Deficiencies	**All Required**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
N/A	0	0	0	0	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. Additionally, "missing" RBS qualifiers are not included in these counts. 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

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	# of Sample Claims	Overpayments			Federal Improper Payment Rate	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	349	2	$18,014	**$28,311,627**	1.49%	100.00%	100.00%	**100.00%**
Total	634	2	$18,014	**$28,311,627**	0.83%	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 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. Since only service types with at least one claim in error appear in this table, the number of sample claims may not sum to the total. 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 Deficiencies	Projected Federal Dollars in Error
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	2	**$28,311,627**	0	**$0**
Prescribed Drugs	0	**$0**	1	**N/A**
Total	2	**$28,311,627**	1	**N/A**

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 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 Findings
Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services	
Provider Information/Enrollment Error (DP10)	
Provider not screened using risk-based criteria prior to claim payment date	2
Prescribed Drugs	
Data Processing Technical Deficiency (DTD)	
Other	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.	

FFS Data Processing Error Descriptions by Service Type

Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services (Category 13)

Two errors were cited for this service type:

Two "Provider Information/Enrollment (DP10)" errors were cited because the newly enrolled limited risk billing providers were not screened using risk-based criteria prior to the claim payment date as required by 42 CFR 455.450 and 42 CFR 455.436. No required databases were checked.

Prescribed Drugs (Category 08)

One deficiency was cited for this service type:

One "Data Processing Technical Deficiency (DTD)" was cited because the prescribing provider is required to be enrolled per 42 CFR 455.410(b) and 42 CFR 440.120. This claim had a pharmacy POS reversal/void to $0.00 payment within sixty days of its original payment. Therefore, it is not a payment accuracy error. The deficiency was cited because the claim could have resulted in a payment error if it had been paid.

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 Required**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
13 - Day Habilitation, Adult Day Care, Foster Care, Waiver Programs, and School-based Services	2	2	0	0	0	0	0	0
Service Type	**# of Deficiencies**	**All Required**	**DMF**	**LEIE**	**SAM/EPLS**	**NPPES**	**On-site Visit***	**FCBC****
N/A	0	0	0	0	0	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. Additionally, "missing" RBS qualifiers are not included in these counts.
*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 data processing review errors in Pennsylvania; therefore, there are no managed care data processing review analyses.

3. Types of Payment Errors

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

Figure 4 shows the Medicaid percentage of state versus provider errors by projected federal dollars in error. In Pennsylvania, state errors account for 68.12% of projected federal dollars in error, while provider errors comprise 31.88%.

Pennsylvania Figure 4: Medicaid Types of Payment Errors

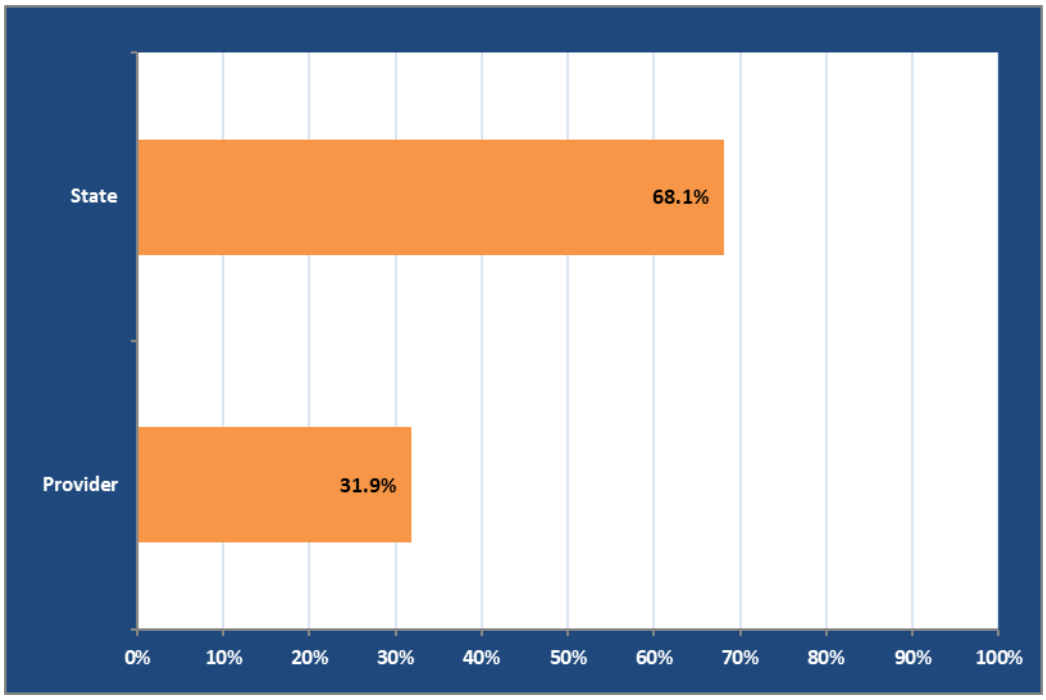


Table 17 shows how the errors aggregate into state and provider payment errors.

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	2	50.00%	$2,740	13.20%	**$13,251,862**	31.88%
Data Processing Errors	State	2	50.00%	$18,014	86.80%	**$28,311,627**	68.12%

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. These notes also apply to Figure 4, above.

G. Medicaid Eligibility Review Findings

1. Medicaid Eligibility Data Analyses

This section describes the types of Medicaid eligibility payment errors. Table 18 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 18: Cycle and State Medicaid 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
Aged, Blind, and Disabled - Mandatory Coverage	5	568	1	45	$601	$81,671	**$66**	**$502**	31.84%	5.47%
Aged, Blind, and Disabled - Optional Categorically Needy	33	107	0	10	$0	$23,802	**$0**	**$166**	0.00%	5.87%
Home and Community-Based Services	93	500	6	53	$7,199	$141,470	**$192**	**$656**	5.66%	6.04%
LTC/Nursing Home	71	554	24	103	$6,516	$283,538	**$52**	**$698**	2.38%	7.51%
MAGI - Children under Age 19	25	675	1	42	$56	$102,892	**$45**	**$594**	3.42%	4.57%
MAGI - Medicaid CHIP Expansion	1	2	0	0	$0	$0	**$0**	**$0**	0.00%	0.00%
MAGI - Medicaid Expansion - Newly Eligible	77	1,079	1	87	$41	$1,953,778	**$33**	**$2,437**	0.55%	6.69%
MAGI - Medicaid Expansion - Not Newly Eligible	4	81	0	7	$0	$18,053	**$0**	**$48**	0.00%	4.73%
MAGI - Parent Caretaker	11	456	1	28	$262	$38,335	**$72**	**$600**	17.89%	6.64%
MAGI - Pregnant Woman	4	79	0	4	$0	$11,146	**$0**	**$65**	0.00%	3.67%
Medically Needy	4	92	0	9	$0	$13,222	**$0**	**$74**	0.00%	5.61%
Newborn	8	245	0	0	$0	$0	**$0**	**$0**	0.00%	0.00%
Other (None of the Above)	3	41	0	2	$0	$346	**$0**	**$30**	0.00%	3.46%
Other Full Benefit Dual Eligible (FBDE)	10	137	1	17	$85	$49,119	**$49**	**$250**	8.90%	10.00%
QMB	1	78	0	6	$0	$351	**$0**	**$499**	N/A	14.71%
SLMB	1	14	0	2	$0	$175	**$0**	**$30**	0.00%	4.02%
SSI Recipients	158	1,126	1	23	$2,992	$55,010	**$47**	**$490**	0.81%	2.05%

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
Title IV-E	1	53	0	1	$0	$434	**$0**	**$16**	0.00%	1.86%
Transitional Medicaid	9	94	0	2	$0	$371	**$0**	**$52**	0.00%	1.81%
Women with Breast or Cervical Cancer	1	9	0	1	$0	$1,972	**$0**	**$16**	0.00%	7.85%
Total	520	5,990	36	442	$17,751	$2,775,688	**$556**	**$7,222**	2.39%	5.40%

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. Medicaid Eligibility Review – Error Type Analysis

Figure 5 shows the percentage of Medicaid eligibility review projected federal dollars in error by error type.

Pennsylvania Figure 5: Medicaid Eligibility Review Percentage of Projected Federal Dollars in Error by Error Type

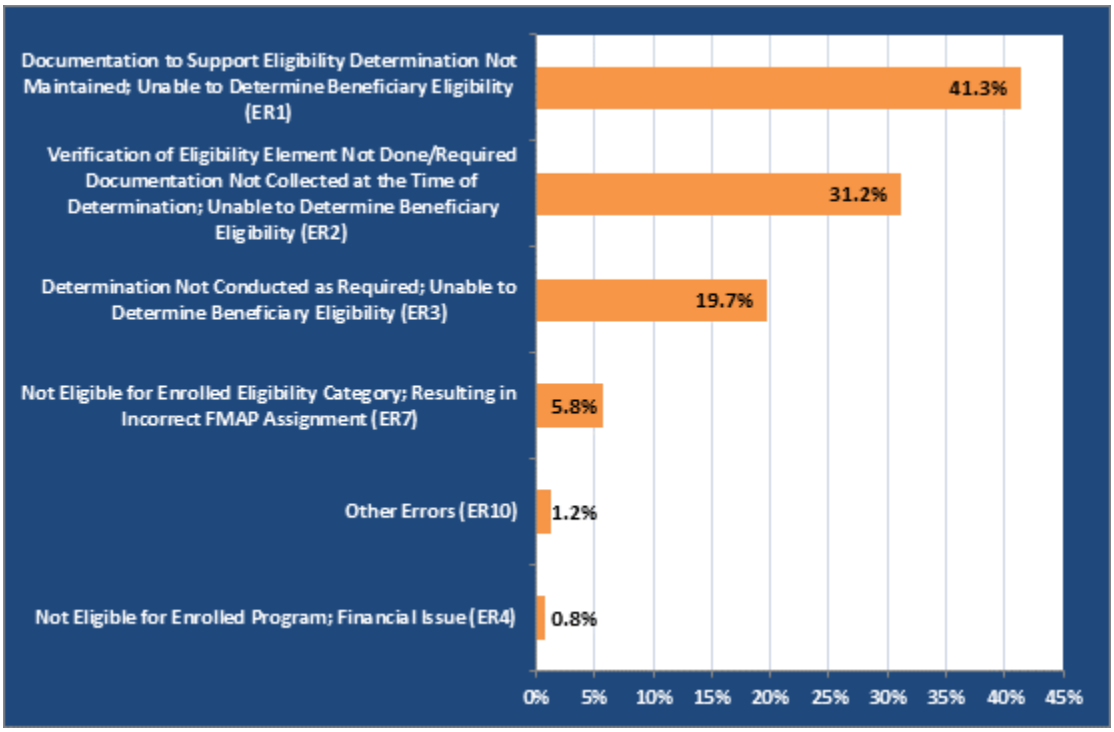


Table 19 contains information on the number of Medicaid eligibility review errors and federal dollars in error for error types by overpayments, underpayments, and percentage of total Medicaid eligibility review errors.

Pennsylvania Table 19: 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 Findings	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# 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)	7	$7,422	**$237,782,797**	0	$0	**$0**	17.50%	40.48%	**41.33%**

Error Type	Overpayments			Underpayments			Percentage of Total Eligibility Review Errors		
	# of Sample Findings	Sample Federal Dollars in Error	Projected Federal Dollars in Error	# 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
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	5	$4,376	**$179,276,185**	0	$0	**$0**	12.50%	23.87%	**31.16%**
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	2	$3,592	**$113,379,248**	0	$0	**$0**	5.00%	19.59%	**19.71%**
Not Eligible for Enrolled Program; Financial Issue (ER4)	1	$498	**$4,659,741**	0	$0	**$0**	2.50%	2.72%	**0.81%**
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	1	$41	**$33,278,855**	0	$0	**$0**	2.50%	0.22%	**5.78%**
Other Errors (ER10)	1	$87	**$810,796**	22	$2,319	**$6,169,533**	57.50%	13.12%	**1.21%**
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	1	N/A	**N/A**	0	N/A	**N/A**	2.50%	N/A	**N/A**
Total	18	$16,016	**$569,187,622**	22	$2,319	**$6,169,533**	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. These notes also apply to Figure 5, above.

Table 20 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 20: Medicaid 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)	
Income verification not on file/incomplete	1
LTC verification not on file/incomplete	1
Resources verification not on file/incomplete	3
Signature not on file	2
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	
Resources verification not on file/incomplete	2
Signature not obtained	3

Error Type and Cause of Error	# of Sample Findings
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	
Determination not conducted after underlying eligibility was terminated	1
Redetermination not conducted within 12 months before date of payment for services	1
Not Eligible for Enrolled Program; Financial Issue (ER4)	
Resources incorrectly calculated	1
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	
MAGI Non-filer/non-dependent status incorrect	1
Other Errors (ER10)	
Contribution to care calculated incorrectly resulting in a partial payment difference	23
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	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)

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. The verification not conducted was in the following area:

- Income - RSDI Income (1)
    - Caseworker (1)

LTC verification not on file/incomplete

One error was cited because there was indication in the case record that the LTC waiver level of care 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. The verification not conducted was in the following area:

- LTC - Level of Care (1)
    - Caseworker (1)

Resources verification not on file/incomplete

Three 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. The verifications not conducted were in the following area:

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

- Resources - Checking Account (3)
    - Caseworker (3)

Signature not on file

Two errors were 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 verifications not conducted were in the following area:

- Renewal (2)
    - Caseworker (2)

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

Resources verification not on file/incomplete

Two errors were cited because there was no indication in the case record that resources were verified during the state's determination. Therefore, eligibility could not be determined to support the state's decision. The verifications not conducted were in the following area:

- Resources - Savings Account (2)
    - Caseworker (2)

Signature not obtained

Three errors were 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 verifications not conducted were in the following area:

- Renewal (3)
    - Caseworker (3)

Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)

Determination not conducted after underlying eligibility was terminated

One error was cited because there was no indication in the case record that a determination was conducted after underlying eligibility was terminated. The state did not have case documentation or system processing records. The error was in the following area:

- Income - SSI Income (1)
    - Caseworker (1)

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

One error was cited because the redetermination was not conducted within the required 12-month renewal date.

- Renewal (1)
    - Caseworker (1)

Not Eligible for Enrolled Program; Financial Issue (ER4)

Resources incorrectly calculated

One error was cited because resources were incorrectly calculated when determining if the beneficiary met the eligibility resource thresholds. Therefore, the beneficiary is not eligible for Medicaid. The error was in the following area:

- Resources - Checking Account (1)
    - Caseworker (1)

Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)

MAGI Non-filer/non-dependent status incorrect

One error was cited because the household size was not constructed correctly based upon the appropriate MAGI non-tax filer or relationship rules. The beneficiary was incorrectly placed in an eligibility category with a different Federal Medical Assistance Percentage (FMAP) rate than the correct eligibility category. The error was in the following area:

- Other - Household Composition or Tax Filing Unit (1)
    - Caseworker (1)

Other (ER10)

Contribution to care calculated incorrectly resulting in a partial payment difference

Twenty-three errors were cited because the contribution of care was incorrectly calculated.

- LTC - Cost of Care (23)
    - Multiple (4)
    - Policy (19)

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

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

One deficiency was cited because there was indication in the case record that self-employment income was verified during the state's determination, but sufficient documentation was not maintained to complete a review of the eligibility element. An error would have been cited if a payment had been made on the sampled claim. The deficiency was in the following area:

- Income - Self-Employment Income (1)
    - Caseworker (1)

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

Pennsylvania Figure 6: Medicaid Eligibility Review Percentage of Projected Federal Dollars in Error by Eligibility Category

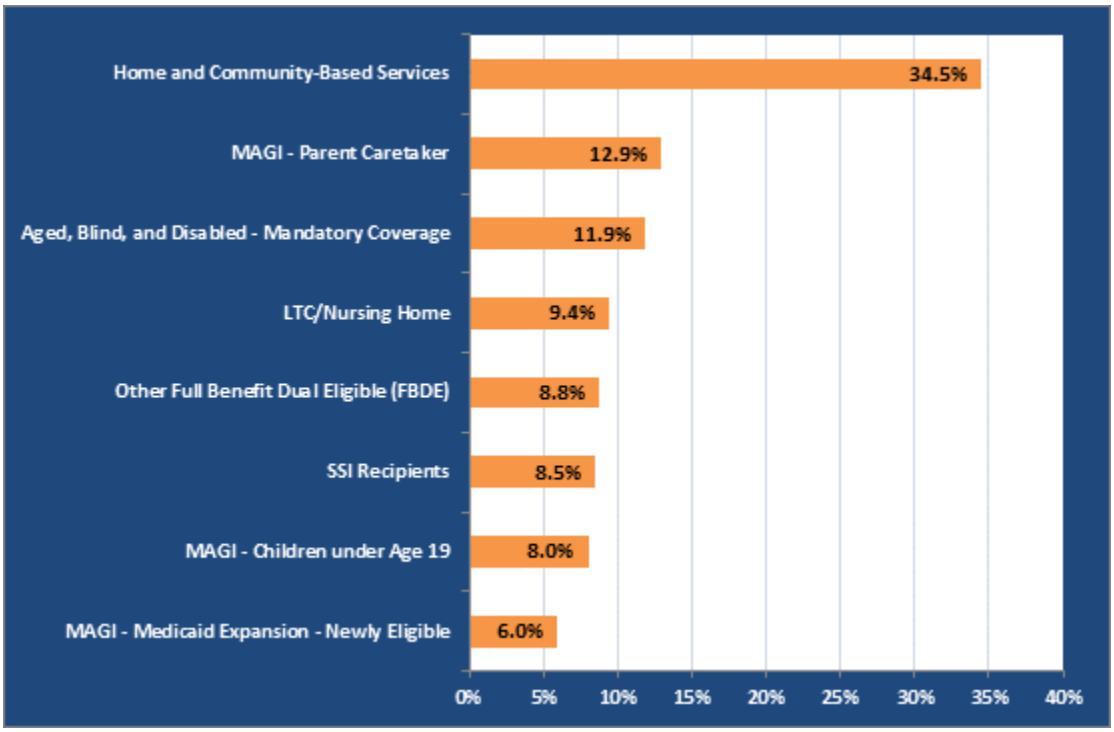


Table 21 contains information on the number of Medicaid eligibility review errors and federal dollars in error by eligibility category by overpayment, underpayments, and percentage of total eligibility review errors.

Pennsylvania Table 21: Medicaid Eligibility Review Errors by Eligibility Category

Eligibility Category	# of Sample Claims	Overpayments			Underpayments			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 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	5	1	$601	**$65,948,355**	0	$0	**$0**	31.84%	2.78%	3.38%	**11.86%**
Aged, Blind, and Disabled - Optional Categorically Needy	33	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Home and Community-Based Services	93	6	$7,199	**$191,682,425**	0	$0	**$0**	5.66%	16.67%	40.55%	**34.48%**
LTC/Nursing Home	71	2	$4,197	**$46,204,886**	22	$2,319	**$6,169,533**	2.38%	66.67%	36.71%	**9.42%**
MAGI - Children under Age 19	25	1	$56	**$44,596,770**	0	$0	**$0**	3.42%	2.78%	0.31%	**8.02%**
MAGI - Medicaid CHIP Expansion	1	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
MAGI - Medicaid Expansion - Newly Eligible	77	1	$41	**$33,278,855**	0	$0	**$0**	0.55%	2.78%	0.23%	**5.99%**
MAGI - Medicaid Expansion - Not Newly Eligible	4	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
MAGI - Parent Caretaker	11	1	$262	**$71,755,434**	0	$0	**$0**	17.89%	2.78%	1.48%	**12.91%**

Eligibility Category	# of Sample Claims	Overpayments			Underpayments			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 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 - Pregnant Woman	4	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Medically Needy	4	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Newborn	8	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Other (None of the Above)	3	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Other Full Benefit Dual Eligible (FBDE)	10	1	$85	**$48,868,931**	0	$0	**$0**	8.90%	2.78%	0.48%	**8.79%**
QMB	1	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
SLMB	1	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
SSI Recipients	158	1	$2,992	**$47,430,893**	0	$0	**$0**	0.81%	2.78%	16.85%	**8.53%**
Title IV-E	1	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Transitional Medicaid	9	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**
Women with Breast or Cervical Cancer	1	0	$0	**$0**	0	$0	**$0**	0.00%	0.00%	0.00%	**0.00%**

Eligibility Category	# of Sample Claims	Overpayments			Underpayments			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 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
Total	520	14	$15,432	**$549,766,549**	22	$2,319	**$6,169,533**	2.39%	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. These notes also apply to Figure 6, above.

Table 22 shows eligibility review errors by eligibility category for Medicaid eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 22: Medicaid 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)		Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)		Not Eligible for Enrolled Program; Financial Issue (ER4)	
	# 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**	1	**$65,948,355**	0	**$0**
Aged, Blind, and Disabled - Optional Categorically Needy	0	**$0**	0	**$0**	0	**$0**	0	**$0**
Home and Community-Based Services	5	**$124,482,217**	3	**$85,810,484**	0	**$0**	0	**$0**
LTC/Nursing Home	1	**$41,545,145**	0	**$0**	0	**$0**	1	**$4,659,741**
MAGI - Children under Age 19	0	**$0**	1	**$44,596,770**	0	**$0**	0	**$0**
MAGI - Medicaid Expansion - Newly Eligible	0	**$0**	0	**$0**	0	**$0**	0	**$0**
MAGI - Parent Caretaker	1	**$71,755,434**	0	**$0**	0	**$0**	0	**$0**
Other Full Benefit Dual Eligible (FBDE)	0	**$0**	1	**$48,868,931**	0	**$0**	0	**$0**
SSI Recipients	0	**$0**	0	**$0**	1	**$47,430,893**	0	**$0**
Total	7	**$237,782,797**	5	**$179,276,185**	2	**$113,379,248**	1	**$4,659,741**

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.

Eligibility Category	Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)		Other Errors (ER10)		Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Deficiencies	Projected Federal Dollars in Error
Aged, Blind, and Disabled - Mandatory Coverage	0	**$0**	0	**$0**	0	**$0**
Aged, Blind, and Disabled - Optional Categorically Needy	0	**$0**	0	**$0**	1	**N/A**
Home and Community-Based Services	0	**$0**	0	**$0**	0	**$0**
LTC/Nursing Home	0	**$0**	23	**$6,980,329**	0	**$0**
MAGI - Children under Age 19	0	**$0**	0	**$0**	0	**$0**
MAGI - Medicaid Expansion - Newly Eligible	1	**$33,278,855**	0	**$0**	0	**$0**
MAGI - Parent Caretaker	0	**$0**	0	**$0**	0	**$0**
Other Full Benefit Dual Eligible (FBDE)	0	**$0**	0	**$0**	0	**$0**
SSI Recipients	0	**$0**	0	**$0**	0	**$0**
Total	1	**$33,278,855**	23	**$6,980,329**	1	**N/A**

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 23 lists the Medicaid eligibility review payment errors by eligibility category.

Pennsylvania Table 23: Medicaid Eligibility Review Error Type and Error Causes by Eligibility Category

Eligibility Category and Error Type	# of Sample Findings
Aged, Blind, and Disabled - Mandatory Coverage	
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	
Redetermination not conducted within 12 months before date of payment for services	1
Aged, Blind, and Disabled - Optional Categorically Needy	
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	1
Home and Community-Based Services	
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	
Income verification not on file/incomplete	1
LTC verification not on file/incomplete	1
Resources verification not on file/incomplete	3
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	
Resources verification not on file/incomplete	1
Signature not obtained	2
LTC/Nursing Home	
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	
Signature not on file	1
Not Eligible for Enrolled Program; Financial Issue (ER4)	
Resources incorrectly calculated	1
Other Errors (ER10)	
Contribution to care calculated incorrectly resulting in a partial payment difference	23
MAGI - Children under Age 19	
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 Expansion - Newly Eligible	
Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	
MAGI Non-filer/non-dependent status incorrect	1
MAGI - Parent Caretaker	
Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	
Signature not on file	1
Other Full Benefit Dual Eligible (FBDE)	
Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	
Resources verification not on file/incomplete	1
SSI Recipients	
Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	

Eligibility Category and Error Type	# of Sample Findings
Determination not conducted after underlying eligibility was terminated	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]

Aged, Blind, and Disabled - Mandatory Coverage

ER3 - Redetermination not conducted within 12 months before date of payment for services

One error was cited because the redetermination was not conducted within the required 12-month renewal date.

- Renewal (1)
    - Caseworker (1)

Aged, Blind, and Disabled - Optional Categorically Needy

ERTD1 - Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility

One deficiency was cited because there was indication in the case record that self-employment income was verified during the state's determination, but sufficient documentation was not maintained to complete a review of the eligibility element. An error would have been cited if a payment had been made on the sampled claim. The deficiency was in the following area:

- Income - Self-Employment Income (1)
    - Caseworker (1)

Home and Community-Based Services

ER1 - 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. The verification not conducted was in the following area:

- Income - RSDI Income (1)
    - Caseworker (1)

ER1 - LTC verification not on file/incomplete

One error was cited because there was indication in the case record that the LTC waiver level of care 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. The verification not conducted was in the following area:

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

- LTC - Level of Care (1)
    - Caseworker (1)

ER1 - Resources verification not on file/incomplete

Three 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. The verifications not conducted were in the following area:

- Resources - Checking Account (3)
    - Caseworker (3)

ER2 - Resources verification not on file/incomplete

One error was cited because there was no indication in the case record that resources were verified during the state's determination. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

- Resources - Savings Account (1)
    - Caseworker (1)

ER2 - Signature not obtained

Two errors were 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 verifications not conducted were in the following area:

- Renewal (2)
    - Caseworker (2)

LTC/Nursing Home

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)

ER4 - Resources incorrectly calculated

One error was cited because resources were incorrectly calculated when determining if the beneficiary met the eligibility resource thresholds. Therefore, the beneficiary is not eligible for Medicaid. The error was in the following area:

- Resources - Checking Account (1)
    - Caseworker (1)

ER10 - Contribution to care calculated incorrectly resulting in a partial payment difference

Twenty-three errors were cited because the contribution of care was incorrectly calculated. The

errors were in the following area:

- LTC - Cost of Care (23)
    - Multiple (4)
    - Policy (19)

MAGI - Children under Age 19

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:

- Renewal (1)
    - Caseworker (1)

MAGI - Medicaid Expansion - Newly Eligible

ER7 - MAGI Non-filer/non-dependent status incorrect

One error was cited because the household size was not constructed correctly based upon the appropriate MAGI non-tax filer or relationship rules. The beneficiary was incorrectly placed in an eligibility category with a different Federal Medical Assistance Percentage (FMAP) rate than the correct eligibility category. The error was in the following area:

- Other - Household Composition or Tax Filing Unit (1)
    - Caseworker (1)

MAGI - Parent Caretaker

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)

Other Full Benefit Dual Eligible (FBDE)

ER2 - Resources verification not on file/incomplete

One error was cited because there was no indication in the case record that resources were verified during the state's determination. Therefore, eligibility could not be determined to support the state's decision. The verification not conducted was in the following area:

- Resources - Savings Account (1)
    - Caseworker (1)

SSI Recipients

ER3 - Determination not conducted after underlying eligibility was terminated

One error was cited because there was no indication in the case record that a determination was

conducted after underlying eligibility was terminated. The state did not have case documentation or system processing records. The error was in the following area:

- Income - SSI Income (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. Medicaid Eligibility Review – MAGI Analysis

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

Figure 7 shows the percentage of Medicaid MAGI versus Non-MAGI errors by projected federal dollars in error. In Pennsylvania, Non-MAGI errors account for 73.08% of projected federal dollars in error, while MAGI errors comprise 26.92%.

Pennsylvania Figure 7: Medicaid Eligibility MAGI versus Non-MAGI Errors

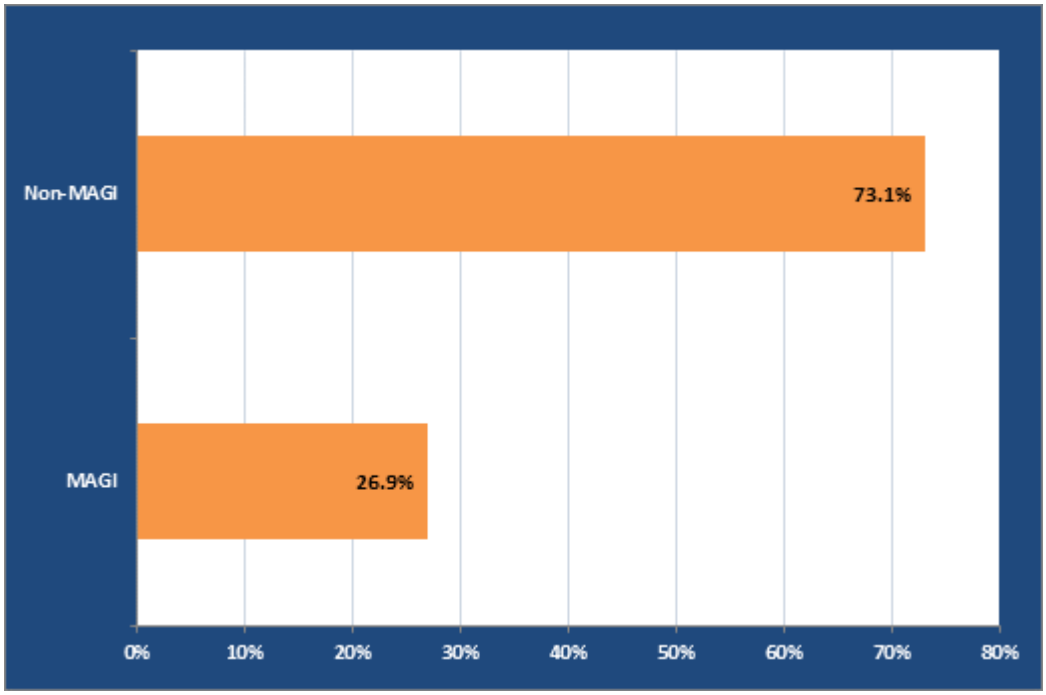


Table 24 shows how the errors aggregate into MAGI and Non-MAGI payment errors.

Pennsylvania Table 24: 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	Federal Improper Payment Rate
MAGI	3	8.33%	$359	2.02%	**$149,631,059**	26.92%	1.83%
Non-MAGI	33	91.67%	$17,391	97.98%	**$406,305,022**	73.08%	2.70%
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. These notes also apply to Figure 7, above.							

Table 25 and Table 26 show how the MAGI and Non-MAGI errors aggregate into system and caseworker errors[6].

Pennsylvania Table 25: Medicaid Eligibility MAGI Errors by System versus Caseworker

Classification	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
Caseworker	3	$359	**$149,631,059**
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.			

Pennsylvania Table 26: Medicaid Eligibility Non-MAGI Errors by System versus Caseworker

Classification	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
Caseworker	13	$15,571	**$418,745,766**
Multiple	4	$798	**$1,007,840**
Policy	19	$1,608	**$5,972,489**

[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.

Classification	# of Sample Errors	Sample Federal Dollars in Error	Projected Federal Dollars in Error
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. Medicaid Eligibility Review – Claim Type Analysis

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

Figure 8 shows the percentage of Medicaid FFS versus managed care errors by projected federal dollars in error. In Pennsylvania, MC errors account for 79.21% of projected federal dollars in error, while FFS errors comprise 20.79%.

Pennsylvania Figure 8: Medicaid Eligibility Errors by Claim Type

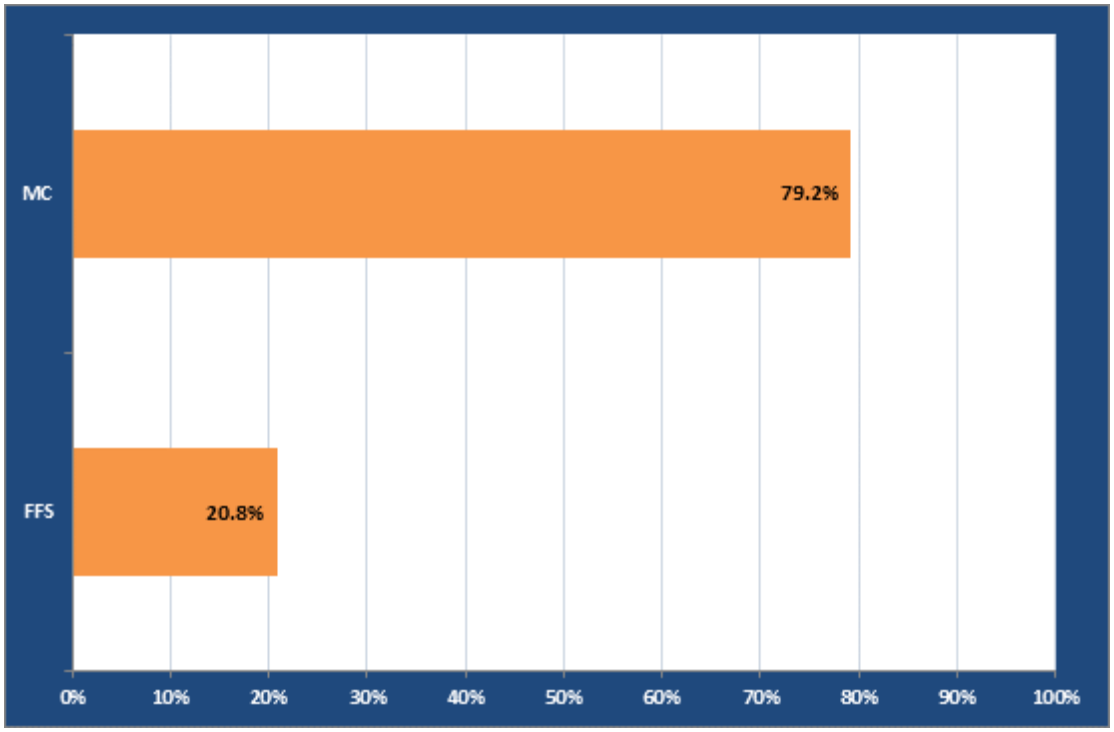


Table 27 shows how the errors aggregate into FFS and managed care payment errors.

Pennsylvania Table 27: 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	Federal Improper Payment Rate
FFS	28	77.78%	$3,992	22.49%	**$115,587,556**	20.79%	3.16%
Managed Care	8	22.22%	$13,759	77.51%	**$440,348,526**	79.21%	2.25%

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. These notes also apply to Figure 8, above.

c. Medicaid Eligibility Review – Case Action Analysis

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

Figure 9 shows the percentage of Medicaid case action errors by projected federal dollars in error. In Pennsylvania, Redetermination errors account for 47.96% of projected federal dollars in error, while Change errors comprise 22.02%, Application errors comprise 21.49%, and Not Applicable errors comprise 8.53%.

Pennsylvania Figure 9: Medicaid Eligibility Case Action Errors

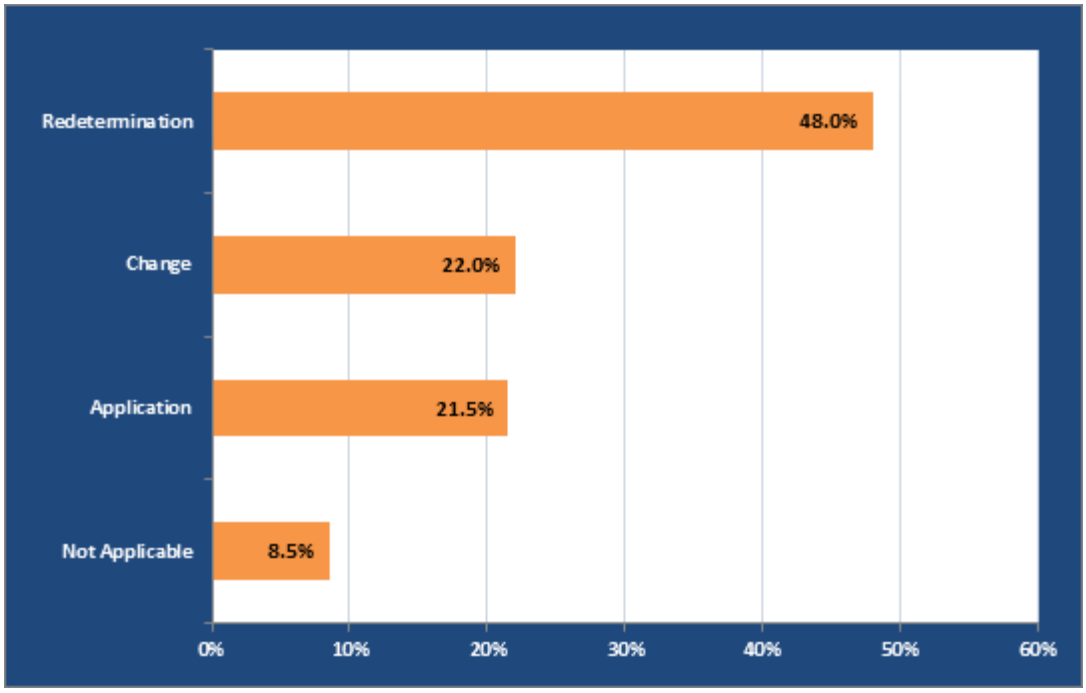


Table 28 shows how the errors aggregate into case action payment errors.

Pennsylvania Table 28: Medicaid 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	24	66.67%	$6,483	36.52%	**$119,458,236**	21.49%	4.64%
Change	3	8.33%	$6,418	36.16%	**$122,405,583**	22.02%	3.56%
Not Applicable	1	2.78%	$2,992	16.85%	**$47,430,893**	8.53%	0.69%
Redetermination	8	22.22%	$1,858	10.47%	**$266,641,370**	47.96%	2.59%

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 9, 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 29 shows eligibility review errors by case action for Medicaid eligibility, including count of errors and projected federal dollars in error.

Pennsylvania Table 29: Medicaid 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)		Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)		Not Eligible for Enrolled Program; Financial Issue (ER4)	
	# 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	1	**$20,586,557**	1	**$55,075,569**	0	**$0**	1	**$4,659,741**
Change	2	**$122,262,649**	0	**$0**	0	**$0**	0	**$0**
Not Applicable	0	**$0**	0	**$0**	1	**$47,430,893**	0	**$0**
Redetermination	4	**$94,933,591**	4	**$124,200,615**	1	**$65,948,355**	0	**$0**
Total	7	**$237,782,797**	5	**$179,276,185**	2	**$113,379,248**	1	**$4,659,741**

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.

Case Action	Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)		Other Errors (ER10)		Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	
	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Errors	Projected Federal Dollars in Error	# of Sample Deficiencies	Projected Federal Dollars in Error
Application	1	**$33,278,855**	21	**$6,668,310**	1	**N/A**
Change	0	**$0**	1	**$142,933**	0	**$0**
Not Applicable	0	**$0**	0	**$0**	0	**$0**
Redetermination	0	**$0**	1	**$169,085**	0	**$0**
Total	1	**$33,278,855**	23	**$6,980,329**	1	**N/A**

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
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Definition
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: Medicaid FFS Medical Review Error by Error Type

PERM ID	Error Type	Qualifier	Service Type
PAM2201F055	Document(s) Absent from Record Error (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
PAM2203F037	Document(s) Absent from Record Error (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

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Pennsylvania Appendix Table 7: Medicaid FFS Data Processing Error by Error Type

PERM ID	Error Type	Qualifier	Service Type
PAM2201F002	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
PAM2201F107	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
PAM2204F025	Data Processing Technical Deficiency (DTD)	Other	Prescribed Drugs

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Pennsylvania Appendix Table 8: Medicaid Eligibility Review Error by Error Type

PERM ID	Error Type	Qualifier	Eligibility Category
PAM2201F106	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Income verification not on file/incomplete	Home and Community-Based Services
PAM2202F083	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	LTC verification not on file/incomplete	Home and Community-Based Services
PAM2201F051	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Resources verification not on file/incomplete	Home and Community-Based Services

PERM ID	Error Type	Qualifier	Eligibility Category
PAM2202M022	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Resources verification not on file/incomplete	Home and Community-Based Services
PAM2201F106	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Resources verification not on file/incomplete	Home and Community-Based Services
PAM2201M004	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Signature not on file	LTC/Nursing Home
PAM2203M051	Documentation to Support Eligibility Determination Not Maintained; Unable to Determine Beneficiary Eligibility (ER1)	Signature not on file	MAGI - Parent Caretaker
PAM2201F120	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	Resources verification not on file/incomplete	Other Full Benefit Dual Eligible (FBDE)
PAM2201M026	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	Resources verification not on file/incomplete	Home and Community-Based Services
PAM2202M060	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 - Children under Age 19
PAM2203F092	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	Signature not obtained	Home and Community-Based Services
PAM2201F051	Verification of Eligibility Element Not Done/Required Documentation Not Collected at the Time of Determination; Unable to Determine Beneficiary Eligibility (ER2)	Signature not obtained	Home and Community-Based Services

PERM ID	Error Type	Qualifier	Eligibility Category
PAM2201M030	Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	Determination not conducted after underlying eligibility was terminated	SSI Recipients
PAM2204M042	Determination Not Conducted as Required; Unable to Determine Beneficiary Eligibility (ER3)	Redetermination not conducted within 12 months before date of payment for services	Aged, Blind, and Disabled - Mandatory Coverage
PAM2204F136	Not Eligible for Enrolled Program; Financial Issue (ER4)	Resources incorrectly calculated	LTC/Nursing Home
PAM2203M061	Not Eligible for Enrolled Eligibility Category; Resulting in Incorrect FMAP Assignment (ER7)	MAGI Non-filer/non-dependent status incorrect	MAGI - Medicaid Expansion - Newly Eligible
PAM2201F132	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2201F134	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2201F136	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2201F138	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2201F144	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F133	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F135	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F137	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F142	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F144	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2202F156	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home

PERM ID	Error Type	Qualifier	Eligibility Category
PAM2203F134	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F136	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F138	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F139	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F143	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F145	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2203F159	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F132	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F137	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F141	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F143	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F136	Other Errors (ER10)	Contribution to care calculated incorrectly resulting in a partial payment difference	LTC/Nursing Home
PAM2204F109	Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	Aged, Blind, and Disabled - Optional Categorically Needy

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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 Medicaid 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.