House of Representatives
Commonwealth of Pennsylvania

Government Oversight Committee

Staff Report on Medicaid:
Provider Fraud & Improper Payments

November 21, 2019

Honorable Chairman Seth Grove
Honorable Chairman Matt Bradford

Contents

GOVERNMENT OVERSIGHT COMMITTEE

HONORABLE
SETH M. GROVE
CHAIR

EXECUTIVE DIRECTOR
MICHAEL J. KANE, Esq.

ADDRESS
7 EAST WING
P.O. BOX 202196
HARRISBURG. PA 17120-2196

TELEPHONE
(717) 783-2655

House of Representatives

Commonwealth of Pennsylvania

July 25, 2019

MEMO

TO: **Mike Kane, Republican Executive Director**

Bridget Lafferty, Democrat Executive Director

FROM: **Chairman Seth Grove & Chairman Matt Bradford**

SUBJECT: **GOC Staff Report on Improper Payments and Provider Fraud**

Background

The adopted FY 2019-2020 budget projects to spend $12.7 billion of state funds in the Department of Human Services (DHS), which does not include other augmented spending through various assessments or the Tobacco Master Settlement. Human Services is the single largest expenditure of government resources in the Commonwealth of Pennsylvania and provides the safety net of programs to help Pennsylvania's most vulnerable. However, current expenditures are exceeding the Commonwealth's revenue collections, thus creating budgetary pressure to crowd out other government expenditures to maintain the Commonwealth's safety net. In order to provide better services at a lower cost to taxpayers, we feel it is imperative to review improper payment and provider fraud policies of the commonwealth.

Improper Payments

In March of 2019, the United States Government Accountability Office (GAO) released a report entitled, "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper

Payments" citing Medicaid Fee For Service (FFS) improper payments were $41.2 billion nationally.[1] Improper payments cover a broad category or errors and is not just fraud, but can be lack of documentation, incomplete documentation, procedure error coding or number of units error. The Federal Improper Payments Information Act of 2002, which has been amended twice, requires federal agencies to report and reduce improper payments. It also requires state agencies, such as DHS to review and report on improper payments through the Payment Error Rate Measurement (PERM) program. DHS's last PERM Cycle 1 report in 2015 shows an improper payment error rate of 9.8% for FFS and 0.5% for managed care and for the state FFS is 7.5% and managed care is 0%.[2] Further the PERM 2015 report shows a projected dollar in error of $694.1 million for FFS. While this is one state agency, states have yet to fully engage to eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to critical programs such as education funding or the Department of Corrections.

For example, according to the PA Waiting List campaign, removing 4,494 people from the emergency list of ID and the 1,270 people on the priority 1 list for autism costs $76.9 million.[3] According the 2015 PERM report, Medicaid FFS Data Processing Review Errors for ICF for Individuals with Intellectual Disabilities/Group Homes was $78.3 million.[4] Just by correcting the errors in data processing review under this one service type we can eliminate the emergency waiting list for ID and the Priority 1 waiting list for autism.

In 2002, the U.S. Treasury started the Do Not Pay program[5] which was codified in federal law with the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).[6] The Do Not Pay program uses data analytics to verify eligibility and to identify and prevent fraud, waste, and abuse associated with improper payments. Pennsylvania already uses one tool, the Death Master File, but a full implementation can reduce improper payments and help with uncollected taxes owed to the Commonwealth.

Provider Fraud

While improper payments do cover fraud, provider fraud has been such an ongoing issue that the Grand Jury issued recommendations for the General Assembly to identify and prevent fraud within the Medical Assistance (MA) program.[7] "Through the course of our investigation, we identified systemic issues within the MA program that permit the exploitation of care-dependent Pennsylvanians for financial gain and impact the quality of care provided". The Grand Jury identified three systemic changes:

(1) Require individuals providing services to be identified on the claim submitted for payment.

---

[1] United States Government Accountability Office. "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments." March, 2019. https://www.gao.gov/assets/700/697981.pdf.
[2] United States Department of Health and Human Services. "Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report." November 16, 2016. http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.
[3] https://pawaitinglistcampaign.org/wp-content/uploads/2015/12/fall-2015-fact-sheet.pdf.
[4] United States Department of Health and Human Services. "Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report." November 16, 2016. Page 17.
[5] https://fiscal.treasury.gov/dnp/.
[6] https://fiscal.treasury.gov/files/dnp/IPERIA.pdf.
[7] https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Progrm.pdf.

(2) MA claims submitted for payment should require specific date and time information before payment if made.
(3) Increase training to individuals providing services for proper billing.

On September 19, 2006, the Center for Medicare and Medicaid services (CMS) issued a letter to State Medicaid Directors encouraging states to implement a State False Claims Act, "The CMS strongly supports State program integrity measures and wants States to be aware that State False Claims Acts may enhance the recovery of falsely or fraudulently obtained Medicaid dollars".[8] Currently there are 29 states, District of Columbia, three large cities including the municipalities of Philadelphia and Allegheny County have implemented a State False Claims Act.[9] According to the Taxpayers Against Fraud[10]:

- Since 1987, the Federal False Claims Act has returned over $53 billion in civil recoveries to the federal government.
- Federal False Claims has resulted in over $7 billion in criminal fines.
- Federal False Claims Act lawsuits have retuned over $10 billion back to the states.

As an incentive for states to adopt a False Claims Act, which meets federal requirements, the Commonwealth can receive an additional 10% for recoveries, instead of the traditional 50/50 split between the federal government and state government.

Scope of the Report

Improper payments and provider fraud have plagued this Commonwealth for far too long. By comprehensively targeting these two areas, the Commonwealth can create more efficiencies and reduce costs to taxpayers without sacrificing program reductions. We are requesting a staff level report to analyze and discuss:

- State level improper payments law.
    - Team of OIG, Auditor General and Treasury will develop a baseline improper payments analysis for agencies, develop an improper payment elimination plan with each state agency targeted towards a 0% improper payment within 5 years of the agency report being finalized and perform a follow up audit of the improper payment elimination plan after 5 years.
- Mandating state agencies to use US Treasury's Do Not Pay program and the possibly of Pennsylvania's Treasurer's Office developing further state specific analytics to enhance the federal Do Not Pay program.
- Grand Jury Recommendations on MA fraud.
- Implementing a State False Claims Act.

Please assign Republican and Democrat staff to coauthor the report.

[8] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD091906.pdf.
[9] https://taf.org/state-false-claims-acts/.
[10] https://taf.org/wp-content/uploads/2018/03/fcabrief16.pdf. Page 5.

Executive Summary

Staff of the House Government Oversight Committee is issuing the following report based on publicly available resources detailing incidents of Medicaid improper payments made by the Medical Assistance program and incidents of provider fraud uncovered by the Attorney General and other resources. It is our intention to raise awareness of improper payments and provider fraud incidents so corrective action can be taken to ensure state taxpayer resources and services are both protected and preserved.

Our research shows there are a number of recommendations listed in a 2019 Grand Jury Report that should be considered by the General Assembly to help identify and prevent fraud occurring within Medicaid (MA).[11] Deficiencies highlighted in that Report include the MA system not requiring the individual providing services to be identified on claims submitted for payment; claims submitted for payment do not require specific date and time information before payment is made; and, providers lack the knowledge and training to provide quality care and to properly bill for services. Based on the findings in the 2019 Grand Jury Report, we suggest the following recommendations to be considered: (1) the use of state provider identification numbers; (2) standardized training; (3) requiring additional information such as date and time services were rendered to be included on claims submitted to MA; and (4) ensuring penalties and remedies are properly in place to address providers and individuals who are providing services.

We extensively reviewed the False Claims Act[12]. Unlike 35 other states (and two larger municipalities located within Pennsylvania—Philadelphia and Allegheny County), the Commonwealth of Pennsylvania has not enacted a state-specific False Claims Act. The federal law has been an effective tool for the federal government to combat fraud and abuse. The law imposes liability on anyone who submits a claim for payment to the government that they know is false, comparable to a provider who bills for services not provided. The federal law provides a financial incentive for states that adopt a state-specific law relating to false or fraudulent Medicaid claims. Those states whose False Claims Act meets federal requirements receive a 10 percentage point increase in their share of the amounts recovered.

The U.S. Department of Justice (DOJ) has investigated hundreds of claims, including lawsuits filed by whistleblowers.[13] The DOJ has collected more than $59 billion since 1986, when Congress strengthened the federal False Claims Act. The relator share awards for this time

[11] Forty-Second Statewide Investigating Grand Jury Report No. 1, Pennsylvania Medical Assistance Program, March 1, 2019, https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Progrm.pdf.
[12] 31 U.S.C. §§ 3729-3733.
[13] "Justice Department Recovers Over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018," U.S. Department of Justice, https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018.

period are over $7 billion.[14] If Pennsylvania enacted a qualified state-specific law, the Commonwealth would be awarded additional dollars. Pennsylvania currently receives about 48 percent of damages recovered in an MA program fraud case; under a qualified state False Claims Act, it would receive 58 percent. A state law would also provide incentives for whistleblowers to come forward with claims extending beyond health care providers. Given the number of cases being pursued against individuals, companies or industries within Pennsylvania, the extra financial incentive offered by the federal government, and the history of passing legislation twice in the House of Representatives in past sessions, further consideration should be given to enacting a state-specific False Claims Act.

In examining the latest Payment Error Rate Measurement (PERM) Summary Report for Pennsylvania (for fiscal year 2015), Pennsylvania's dollars in error for MA FFS are $694.1 million. The Report states the following improper payment rates for Pennsylvania: 7.5% for state FFS claims; and, no sampled errors for managed care. However, we believe the full picture of errors is not being uncovered. For the managed care measurement, PERM only reviews the payments made by states to managed care organizations and not the claims submitted by providers for services rendered. Efforts should be made to reduce our errors of payment rates to a rate between 0.0% and 3.0%.

Section 139b of the Social Security Act restricts payments to states with an error rate that exceeds the rate of 0.03 (or 3 percent):

> Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this subchapter exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.
> 42 U.S.C.A. § 1396b.

While the Pennsylvania Department of Human Services is one state agency, states, such as Pennsylvania, have yet to fully engage to eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to critical programs such as education funding or the Department of Corrections. The Report advocates for the corrective action process – to establish a Corrective Action Plan. Some of the recommendations outlined in the Attorney General's Grand Jury Report are the same causes given for the disbursement of improper payments. The call for greater action and oversight is also echoed in the Office of

[14] Fraud Statistics – Overview, Civil Division, U.S. Department of Justice: https://www.falseclaimsact.com/wp-content/uploads/2019/02/fy18_fraud_statistics_002_final_for_2018.pdf.

Inspector General's Report. It is important to note that a full review of improper payments has never been performed across all state agencies in this Commonwealth. This process should be performed.

The Commonwealth does not participate in the federal Do Not Pay program as a means to cross-check payments to be released to providers.[15] While systems are in place to screen providers for participation in the program and the Bureau of Program Integrity was established to review fraud and abuse, we believe more should be done to protect taxpayer dollars before they are released to providers.

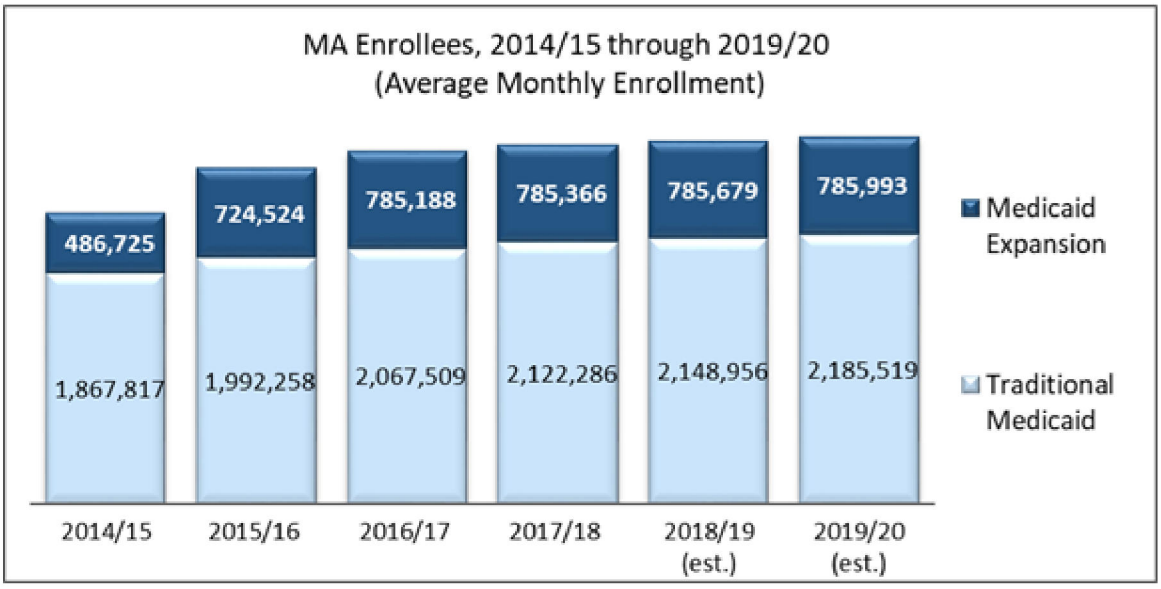
[15] In 2009, President Obama issued Executive Order 13520 -- Reducing Improper Payments and Eliminating Waste in Federal Programs. In 2011, the Treasury's Bureau of the Fiscal Service, in partnership with others, developed the Do Not Pay Business Center as part of the "Do Not Pay" solution.

The Analysis

Background

The Department of Human Services (DHS) is the administrative authority responsible for overseeing the Pennsylvania's Medicaid program, known as Medical Assistance (MA). The MA program provides health coverage to low-income Pennsylvanians, including: children, pregnant women, senior citizens and individuals with disabilities. It also provides long term services and supports to elderly MA recipients and individuals with disabilities. Over the years, the Commonwealth has expanded services and created programs. Today, more than 2.9 million Pennsylvanians are enrolled in Medicaid.[16]

The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act (ACA), authorized states to expand eligibility rules and access to the states' MA programs. Under the ACA, states were given permission to expand Medicaid eligibility to portions of their uninsured population. In February 2015, the expansion of the Medicaid program was implemented in Pennsylvania giving more low-income adults access to the state insurance plan.[17] At the end of CY 2015, 559,851 individuals were enrolled in the expanded MA program in the Commonwealth.[18]



[16] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
[17] Press Release, February 9, 2015. https://www.governor.pa.gov/newsroom/medicaid-expansion-in-pennsylvania/
[18] http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_257436.pdf.

More enrollees in the program required an increase in participating providers to handle the increase in service demands. While the increased enrollment in the MA program has decreased the uninsured rates, the rise in claims being processed for payment every year creates the potential for missed "fraud" and "error" payments for various reasons including incomplete documentation, procedure error coding or number of units errors. Incidents of reported provider fraud have increased and lead to various investigations, arrests and citizen concerns.[19] Payment in error concerns for years has led to increased federal agency oversight and enhanced requirements to reduce improper payments.[20]

Over the last ten years, overall funding for the MA program has grown by 54 percent. Looking at state general fund dollars, the increase grows by 71 percent (from $5,341,780,000 in 2010-11 to $9,121,053,000 in 2019-20); however, in 2010-11, general fund dollars were reduced and federal funds were increased by $1.77 billion due to the Enhanced Federal Medical Assistance Percentage (FMAP) included in the Federal American Recovery and Reinvestment Act of 2009.[21] Taking these enhanced federal dollars into account, state-related expenditures grew by 28 percent.

The table below illustrates how the number of enrollees being provided MA services has continued to grow over the last ten years. The greatest share of MA funding is for the elderly and persons with disabilities, reflecting their intensive use of acute and long-term care services. Although the elderly and disabled represent less than 30 percent of all recipients, they account for nearly 70 percent of MA expenditures.

[19] *See*: Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release November 27, 2018. https://www.justice.gov/usao-wdpa/pr/twelve-individuals-charged-extensive-health-care-fraud-conspiracy-defraud-medicaid-home; Attorney General Press Release, June 29, 2018. https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-shapiro-announces-15-arrests-in-statewide-medicaid-fraud-sweep/.; and Skiba, Katherine. 24 Charged in Alleged Massive Medicare Fraud. AARP. April 10, 2019. https://www.aarp.org/money/scams-fraud/info-2019/feds-crackdown-medicare-fraud.html.

[20] The Federal Improper Payments Information Act of 2002.

[21] Governor's Executive Budget books for FY 2010-11. FY 2018-19 amounts are the SAP accounting System. FY 2019-20 is enacted.

Select DHS Program Measures										
Soure: Governor's Executive Budget Book										
Program	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Medical Assistance:										
Medical Assistance (monthly avg)	2,134,477	2,225,011	2,123,710	2,147,889	2,354,542	2,716,782	2,852,697	2,907,652	2,934,635	2,971,512
MA Workers w Disabilities (monthly avg)	22,795	27,208	29,897	34,933	37,067	31,032	29,223	29,697	28,702	27,976
Long-Term Living (monthly averages) :										
Institutional Care	N/A	N/A	56,342	49,764	48,119	49,543	50,451	39,069	27,256	5,976
CHC - Institutional Care (new January 2018)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11,085	23,172	44,760
Subtotal Insitutional Care	0	0	56,342	49,764	48,119	49,543	50,451	50,154	50,428	50,736
Home & Community-Based Services	N/A	N/A	38,080	40,496	46,020	51,271	55,994	57,971	22,178	670
Community HealthChoices - HCBS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11,059	54,111	80,627
People with DD in OBRA waiver	N/A	N/A	incl above	1,400	1,360	1,340	1,389	1,116	558	347
Subtotal HCBS	0	0	38,080	41,896	47,380	52,611	57,383	70,146	76,847	81,644
LIFE Program	N/A	N/A	3,664	4,048	4,698	5,321	5,767	6,247	6,671	7,096
Mental Health:										
Community Mental Health Services (unduplicated):										
People Served w MA Funding	428,225	411,678	476,206	480,014	531,912	570,175	600,000	601,050	602,100	603,155
Intellectual Disabilities:										
Persons receiving autism services	323	398	447	568	661	695	819	875	909	909
Persons receiving ID services	53,455	53,569	53,613	53,648	54,091	54,692	55,199	55,699	57,399	58,264
Home and Community Service Waivers (unduplicated):										
ID Services Base and Waiver	N/A	N/A	50,827	50,952	51,459	52,210	52,860	53,457	55,251	56,116
Consolidated Waiver	N/A	N/A	16,757	17,251	17,594	18,085	18,267	18,396	18,651	18,751
Person/Family Directed Supports	N/A	N/A	11,861	12,586	13,039	13,647	13,721	14,658	14,658	14,658
Community Living Waiver (new in FY 17-18)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1,006	2,600	3,365
Total ID HCBS Waivers			28,618	29,837	30,633	31,732	31,988	34,060	35,909	36,774

As funding and enrollment continues to grow year-over-year, before the General Assembly asks taxpayers to increase their contributions for MA, a serious look at all forms of fraud and error payments should be considered. To provide quality services to more citizens at a lower cost to taxpayers, it is imperative to review the improper payment and provider fraud policies of the Commonwealth.

Attorney General: Provider Fraud

In April of 2019, Attorney General Josh Shapiro announced recommendations made from a statewide Grand Jury investigation into how to identify and prevent fraud occurring within Medicaid to ensure delivery of satisfactory care.[22]

"Medicaid provides essential care to some of Pennsylvania's most vulnerable citizens, including low-income individuals, children with serious health conditions, and individuals suffering from substance use disorder," said Attorney General Josh Shapiro. "When bad actors take advantage

[22] Attorney General Press Release, April 15, 2019. https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-josh-shapiro-announces-grand-jury-recommendations-for-the-pennsylvania-medicaid-program/.

of the system, they deny these people the care they deserve, take advantage of hard-working care providers, and scam Pennsylvanians out of their hard-earned tax dollars."

The investigation was prompted by two independent Medicaid Fraud investigations of individuals who fraudulently billed the program for services not rendered. The evidence in the investigation revealed "deficiencies within the MA program, its complexities and many subdivisions."[23]

According to the Grand Jury Report, the investigation "…identified systemic issues within the MA program that permit the exploitation of care-dependent Pennsylvanians for financial gain and impact the quality of care provided."[24] These deficiencies include the MA system not requiring the individual providing services to be identified on claims, information providing the date and time are not required on claims for payment, and providers lacking the knowledge and training to provide quality care and proper billing for services.

Deficiency #1

First, many provider agencies that offer community-based services use employees or independent contractors to provide services such as personal care and home health; these individuals do not have an MA provider identification number (MAID). The provider agency is the entity who submits a claim to MA using its own MAID. Typically, these claims do not identify the individual who directly performed the services. In the case of independent contractors, these individuals will not be listed on the Pennsylvania Department of Labor and Industry database to reveal where they are working. Without the claim identifying who performed the service, it is impossible to determine (through a review of claims process) whether a claim should be denied because these individuals are banned from providing MA services. It is important to note that for some services, such as therapeutic services paid through long-term care waivers, the submitted claim identifies the individual performing the service. This inclusion should be a continued practice spanning across all of MA submitted claim services.

A similar lack of identification of the individuals performing services also exists with MA claims submitted to the managed care organizations (MCOs) that operate DHS's managed care programs: HealthChoices Physical Health, HealthChoices Behavioral Health, and Community HealthChoices.[25] MCOs contract with a network of MA providers and negotiate rates for services furnished to persons enrolled in their plan; the actual services are performed by the provider's employees or independent contractors. While we understand MCOs are required to

[23] 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 1. https://www.attorneygeneral.gov/wp-content/uploads/2019/04/2019-04-15-GJ-Recommendations-for-Medicaid-Progrm.pdf
[24] Ibid, p. 2.
[25] Ibid, p. 7.

establish a fraud, waste and abuse unit to prevent, detect and investigate fraud, the responsibility remains in the hands of DHS. These are taxpayer dollars and every effort by the department should be made to ensure dollars are not spent on fraudulent activity, regardless of agreements made between DHS and MCOs or federal law requirements.

To address this deficiency, the Grand Jury recommended creating a system to assign each individual who provides services under MA a unique identifying number (a "State Provider Identification") and to use that number to identify who provided services on all submitted claims for payment.[26] A unique identifying number is not a new idea, as many providers currently have either NPI (National Provider Identifier) or MAID numbers assigned. The point is to make all individuals who perform services be identified and not just the provider agency.
All individuals who provide goods or services paid for through MA, should be required to have either the NPI or a State Provider Identification number. We also believe it is important to be able to make a distinction between providers and the actual individuals who are performing the services who submit or cause to be submitted information for compensation in connection with MA.

The MA program would benefit from being equipped to perform pre-payment reviews for fraudulent activity; cross reference individuals for background checks with all necessary records including licensure registry, health care exclusionary and criminal records; make it easier to identify fraud; and pinpoint which individuals are providing services to clients. This would provide instant identification to enhance patient safety and situations where law enforcement is involved. This is a recommendation for the General Assembly for legislative guidance and enactment.

Deficiency #2

The Grand Jury spent time discussing various cases where individuals reported providing services in two places at the same time or providing services to an individual after his death. Because the date and times for the individual providing services was not submitted to DHS on the claim, this type of fraud was not detected. Instead, the provider agency and the number of units of service was provided.[27] The lapse of having this information on MA claims underscores any review the department does against MA enrollees with death records and provides a means for payments to be made that should not be made because of fraudulent activity. Fraudulent activity could be detected, prior to the release of any payments, if adequate information was contained within submitted claims for payment.

[26] 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 17.
[27] Ibid, p. 12.

If the date and time of services provided are not contained within the claim for payment, any comparison of MA enrolled recipients against records of death can possibly be disputed by providers seeking payment. The date and time of services listed on each MA claim submission would validate any cost associated with comparing death records.

Under Act 22 of 2011, the General Assembly enacted several reforms to the state's welfare system..[28] One of those reforms included the codification of a computerized eligibility verification system that requires the department to match the social security number of an applicant and recipient with the death register information maintained by the Social Security Administration. Unfortunately, in practice, this is only done upon the time of enrollment and at renewal. Perhaps, a further review of the sharing of records and the promptness of the department to check the records should be executed.

The practice of including the date and time-specific information on MA claims is currently in practice in some fashion. While the date may be submitted on MA claims for payment, the time the services are started or finished is not. MA hospital claims are one example that can be mimicked by all MA claim submissions since they already contain date and time-specific information requirements.

Based on requirements under federal law,[29] states are required to implement electronic visit verification (EVV) for all Medicaid personal care services and home health services requiring an in-home visit. EVV is required to be in place for personal care services by January 1, 2020 and by January 1, 2023 for home health care services. Failure to do so will result in incremental FMAP reductions up to 1 percent unless the state has made both a good faith effort and experienced unavoidable delays.[30]

While DHS is in the process of implementing EVV, legislative action should be examined to build off the federal requirement and incorporate it at the state level across all Medicaid services. The General Assembly should enact legislation that mandates all claims submitted include the date a service was provided, as well as the start and end times for each date of service. A broader range of provider identification and times of service for all MA programs has the potential to unveil fraudulent submissions by providers and save millions of taxpayer dollars.

---

[28] Legislative Data Processing Center. https://ldpc6.legis.state.pa.us/CFDOCS/LEGIS/LI/uconsCheck.cfm?txtType=HTM&yr=2011&sessInd=0&smthLwInd=0&act=0022.

[29] 21st Century Cures Act. https://www.congress.gov/bill/114th-congress/house-bill/34/text.

[30] Centers for Medicare & Medicaid Services. Electronic Visit Verification (EVV). https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html

Deficiency #3

Lastly, the Grand Jury Report revealed the individuals who provide services lack "standardized training on proper care, critical incident/fraud reporting, or appropriate billing practices.[31] This failure, as noted by the Grand Jury, results in incomplete, inaccurate, or conflicting information. This not only places recipients at risk, it also impedes law enforcement from proving fraud and holding those accountable for fraudulent acts.

Investigations into fraudulent activity are hampered by the lack of information shared with DHS by provider agencies. The scale of fraud may be even larger given the possibility of providers exploiting billing gaps. They lack supporting documentation. While records can be requested, this can lead to destruction or falsification of supporting documents. With the inclusion of identifying the individual providing services and standardized training, provider agencies could not point blame on the individuals providing the services.[32]

While the focus of the Grand Jury was providing training for providers, we want to take the time to focus attention on the department to ensure employee vigilance against fraud. The department is the entity that processes millions of claims and the workers who assist in the processing of those claims play a vital role in being vigilant against fraud. Ensuring updated comprehensive employee anti-fraud training should be ongoing. An updated fraud risk assessment for Medicaid may be a matter worth consideration.

While the department has indicated provider training requirements are in place, the cases respectfully suggest the training is not sufficient. While the General Assembly will not duplicate any training currently required, consideration should be given to updating the training requirements to include a focus on provider fraud activity and keep pace with the services and delivery systems used to provide recipients with the care they need. Minimizing fraud and ensuring enrollees receive services should go hand in hand. The General Assembly should enact legislation mandating standardized training for all persons providing services. The legislation should involve the type of service, the level of care required and types of services that are appropriately billable, and how to report fraud within the MA program.

[31] 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 16.
[32] Ibid, p. 17.

Overall Grand Jury Recommendations

The Grand Jury made three recommendations in their Report.[33]

1. The Legislature should enact a statute mandating that any individual seeking to provide services paid for, in whole or in part, with MA funds who does not have an NPI be required to register with the Commonwealth of Pennsylvania and obtain a SPI prior to the performance of said services. The legislation should mandate that every claim for MA services identify the actual individual providing the services by requiring that the providing individual's NPI or SPI be placed on every claim.
2. The Legislature should enact a statute mandating that every claim for MA services document every date that a service was provided as well as the start and end times for each time of service.
3. The Legislature should require that DHS establish and mandate standardized training for all persons providing service utilizing SPI. The standardized training should be specific to the type of services being provided and focus on the required level of care the recipient is to receive and what services are appropriately billable under that program. The training should also provide information on how to contact Protective Services and where to report fraud within the MA program. The standardized training for each specific type of service must be completed prior to providing services.

While we acknowledge the recommendations made by the Grand Jury are not insurmountable, we appreciate some of the concerns expressed by DHS in response to the Grand Jury Report. The costs of system modifications should be considered in conjunction with recoveries and the effect these recommendations would have upon payment avoidance in the first place. As the Department noted, a total of $2 billion in cost avoidance and recoveries has been realized since 2015. We believe millions of dollars could be added to this total if further efforts were made to incorporate the Grand Jury recommendations.

The actual loss of taxpayer dollars due to provider fraud is unknown. Given the examples of fraud recently investigated, there stands a possibility of a large number of providers who are submitting claims of services for payment that are taking advantages of the deficiencies currently existing in the MA program.

Safeguarding the integrity of the system while being mindful of the taxpayer dollars used to pay for such services is as important as ensuring those who are eligible and in need of services actually receive the services they need. There is need to protect these individuals from fraudulent billing, aside from fiscal concerns. Any services approved are needed and must be provided.

[33] 42nd Statewide Grand Jury Investigation Report. March 1, 2019. p. 22.

We also suggest the General Assembly consider updating the Human Services Code to ensure penalties and remedies are in place to properly address both providers and individuals performing services for MA that submit or cause to be submitted false information for compensation.

State False Claims Act

A federal law, called the False Claims Act (also called the "Lincoln Law"), imposes severe financial penalties against a provider who knowingly submits a fraudulent claim for payment involving federal dollars.[34] The law imposes liability on anyone who submits a claim for payment to the federal government that they know is false, like a provider who submits a bill to Medicare for services they did not provide. The person is liable for a civil penalty between $5,000 and $10,000, plus 3 times the amount of damages the government sustained.

The law allows private parties to bring an action on behalf of the United States (31 U.S.C. 3730 (b)). When the government intervenes, the private party stands to receive between 15 and 25 percent of the proceeds for the action. When the government does not intervene, the private party stands to receive between 25 and 30 percent of the proceeds.[35]

Since it was amended in 1986, the False Claims Act has become an effective and efficient tool for the federal government to combat fraud. Between 1986 and 2018, the federal government has recovered $59 billion from lawsuits brought by whistleblowers (qui tam). These whistleblowers have been paid over $7 billion in rewards.[36] Whistleblower cases account for 71% of all FCA cases filed. Just this May, the United States Justice Department issued new formal guidelines to litigators under the law to incentivize companies to voluntarily disclose misconduct and cooperate with investigations.[37] This illustrates the continued success of the federal government's reliance and partnership with private whistleblowers to identify fraud.

The Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, contained provisions to incentivize states to enact anti-fraud legislation modeled after the federal False Claims Act (FCA). The incentive entitles any state that meets federal standards outlined in the Act to an

[34] Centers for Medicare & Medicaid Services. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf.
[35] Centers for Medicare & Medicaid Services. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att2.pdf.
[36] https://www.falseclaimsact.com/federal-false-claims-act.
[37] U.S. Department of Justice. *Department of Justice Issues Guidance on False Claims Act Matters and Updates Justice Manual*. May 7, 2019. https://www.justice.gov/opa/pr/department-justice-issues-guidance-false-claims-act-matters-and-updates-justice-manual.

additional share of settlement amounts reached through their state FCA.[38] Just as the state and federal government jointly fund Medicaid expenditures, with the federal share of qualifying costs based on the federal medical assistance percentage (FMAP), so do the state and federal government share recoveries based on the FMAP. For fiscal year 2020, the annual FMAP for Pennsylvania is 52.25% which means the Commonwealth generally pays 47.75% of every Medicaid dollar spent on services and receives 47.75% of recoveries. The financial incentive for states with a qualified state False Claims Act is an increase by 10 percentage points of their share for any amounts recovered as the result of an action brought under the state law.

On August 21, 2006, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services published guidelines for evaluating State False Claims Acts to determine if the State law meets certain enumerated requirements that would qualify the state for the federal financial incentive.[39] The state laws must include provisions rewarding and facilitating whistleblower actions, contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, and contain a civil penalty not less than the civil penalty under federal law.

The FCA has been amended three times since the enactment of section 1909 (provisions providing financial incentives to states to enact a state-specific False Claims Act): May 20, 2009 in the Fraud Enforcement and Recovery Act of 2009; on Marcy 23, 2010, in the Patient Protection and Affordable Care Act; and on July 21, 2010, in the Dodd-Frank Wall Street Reform and Consumer Protection Act. New guidelines were published in 2013 on how the determination is made on whether a State law met the requirements of section 1909 of the Social Security Act.[40] Currently, the federal government recovers $20 for every $1 spent investigating, prosecuting whistleblower cases evolving from the FCA.[41]

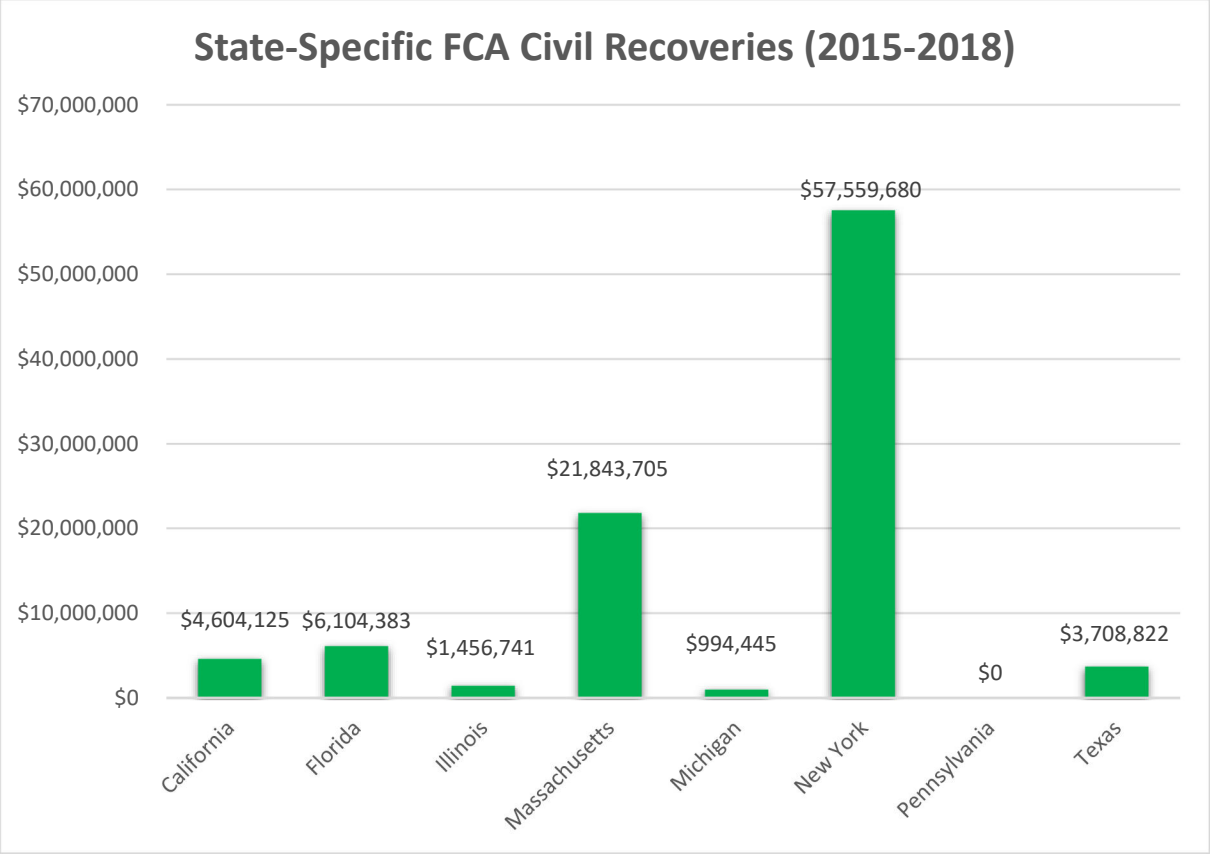
In addition to the federal law, 35 states and the District of Columbia have enacted State-Specific False Claims Acts. Pennsylvania has not adopted a State False Claims Act (though two large municipalities—Philadelphia and Allegheny County—have adopted false claims ordinances to cover false or fraudulent claims made on their municipality).[42] Those states that have approved state False Claims Acts qualify for the financial incentive under section 1909 of the Social Security Act.

---

[38] National Conference of State Legislatures. *Incentivizing State False Claims*. May 7, 2013. http://www.ncsl.org/research/health/clarifying-requirements-for-a-state-false-claims-a.aspx.
[39] Federal Register. Vol. 71, No. 161. August 21, 2006. https://oig.hhs.gov/authorities/docs/06/waisgate.pdf.
[40] U.S. Department of Health & Human Services, Office of Inspector General. *Updated OIG Guidelines for Evaluating State False Claims Acts.* March 15, 2013. https://oig.hhs.gov/fraud/docs/falseclaimsact/guidelines-sfca.pdf.
[41] Niland, Kurt. *U.S. Recovers $20 For Every $1 Spent Investigating, Prosecuting Whistleblower Case*. October 19, 2015. http://www.rightinginjustice.com/news/2015/10/19/u-s-recovers-20-for-every-1-spent-investigating-prosecuting-whistleblower-cases/.
[42] Taxpayers Against Fraud. *State False Claims Acts*. https://taf.org/state-false-claims-acts/.

While Pennsylvania does not have a State False Claims Act, under the FCA, the state is still able to collect its normal share of a recovery. However, because Pennsylvania has not enacted a state-specific False Claims Act, the Commonwealth is not able to receive the additional 10 percentage points in the State's share of any recovery in an action under such a law. For Pennsylvania (using the fiscal year 2020 FMAP), this 10 percentage incentive would increase the Commonwealth's recovery portion from 46.75 percent to 57.75%. We suggest fully arming the Attorney General's office with the authority to pursue recoveries for false claims like so many other states who have a state-specific FCA.

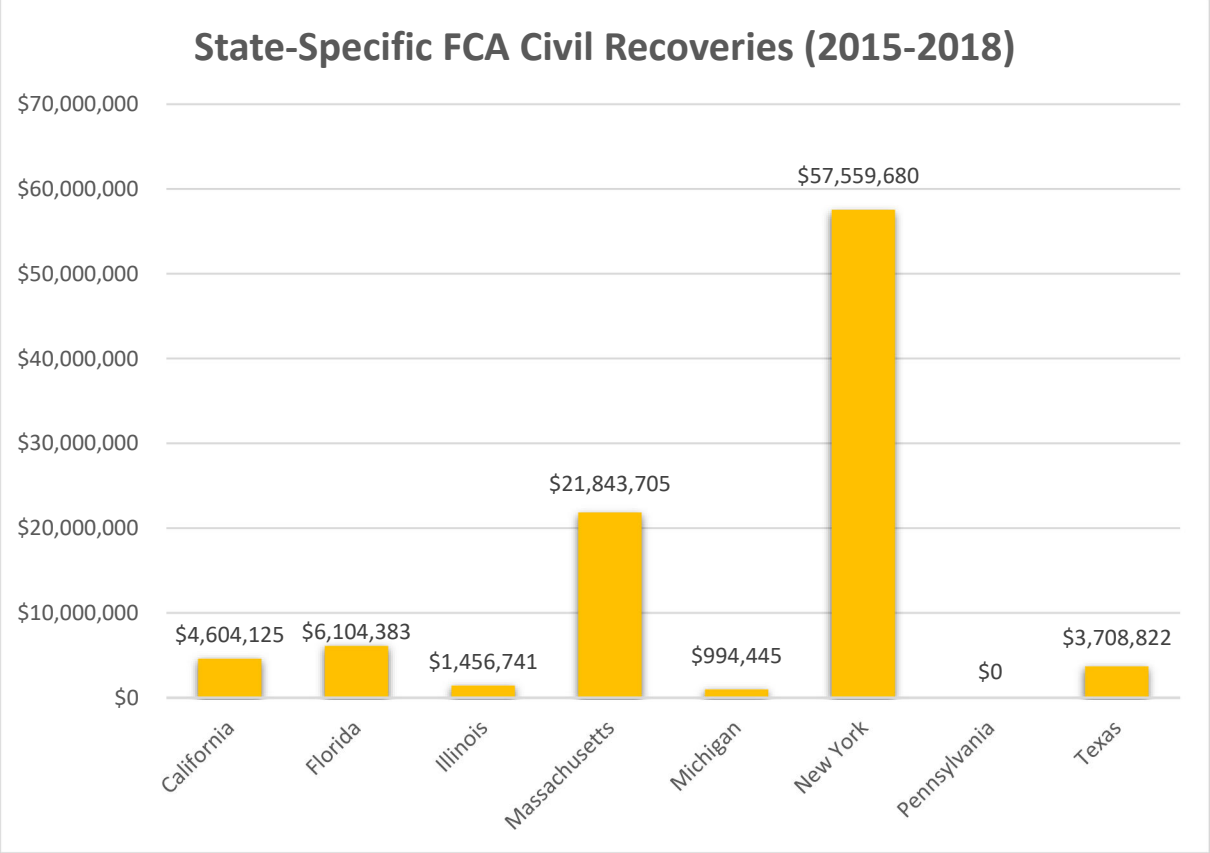
Aside from enhanced financial incentives offered by the federal government, states who have enacted a state-specific False Claims Act have pursued civil remedies for false claims. The Commonwealth has not. Below is a table depicting the actual recoveries made by states with a state-specific FCA over several years and a table showing the 2018 recoveries made as well as providing the Medicaid expenditures in 2018. We provided the longer table to provide a more accurate depiction since these cases can take up to 5 years to pursue.



[43]

[43] Selected States Used.

During the time span of 2015 to 2018, the state of California received $42.0 million in state-specific false claim civil remedies. During this time, it spent the most on Medicaid expenditures at $354.7 billion. Florida received $78.8 million in civil remedies and spent $92.0 billion on Medicaid expenditures. Illinois received $15.0 million in recoveries while spending $77.3 billion on Medicaid expenditures. Massachusetts received $38.5 million in recoveries while spending $70.8 billion on Medicaid expenditures. Michigan received $4.8 million in recoveries while spending $68.4 billion on Medicaid expenditures. New York received the most in recoveries at $236.2 million and it spent $276.4 billion on Medicaid expenditures. Texas received $13.6 million in recoveries while spending $153.3 billion on Medicaid. Meanwhile, the Commonwealth spent $112.1 billion on Medicaid expenditures and received $0 in state-specific false claims remedies. [44]



[45]

During 2018, 43 states received civil remedies totally $178.3 million. California spent the most on Medicaid at nearly $89 billion and received $4.6 million in state-specific civil remedies. Florida spent $23.7 billion on Medicaid and received $6.1 million in recoveries. Illinois spent $23.1 billion on Medicaid and received $1.5 million in recoveries. Massachusetts spent $18.7

[44] U.S. Department of Health and Human Services, Office of Inspector General. MFCU Statistical Data for Fiscal Years 2015-2018.
[45] Selected States Used.

billion on Medicaid and received nearly $22 million in recoveries. Michigan spent $17 billion on Medicaid and received nearly $1 million in recoveries. New York spent $75 billion and received the highest amount in recoveries at nearly $56 million. Texas spent nearly $39 billion on Medicaid and received almost $4 million in recoveries. Pennsylvania spent $30.7 billion on Medicaid and received $0 in state-specific civil false claims remedies.[46]

State False Claims Statutes[47]

While some State False Claims laws encourage whistleblowers to file cases involving any type of fraud committed against the state, many specify only health care or Medicaid fraud. A few permit plaintiffs to bring claims on behalf of a city or town that has been the victim of fraud.

Arkansas [Medicaid only/No private right of action] Medicaid Fraud False Claims Act,
Ark. Code Ann. 20-77-901, *et seq.*

California
False Claims Act
Cal. Gov't Code § 12650, *et. seq.*

Colorado [Medicaid only] Medicaid False Claims Act
Colo. Rev. Stat. § 25.5-4-303.5, *et. seq.*

Connecticut
False Claims Act
Conn. Gen. Stat. § 4-274, et seq.

Delaware
False Claims and Reporting Act
Del. Code tit. 6, § 1201, *et seq.*

District of Columbia
False Claims Law
D.C. Code Ann. § 2-308.01, *et seq.*

Florida
False Claims Act
Fla. Stat. Ann. § 68.083, *et seq.*

Georgia
Taxpayer Protection False Claims Act
Ga. Code Ann. § 23-3-120, *et seq.*
State False Medicaid Claims Act
Ga. Code Ann. § 49-4-168, *et seq.*

Hawaii
False Claims Act
Haw. Rev. Stat. § 661-22, *et seq.* (state)
Haw. Rev. Stat. § 46-171, *et seq.* (counties)

Illinois
False Claims Act
740 Ill. Comp. Stat. § 175/1, *et seq.*

Indiana
False Claims and Whistleblower Protection Act
Ind. Code § 5-11-5.7-1, *et seq.*

Iowa
False Claims Act
Iowa Code § 685.1, *et. seq.*

Kansas [No private right of action] False Claims Act
Kan. Stat. Ann. § 75-7501, *et seq.*

Louisiana [Medicaid only] Medical Assistance Programs Integrity Law
La. Rev. Stat. Ann. § 46:437.1, *et seq.*

[46] U.S. Department of Health and Human Services. MFCU Statistical Data for FYI 2018. February 21, 2019. https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2018-statistical-chart.pdf.
[47] Kreindler & Associates. *State and Local Versions of the False Claims Act.* http://blowthewhistle.com/services/false-claims/state-and-local-statutes/; https://www.falseclaimsact.com/states/DC.pdf.

Maryland [Medicaid only] False Health Claim Act
Md. Code Ann. §8-101, *et seq.*

Massachusetts
False Claims Law
Mass. Ann. Laws Ch. 12, § 5, *et seq.*

Michigan [Medicaid only] Medicaid False Claims Act
Mich. Comp. Laws § 400.602, ***et seq.***

Minnesota
False Claims Act
Minn. Stat. § 15C.01, *et seq.*

Missouri [Medicaid only/No private right of action] Health Care Payment Fraud and Abuse Act
Mo. Rev. Stat. § 191.900, *et seq.*

Montana
False Claims Act
Mont. Code Ann. § 17-8-401, *et seq.*

Nevada
False Claims Act
Nev. Rev. Stat. § 357.010, *et seq.*

New Hampshire [Medicaid only] Health Care False Claims Act
N.H. Rev. Stat. Ann. § 167:61-b, *et seq.*

New Jersey
False Claims Act
N.J. Stat. Ann. § 2A:32C-1, *et. seq.*

New Mexico
Fraud Against Taxpayers Act
N.M. Stat. Ann. § 44-9-1, *et seq.*
Medicaid False Claims Act
N.M. Stat. Ann. § 27-14-1

New York
State False Claims Act
N.Y. Fin. Law Ch. 56 § 187, *et seq.*

North Carolina
False Claims Act
N.C. Gen. Stat. § 1-605, e*t seq.*

Oklahoma
Medicaid False Claims Act
Okla. Stat title 63, § 5053, *et. seq*.

Oregon [No private right of action] False Claims Act
Ore. Rev. Stat. § 180.750, *et seq.*

Rhode Island
State False Claims Act
R.I. Gen. Laws § 9-1.1-1, *et seq.*

Tennessee
False Claims Act
Tenn. Code Ann. § 4-18-101, *et seq.*
Medicaid False Claims Act
Tenn. Code. § 71-5-181, *et seq.*

Texas [Medicaid only] Medicaid Fraud Prevention Act
Tex. Hum. Res. Code, § 36.001, *et seq*.

Utah [Medicaid only/No private right of action] False Claims Act
Utah Code Ann. § 26-20-1, *et seq.*

Vermont
False Claims Act
Vt. Stat. Ann. tit. 32, § 630, *et seq*.

Virginia
Fraud Against Taxpayers Act
Va. Code Ann. § 8.01-216.1, *et seq.*

Washington [Medicaid only] Medicaid False Claims Act
Wash. Rev. Code § 74.66.005, *et seq.*

~~**Wisconsin** [Medicaid only] False Claims for Medical Assistance Act~~
~~Wis. Stat. § 635. 20.931, *et seq.*~~ *REPEALED 2015*

Wyoming [Medicaid only/No private right of action] Medicaid False Claims Act
Wyo. Stat. Ann. § 42-4-303, *et seq.*

Municipal False Claims Statutes and Ordinances[48]

Bay Harbor Islands
False Claims Ordinance
§ 14-70, et seq.

Broward County
False Claims Ordinance
§ 1-276, et seq.

Chicago
False Claims Act
Municipal Code of Chicago § 1-21-010, et seq.

District of Columbia
False Claims Act
§ 2-308.03, et seq.

City of Hallandale Beach
False Claims Act
§ 19-100, et seq.

New York City
False Claims Act
N.Y.C. Admin. Code § 7-801, *et seq.*

Philadelphia
False Claims Act
Phila. Mun. Code § 19-3601, *et seq.*
The Philadelphia Ordinance is different from the FCA in that a private individual is only permitted to pursue a case after filing if the City Solicitor designates that person.[49]

Allegheny County, Pennsylvania
False Claims Ordinance
Code of Ordinances § 485-1, *et seq.*
Allegheny County was the first municipal government in Pennsylvania, and the fourth in the nation to adopt a local FCA.[50]

Miami-Dade County, Florida
False Claims Ordinance
Code of M.D.C. § 21-255, *et seq.*

Pennsylvania's Recent History of False Claims Legislation

For over the last 20 years, in nearly every regular legislative session since 1997, a member of the House of Representatives has proposed a State False Claims Act. No such legislation has been introduced during this legislative session.

---

[48] Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP. *False Claims Act Resource Center*. https://www.falseclaimsact.com/states-municipalities-fcas/municipality-false-claims-act-overview
[49] Berger/Montague. *Philadelphia False Claims Ordinance*. https://bergermontague.com/philadelphia-false-claims-ordinance/.
[50] Pietragallo, Gordon, Alfano, Bosick & Raspanti, LLP. *Allegheny County Surfs the False Claims Waive*. https://www.fraudwhistleblowersblog.com/federal-false-claims-act/allegheny-county-surfs-the-false-claims-wave/.

Legislative Session	Bill Number	Member	History
1997-1998[51]	HB 1671	Kenney	Amended in House Judiciary Committee, 4/28/98
1999-2000[52]	HB 849	Kenney	Passed House (201-0), 6/15/99
2001-2002[53]	HB 1285	Kenney	Passed House (197-0), 12/11/01
2005-2006[54]	HB 2994	Kenney	Referred House Judiciary Committee, 10/4/06
2007-2008[55]	HB 2509	Gerber	Re-committed to House Appropriations 6/16/08
2007-2008	HB 1523	Gerber	Referred to Health and Human Services, 6/13/07
2007-2008	HB 329	Kenney	Referred to Judiciary, 2/13/07
2009-2010[56]	SB 1113	Williams	Referred to Senate Judiciary, 10/8/09
2009-2010	HB 1679	Gerber	Re-committed to Appropriations, 6/23/10
2009-2010	HB 1351	D. Evans	Referred to Health and Human Services, 4/28/09
2011-2012[57]	SB 125	Williams	Referred to Senate Judiciary, 1/12/11
2011-2012	HB 1725	Gerber	Referred to Judiciary, 6/24/11

[51] Legislative Data Processing Center. https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=1997&sind=0&body=H&type=B&bn=1671
[52]Legislative Data Processing Center. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=19990txt&search=Search.
[53] Ibid. https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=2001&sind=0&body=H&type=B&bn=1285.
[54] Ibid. https://ldpc6.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?syear=2005&sind=0&body=H&type=B&bn=2994.
[55]Ibid. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20070txt&search=Search.
[56]Ibid. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20090txt&search=Search.
[57]Ibid. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20110txt&search=Search.

2013-2014[58]	HB 1493	Neuman	Referred to Judiciary, 6/10/13
2015-2016[59]	HB 654	Neuman	Referred to Judiciary, 2/26/15
2017-2018[60]	HB 1027	Neuman	Referred to Judiciary, 3/30/17

According to the House Journal, when House Bill 849 was debated on the floor during third consideration it was amended three times before final passage.[61]

Of the amendments offered, one addressed a concern about provisions of the bill addressing employer penalties and unlimited punitive-damages going beyond the Federal version of the False Claims Act. With a vote of 170-30, amendment A2358 offered by Rep. Schroder was approved that would allow for international misconduct damages to be unlimited while limiting punitive damages to 200 percent of the compensatory damages awarded. Aside from the maker's remarks on the amendment, no other discussion was held.

A comprehensive amendment, A2333, was offered by the maker of the bill. The amendment addressed "reasonable grounds," the ability of the prosecuting authority to proceed in either the Commonwealth Court or the Court of Common Pleas, jurisdiction over an action brought by former employees, investigators or certain contracted employees. In addition, any settlements would require consultation with the political subdivision and the district attorney and the use of recoveries awarded. This amendment was unanimously adopted.

Representative Blaum offered amendment A2652 that was also unanimously adopted providing for good faith reporting to an employer. The amendment provided retaliation protections of an employee's compensation, terms, conditions, locations or privileges if the employee made a good faith report to the employer regarding a false claim. Following the adoption of the amendment the bill was voted on final consideration and passed unanimously.[62]

When the bill reached the Senate, it was amended in the Senate Judiciary Committee and later came to rest in the Senate Rules and Executive Nominations Committee. The Senate

---

[58]Ibid. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20130txt&search=Search.
[59]Ibid. https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20150txt&search=Search.
[60]Legislative Data Processing Center https://ldpc6.legis.state.pa.us/cfdocs/legis/search//KeywordSearchAction.cfm?searchType=txt&request=False+Claims+Act&index=20170txt&search=Search.
[61] Ibid. https://ldpc6.legis.state.pa.us/WU01/LI/HJ/1999/0/19990615.pdf.
[62]Ibid. https://ldpc6.legis.state.pa.us/WU01/LI/HJ/1999/0/19990615.pdf.

amendments introduced the inclusion of a severability clause so the invalidity of one provision would not affect other provisions that can be given effect without the invalidated provision.[63]

According to the Legislative Journal, when the bill was deliberated the following legislative session there were no amendments offered on the House floor and there was no debate.[64] This time, there was a fiscal note attached to the legislation that was favorable to taxpayers which stated there was an anticipation of increased revenues.[65] The House, again, passed the bill unanimously. Regardless, the legislation would ultimately die at the end of the legislative session without the Senate holding a vote on the measure.

> ***FISCAL IMPACT****: It is anticipated that enactment of the bill will increase revenue to the General Fund largely as a result of the qui tam provisions, which will give individuals an incentive to report over-billings and fraudulent claims being made against the Commonwealth and political subdivisions. The amount of revenue to be generated from the enactment of the bill is a minimum estimate, based on what other states with similar laws collect. It is anticipated that revenue generated from the act will increase as citizens and attorneys become familiar with the law's provisions. The Attorney General will incur costs to process the civil actions; however, the act provides that costs associated with the civil actions can be recovered from the persons submitting the false claims.*

United States Department of Justice

In 2018, the United States Department of Justice resolved affirmative civil enforcements (ACE) achievements by the U.S. Attorney's Office Civil Division. The U.S. recovered over $108 million from False Claims Act cases, mostly from those alleging healthcare fraud violations. Whistleblowers recovered over $18 million from these resolutions. These cases originated largely from qui tam, or whistleblower filings and agency referrals.[66] Some of these cases involved:

- Miller et. al. vs. Health Management Associates, Inc., et al.
    - The settlement amount is $55 million for the joint venture piece of the litigation arising out of EDPA, with a global settlement of $260 million for eight qui tams filed in five districts.
- Johnson v. Post Acute Medical, LLC, et al.
    - The settlement amount is $13,031,502 to the United States, $114,016 to Texas, $22,482 to Louisiana, and $2,345,670 to the qui tam whistleblower.
- Emanuele v. Medicor Associates, Inc., et al.

---

[63] Ibid. https://ldpc6.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=1999&sessInd=0&billBody=H&billTyp=B&billNbr=0849&pn=2541.
[64] Ibid. https://ldpc6.legis.state.pa.us/WU01/LI/HJ/2001/0/20011211.pdf.
[65] Ibid. https://ldpc6.legis.state.pa.us/WU01/LI/BI/FN/2001/0/HB1285P3012.pdf.
[66] U.S. DOJ, "EDPA Announces 2018 Affirmative Civil Enforcement Achievements," https://www.justice.gov/usao-edpa/pr/edpa-announces-2018-affirmative-civil-enforcement-achievements.

    - The settlement amount is $20,750,000 to the United States and $6,017,500 to the qui tam whistleblower.
- Thomas and Mizak v. Horizons Hospice LLC, et al.
    - The settlement amount is $1,240,000 to the United States.

In fiscal year 2018, 646 qui tam complaints were filed. The United States intervened in 119 cases in 2018 (which may have been filed in years prior) for litigation or settlement purposes. Of those cases, 15 were in Pennsylvania.

Summary of Federal FCA Cases Filed in Pennsylvania

While not all inclusive, below are examples of cases and settlements reached by the United States with companies doing business or defendants residing within the Commonwealth who have been alleged of committing and settling FCA claims. More cases can be found at the United Sates Attorneys websites (USAO for Western District of Pennsylvania and the USAO of Eastern District of Pennsylvania).

On June 26, 2019, the trustees of the University of Pennsylvania Health System (Penn Medicine) agreed to pay $275,000 to settle FCA allegations that Lancaster General Hospital's division of Maternal Fetal Medicine submitted false Medicaid claims for obstetric ultrasounds.[67]

On July 23, 2019, the owner of E-Z Pharmacy II in Philadelphia agreed to pay $400,000 to settle FCA allegations. The settlement resolves allegations the pharmacy violated the FCA by billing Medicare for prescriptions that were not dispensed.[68]

On July 15, 2019, Millcreek Community Hospital agreed to pay $2.45 million to settle FCA allegations of billing Medicare and Medicaid for medically unnecessary inpatient rehabilitation services.[69]

On July 24, 2019, Eagleville Hospital agreed to pay $2.85 million to settle FCA allegations the hospital submitted false claims to Medicare, Medicaid and the Federal Employees Health Benefits Program for detoxification treatment services for patients who were ineligible.[70]

On June 6, 2019, a Florida doctor agreed to pay $911,136.75 to settle allegations he received improper payments for making referrals to a drug testing lab (Universal Oral Fluid Laboratories)

---

[67] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. June 26, 2019. https://www.justice.gov/usao-edpa/pr/penn-medicine-agrees-pay-275000-settle-false-claims-act-allegations.
[68] Ibid, July 23, 2019. https://www.justice.gov/usao-edpa/pr/philadelphia-based-pharmacy-owners-agree-pay-400000-resolve-false-claims-act-liability.

[69] Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 15, 2019. https://www.justice.gov/usao-wdpa/pr/millcreek-community-hospital-will-pay-2451000-settle-claims-medically-unnecessary.
[70] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. July 24, 2019. https://www.justice.gov/usao-edpa/pr/eagleville-hospital-pays-285-million-resolve-allegations-improper-billing-detox.

in Greensburg, PA. These referrals resulted in false claims submitted to Medicare for drug testing services. The doctor was engaged in a financial relationship with UOFL.[71]

On May 29, 2019, the pharmaceutical company Almirall, LLC (Aqua Pharmaceuticals) agreed to pay $3.5 million to resolve FCA allegations that it paid kickbacks to dermatology providers to induce prescriptions. The suit was filed under the FCA.[72]

On May 31, 2019, Heritage Pharmaceuticals agreed to pay over $7 million to settle civil FCA allegations that the company paid and received remuneration from other drug manufacturers between 2015 and 2015.[73]

On February 22, 2019, Lehigh Valley Technologies, Inc. agreed to pay $4 million to settle FCA allegations it avoided paying fees associated with new drug applications to the FDA.[74]

On February 14, 2019, Prime Healthcare Services, Inc. agreed to pay $1.25 million to settle FCA allegations that two hospitals in Pennsylvania (Roxborough Memorial and Lower Bucks) submitted false claims to Medicare.[75]

On February 4, 2019, Pentec Health, Inc. (located in Glen Mills, PA) agreed to pay $17 million to settle FCA claims that it submitted false claims to Medicare and other government healthcare programs.[76]

On December 21, 2018, the United States intervened in a lawsuit brought against Wheeling Hospital, Inc., R & V Associates, Ltd by Ronald Violi who was previously employed as Wheeling's Executive Vice President under the whistleblower provisions of the FCA. The government intervened with the allegations that Wheeling violated the Stark Law and Anti-Kickback Statute, which prohibits a hospital from billing Medicare for services referred by physicians with an improper financial relationship with a hospital.[77]

---

[71] Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. June 6, 2019. https://www.justice.gov/usao-wdpa/pr/florida-doctor-agrees-pay-91113675-settle-alleged-false-claims-act-violations-arising.

[72] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 29, 2019. https://www.justice.gov/usao-edpa/pr/pharmaceutical-company-pay-35m-resolve-allegations-paying-kickbacks-doctors.

[73]Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 31, 2019. https://www.justice.gov/usao-edpa/pr/heritage-pharmaceuticals-pays-over-7-million-resolve-civil-false-claims-act-allegations.

[74] Ibid, February 22, 2019. https://www.justice.gov/usao-edpa/pr/lehigh-valley-technologies-inc-pay-4-million-resolve-false-claims-act-liability-schem-0.

[75]Ibid, February 14, 2019. https://www.justice.gov/usao-edpa/pr/prime-healthcare-services-and-ceo-dr-prem-reddy-pay-125-million-settle-false-claims-act.

[76] Ibid, February 4, 2019. https://www.justice.gov/usao-edpa/pr/pentec-health-inc-pay-17-million-settle-false-claims-act-allegations.

[77]Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. December 21, 2018. https://www.justice.gov/usao-wdpa/pr/united-states-joins-false-claims-act-lawsuit-against-wheeling-hospital-r-v-associates.

On December 13, 2018, Hospice Care Provider, SouthernCare, Inc., agreed to pay $6 million to resolve FCA allegations that they submitted claims to Medicare for hospice care that was medically unnecessary or lacked documentation. The claim was submitted by whistleblowers.[78]

On October 24, 2018, Passavant Memorial Homes and its subsidiaries (Passavant Development Corporation, PDC Pharmacy Pittsburgh, PDC Pharmacy Philadelphia, and PDC Pharmacy Colorado) agreed to pay the United States $1.85 million to settle FCA and Controlled Substances Act violations. The settlement resolves a claim that Passavant dispensed controlled substances on Schedules III, IV, and V to patients for legitimate purposes but without a valid prescription and with only a physician order. Since the claims were submitted to Medicare and Medicaid, it was a violation of the FCA.[79]

On October 26, 2018, Abbott Laboratories and AbbVie Inc. agreed to pay $25 million to resolve FCA allegations of kickbacks and off-labeling marketing for TriCor brought about by a whistleblower claim filed by Amy Bergman. The State Medicaid program will receive $1.8 million.[80]

On September 25, 2018, Health Management Associates agreed to pay $55 million civil settlement to resolve allegations relating to two hospitals in Lancaster. It is part of a larger $260 million settlement arising from fraudulent billing practices in multiple healthcare facilities across the nation. The allegations were brought in eight lawsuits filed under the qui tam provisions of the FCA.[81]

On July 12, 2018, Weis Markets, Inc., agreed to pay $77,320 to settle false claims allegations. The claim submitted that Weis violated the FCA by using gift cards to induce Medicare and Medicaid recipients to transfer or fill their prescriptions at its affiliated pharmacies.[82]

On July 3, 2018, a former Pittsburgh family physician, Brent E. Clark, agreed to pay $360,000 to settle an FCA allegation. Between February 2015 and February 2017, Dr. Clark billed Medicare and Medicaid for unreasonable and unnecessary office visits, procedures, and falsified records to support those payment claims.[83]

---

[78] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. December 13, 2018. https://www.justice.gov/usao-edpa/pr/hospice-care-provider-pays-nearly-6-million-resolve-false-claims-act-allegations.

[79] Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. October 24, 2018. https://www.justice.gov/usao-wdpa/pr/passavant-memorial-homes-and-subsidiaries-settle-false-claims-act-allegations.

[80] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. October 26, 2018. https://www.justice.gov/usao-edpa/pr/abbott-laboratories-and-abbvie-inc-pay-25-million-resolve-false-claims-act-allegations.

[81] Ibid, September 25, 2018. https://www.justice.gov/usao-edpa/pr/national-hospital-chain-will-pay-over-260-million-resolve.

[82] Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 12, 2018. https://www.justice.gov/usao-wdpa/pr/weis-markets-inc-settles-false-claims-act-allegations.

[83] Ibid, July 3, 2018. https://www.justice.gov/usao-wdpa/pr/family-practice-doctor-pays-360000-settle-false-claims-act-allegations.

On July 3, 2018, North American Power Group, Ltd., and its owner agreed to pay the United States $14.4 million to settle FCA allegations by submitting fraudulent claims under a cooperative agreement with the Department of Energy National Energy and Technology Laboratory.[84]

On June 28, 2018, a company providing treatments for varicose veins (circulatory Centers of America, LLC) agreed to pay $1.2 million to resolve FCA allegations. The settlement resolves a whistleblower suit contending the company submitted claims to the Medicare program for services performed by non-physicians with supervision of a physician, when no such supervision was performed. Billing services with physician supervision receives higher reimbursements. The suit also alleged the company submitted claims for medically unnecessary and unreasonable services performed by technicians without proper licensing and or training.[85]

On May 7, 2018, three physicians agreed to pay $700,000 to settle FCA violations for receiving improper payments for referrals from Greensburg, PA drug testing lab Universal Oral Fluid Laboratories. These referrals resulted in false claims submitted to Medicare for drug testing.[86]

On Marcy 21, 2018, professor Christian Schunn at the University of Pittsburgh agreed to pay $132,000 to resolve allegations of the FCA by submitting false documents to the National Science Foundation to obtain federal grants to fund his research. He will be prohibited from applying for or participating in federal grants through October 15, 2019. The settlement resolve claims from 2006 to 2016 Schunn created false institutional review board approvals and submitting them to the NSF for funding totaling over $2.3 million.[87]

On May 31, 2018, the owners of I&L Express Pharmacy in Philadelphia agreed to pay $3.2 million to settle FCA allegations for billing Medicare for prescriptions that were not dispensed.[88]

On February 8, 2018, a private owned for-profit hospice company agreed to pay $1.24 million to settle two False Claims Act Whistleblower lawsuits, alleging the company fraudulently billed Medicare and Medicaid for services to patients who were ineligible for hospice.[89] The claims settled content from June 2007 to August 2012, the defendants submitted false claims to Medicare and Medicaid for patients who did not qualify for services because they did not have a

[84] Ibid, July 3, 2018. https://www.justice.gov/usao-wdpa/pr/north-american-power-group-ltd-and-michael-ruffatto-agree-pay-144-million-resolve.
[85]Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. June 28, 2018. https://www.justice.gov/usao-wdpa/pr/varicose-vein-treatment-company-agrees-pay-1205000-resolve-false-claims-act-allegations
[86] Ibid, May 7, 2018. https://www.justice.gov/usao-wdpa/pr/three-physicians-agree-pay-total-700000-settle-alleged-false-claims-act-violations
[87] Ibid, March 21, 2018. https://www.justice.gov/usao-wdpa/pr/university-pittsburgh-professor-pays-132000-and-agrees-exclusion-resolve-allegations

[88] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. May 31, 2018. https://www.justice.gov/usao-edpa/pr/pharmacy-owners-agree-pay-32-million-resolve-false-claims-case.
[89]Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. February 8, 2018. https://www.justice.gov/usao-wdpa/pr/hospice-company-and-owner-agree-pay-124-million-settle-two-false-claims-act.

life expectancy of six months or less. They also contended records were falsified to support the false claims.[90]

On December 19, 2017, Lancaster Physician Group (Physician's Alliance Ltd.) agreed to pay over $4 million for receiving illegal remuneration to refer patients to two hospitals (Lancaster Regional Medical Center and Heart of Lancaster Medical Center). The suit was filed under the qui tam provisions of the FCA.[91]

On July 27, 2016, the University of Pittsburgh Medical Center, together with the University of Pittsburgh Physicians, UPMC community Medicine, Inc., and Tri-State Neurosurgical Associates-UPMC. Inc. agreed to pay the United States $2.5 million to settle FCA violations. The complaint filed alleged neurosurgeons employed by UPMC submitted false claims to Medicare for assisting or supervising procedures performed when they did not participate in those procedures. In addition, it was alleged a neurosurgeon submitted claims for performing a procedure during spinal surgeries which was not performed. Not all claims asserted the whistleblowers in their Complaint are resolved by the settlement, therefore they will pursue those claims.[92]

On April 15, 2015, Asbury Health Center agreed to pay $1.3 million to settle FCA allegations. The settlement result from a self-disclosure regarding Medicare payments for skilled nursing facility services.[93]

On July 13, 2013, the University of Pittsburgh Medical Center and a related joint venture agreed to pay $956,590 to settle FCA allegations resulting from a self-disclosure to the United States Attorney's Office regarding referrals for home health services.[94]

In September 2000, the University of Pennsylvania Health Systems settled a civil Medicare False Claims case for $12 million. The complaint was filed by a whistleblower complaint who was a former mental health counsel for UPHS who alleged Medicare fraud involving unnecessary psychiatric treatment for nursing home patients.[95] The whistleblower was awarded $2 million.

---

[90] Ibid, February 8, 2018. https://www.justice.gov/usao-wdpa/pr/hospice-company-and-owner-agree-pay-124-million-settle-two-false-claims-act.

[91] Department of Justice, U.S. Attorney's Office Eastern District of Pennsylvania, Press Release. December 19, 2017. https://www.justice.gov/usao-edpa/pr/lancaster-physican-group-pays-over-4-million-resolve-kickback-claims-involving-hma.

[92] Department of Justice, U.S. Attorney's Office Western District of Pennsylvania, Press Release. July 27, 2016. https://www.justice.gov/usao-wdpa/pr/false-claims-act-violation-upmc-resolved-25-million.

[93] Ibid, Press Release. April 15, 2015. https://www.justice.gov/usao-wdpa/pr/13m-settlement-asbury-health-center-resolves-false-claims-act-allegations.

[94] Ibid, Press Release. July 13, 2013. https://www.justice.gov/usao-wdpa/pr/956590-settlement-upmc-resolves-false-claims-act-allegations.

[95] Pietragallo, Gordon, Alfano, Bosick & Raspanti LLP. *United States Government Gets $12 Million Settlement From the Hospital of the University of Pennsylvania over Allegations of Medicare Billing Fraud.* https://www.falseclaimsact.com/case/united-states-government-gets-12-million-settlement-from-the-hospital-of-the-university-of-pennsylvania-over-allegations-of-medicare-billing-fraud.

Summary of Federal Government FCA Cases

Since 1987, $38.8 billion in remedies have been a result of false claims settlements and judgments related to the health care industry. This accounts for 48.6% of all judgments under the FCA.[96] Likewise, $5.9 billion resulted from false claims involving the Department of Defense (16.6% of all judgments) and another $14.3 billion have been for other false claims cases (34.7% of all judgments).[97]

Since 1986, the number of lawsuits filed under qui tam provisions have grown – 645 in 2018 alone averaging 12 new cases a week.[98] According to the United States Department of Justice, the department brought in over $2.8 billion from FCA claims in the fiscal year 2018. Of this amount, over $2.1 billion arose from FCA lawsuits filed by whistleblowers. The government paid out $301 million to these individuals for filing the actions.

Of the amounts recovered in 2018, $2.5 billion involved the health care industry which encompasses managed care providers, hospitals, drug and medical device manufacturers, pharmacies, laboratories, hospice organizations and physicians. This total is for federal losses only and does not include the additional millions of dollars for state Medicaid programs. [99]

Some of the largest recoveries came from drug and medical device false claims. $625 million was paid by the AmericsourceBergen Corporation (ABC) over allegations they improperly repackaged injectable drugs into pre-filled syringes and then distributed the syringes to cancer patients. States received $43.2 million in recoveries for Medicaid.[100] The settlement resolves three FCA cases filed.

In another case involving drug and medical devices, the manufacturer Alere paid $33.2 million to resolve allegations it sold unreliable point-of-care testing devices, marketed as Triage, intended to be used to diagnosis drug overdoses, acute coronary syndrome and other serious conditions. States received $4.8 million in recoveries for Medicaid. The settlement resolved an FCA allegation filed by a former employee who was a senior quality control analyst. She received $5.6 million.[101]

The federal government also investigated fraud matters relating to procurement fraud. In one example, Toyobo Co. Ltd. Of Japan agreed to pay $66 million to settle claims it sold defective

---

[96] The U.S. Department of Justice, Civil Division. Fraud Statistics. Health and Human Services. October 1, 1986-September 30, 2018.
[97] The U.S. Department of Justice, Civil Division. Fraud Statistics. Department of Defense. October 1, 1986-September 30, 2018.
[98] The U.S. Department of Justice. Press Release. December 21, 2018. https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018.
[99] The U.S. Department of Justice. Press Release. December 21, 2018.
[100] The U.S. Department of Justice. Press Release. October 1, 2018. https://www.justice.gov/opa/pr/amerisourcebergen-corporation-agrees-pay-625-million-resolve-allegations-it-illegally?utm_medium=email&utm_source=govdelivery.
[101] The U.S. Department of Justice. Press Release. March 23, 2018. https://www.justice.gov/opa/pr/alere-pay-us-332-million-settle-false-claims-act-allegations-relating-unreliable-diagnostic?utm_medium=email&utm_source=govdelivery.

Zylon used in bullet proof vests purchases for federal, state, local and tribal law enforcement agencies in the United States. The settlement resolves two lawsuits, one brought by the United States and another filed by a law enforcement officer. The law enforcement officer received $5.8 million.[102]

In another case, 3M Company of St. Paul Minnesota agreed to pay $9.1 million to resolve allegations it sold defective dual-ended Combat Arms Earplugs to the military without disclosing the defects. The settlement resolves a lawsuit brought by its competitor, Moldex-Metrics. The whistleblower will receive $1.9 million plus nearly $645,000 in attorney fees.[103]

Deloitte & Touche LLP paid $149.5 million to settle FCA claims involving the outside audit of Taylor, Bean & Whitaker Mortgage Corp (TBW). TBW was authorized to originate and underwrite mortgage loans insured by the FHA. TBW was engaged in a fraudulent scheme involving the sale of fictitious or double-pledged mortgage loans. As the independent outside auditor, Deloitte was alleged to knowingly deviate from auditing standards which failed to detect the fraudulent activity and detecting false and misleading financial statements.[104]

Former professional cyclist Lance Armstrong agreed to pay $5 million to resolve FCA allegations arising from his use of performance-enhancing drugs resulting in the submission of millions of dollars in false claim payments for the USPS sponsorship. The suit was originally brought forward by a former teammate (Floyd Landis) in June 2010 under the whistleblower provisions of the FCA. Landis received $1.1 million.[105]

Over $114 million was awarded to the federal government against three defendants for FCA allegations they paid physicians for referring patients to two blood testing laboratories, Health Diagnostic Laboratory and Singulex Inc. Evidence also showed physicians were referring patients to the laboratories for medical unnecessary test and billing federal health care programs. The claim was originally brought in three lawsuits under the whistleblower provisions of the FCA.[106]

Prime Healthcare Services agreed to pay $65 million to settle FCA allegations that 14 hospitals knowingly submitted false claims to Medicare by admitting patients who required outpatient care and billing for more expensive diagnosis. The suit was brought through the whistleblower

---

[102] The U.S. Department of Justice. Press Release. March 15, 2018. https://www.justice.gov/opa/pr/japanese-fiber-manufacturer-pay-66-million-alleged-false-claims-related-defective-bullet?utm_medium=email&utm_source=govdelivery.

[103] Whistleblower News Review. *Defense Contractor 3M Settles Defective Earplug Lawsuit at $9.1 million, $1.9 mill to Whistleblower.* August 7, 2018. https://www.whistleblowergov.org/government-contracts.php?article=3m-pays-9.1-million-on-alleged-military-contract-scam-1.9m-to-whistleblower_130.

[104] Eastin, Parker. *Deloitte & Touche Agrees to Pay $149.5 Million to Settle Claims Arising from Its Audits of Failed Mortgage Lender Taylor, Bean & Whitaker*. The Whistleblower Resource. March 1, 2018. http://thewhistleblowerresource.com/deloitte-touche-agrees-to-pay-149-5-million-to-settle-claims-arising-from-its-audits-of-failed-mortgage-lender-taylor-bean-whitaker/.

[105] The U.S. Department of Justice. Press Release. April 19, 2018. https://www.justice.gov/opa/pr/lance-armstrong-agrees-pay-5-million-settle-false-claims-allegations-arising-violation-anti?utm_medium=email&utm_source=govdelivery.

[106] The U.S. Department of Justice. Press Release. May 29, 2018. https://www.justice.gov/opa/pr/united-states-obtains-114-million-judgment-against-three-individuals-paying-kickbacks.

provisions of the FCA by a former Director of performance Improvement at Alvarado Hospital Medical Center (one of the hospitals owned by the defendants). She received $17.2 million.[107]

Summary of Relevant Existing Law

While Pennsylvania has no false claims legislation akin to the federal False Claims Act, most false claims are pursued under the criminal statute, 18 Pa.C.S. § 3922, of theft by deception.

> § 3922. Theft by deception.
>
> (a) Offense defined. --A person is guilty of theft if he intentionally obtains or withholds property of another by deception. A person deceives if he intentionally:
>
> (1) creates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind; but deception as to a person's intention to perform a promise shall not be inferred from the fact alone that he did not subsequently perform the promise;
>
> (2) prevents another from acquiring information which would affect his judgment of a transaction; or
>
> (3) fails to correct a false impression which the deceiver previously created or reinforced, or which the deceiver knows to be influencing another to whom he stands in a fiduciary or confidential relationship.
>
> (b) Exception. --The term "deceive" does not, however, include falsity as to matters having no pecuniary significance, or puffing by statements unlikely to deceive ordinary persons in the group addressed.

Pennsylvania's Whistleblower Law (43 P.S. §§ 1421-1428), provides that: "No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer…"

Other instances in which the Commonwealth provides whistleblower protection are:

- The Hazardous Sites Cleanup Act (35 P.S. §§ 6020.101 et seq.).
- The Low-Level Radioactive Waste Disposal Act (35 P.S. §§ 7130.101 et seq.).
- The Municipal Waste Planning, Recycling and Waste Reduction Act (53 P.S. §§4000.101 et seq.).

The following statutes address "false claims" in various situations, via criminal or civil sanctions:

- Insurance fraud (18 Pa.C.S. § 4117).
- Unlawful acts (34 Pa.C.S. § 547).

[107] The U.S. Department of Justice. Press Release. August 3, 2018. https://www.justice.gov/opa/pr/prime-healthcare-services-and-ceo-pay-65-million-settle-false-claims-act-allegations?utm_medium=email&utm_source=govdelivery.

- Discharge of insolvent; forced insolvent (39 P.S. § 100).
- Frauds against government (51 Pa.C.S. § 6041).
- Provider prohibited acts, criminal penalties and civil remedies (62 P.S. § 1407).
- Penalty for false claims (71 P.S. § 1689.205).
- Penalties (72 P.S. § 3761-521).
- Crimes (72 P.S. § 7353).
- Warning notice on application for insurance and claim forms (75 Pa.C.S. § 1822).
- Offenses (77 P.S. § 1039.2).

False Claims Conclusion

Given the number of cases being pursued against individuals, companies or industries, within Pennsylvania, by the federal government, the enhanced financial incentive offered by the federal government to states with a state-specific FCA, the history of legislation being passed by the House during two previous legislative sessions, and actual state-specific FCA civil recoveries made by other states, we believe there is ample evidence to support the consideration of enacting a state-specific False Claims Act.

We acknowledge the benefit of pursuing these remedies is not measured over a short period of time. The task of investigating and conducting a civil remedies case can take three to five years, but we believe the payoff to taxpayers is one that the Commonwealth has the endurance to undertake. If an industry is making money from taxpayer dollars, then the state should have the ability to go after wrongdoers and recover civil remedies. It is our duty to protect taxpayer dollars, ensure the integrity of programs and make sure the state can be adequately repaid in full by those who try to cheat the system.

Improper Payments

Similar to the instances of fraud unveiled in the Attorney General's Grand Jury Report, are the circumstances resulting in improper payments.

The Improper Payments Information Act (IPIA) of 2002 (amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012) requires federal government agencies to review programs and identify those susceptible to significant improper payments, estimate the improper payments, submit the estimates to Congress and a report on actions taken to reduce those payments. As a result of the Children's Health Insurance Program (CHIP) and Medicaid as being programs at

greatest risk of improper payments, CMS developed the Payment Error Rate Measurement (PERM) program.[108]

PERM measures improper payments of Medicaid and CHIP and establishes error rates based on reviews of three components: fee-for-service, managed care, and eligibility. These are not "fraud rates" but rather a measurement of payments that did not meet statutory, regulatory, or administrative requirements. Improper payments cover a broad category of errors not necessarily fraudulent which can be lack of documentation, incomplete documentation, procedure error coding or number of units error. CMS and HHS report improper payments annually in the Agency Financial Report (AFR) http://www.hss.gov/afr/.

As part of the PERM review, a CMS contractor requests medical records from a selection of providers. This requires cooperation between CMS and the states. Medicaid Fee-For-Service (FFS) payments undergo two reviews: (1) A Data Processing Review to determine if the state processed the claim correctly; and (2) A Medical Review of provider records to ensure there is documentation that support the claim billed, coding accuracy and medical necessity of the service Managed Care payments involve only a Data Processing Review to determine if the state accurately process the capitation payment (premium); there is no Medical Review because the managed care organizations do not provide a medical service. In March of 2019, the United States Government Accountability Office (GAO) released a report entitled, "Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments" citing FFS improper payments were $41.2 billion nationally.[109]

CMS uses a 17-state rotation for PERM which allows each state to be reviewed once every three years. Pennsylvania is a cycle 1 state.[110] PERM audits take approximately 2.5 years to complete.[111]

- **Cycle 1:** Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, **Pennsylvania,** Virginia, Wisconsin, and Wyoming.
- **Cycle 2:** Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and West Virginia.

---

[108] Centers for Medicare & Medicaid Services. Payment Error Rate Measurement (PERM). https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html.

[109] United States Government Accountability Office. *Medicare and Medicaid: CMS Should Assess Documentation Necessary to Identify Improper Payments.* March 2019. https://www.gao.gov/assets/700/697981.pdf.

[110] Centers for Medicare & Medicaid Services. *Payment Error Rate Measurement (PERM)*. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/PERMOVERVIEWFORPROVIDERS.pdf.

[111] PA Department of Human Services. *Payment Error Rate Measurement (PERM).* http://dhs.pa.gov/provider/paymenterrorratemeasurement/index.htm.

- **Cycle 3:** Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Maine, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, and Washington.

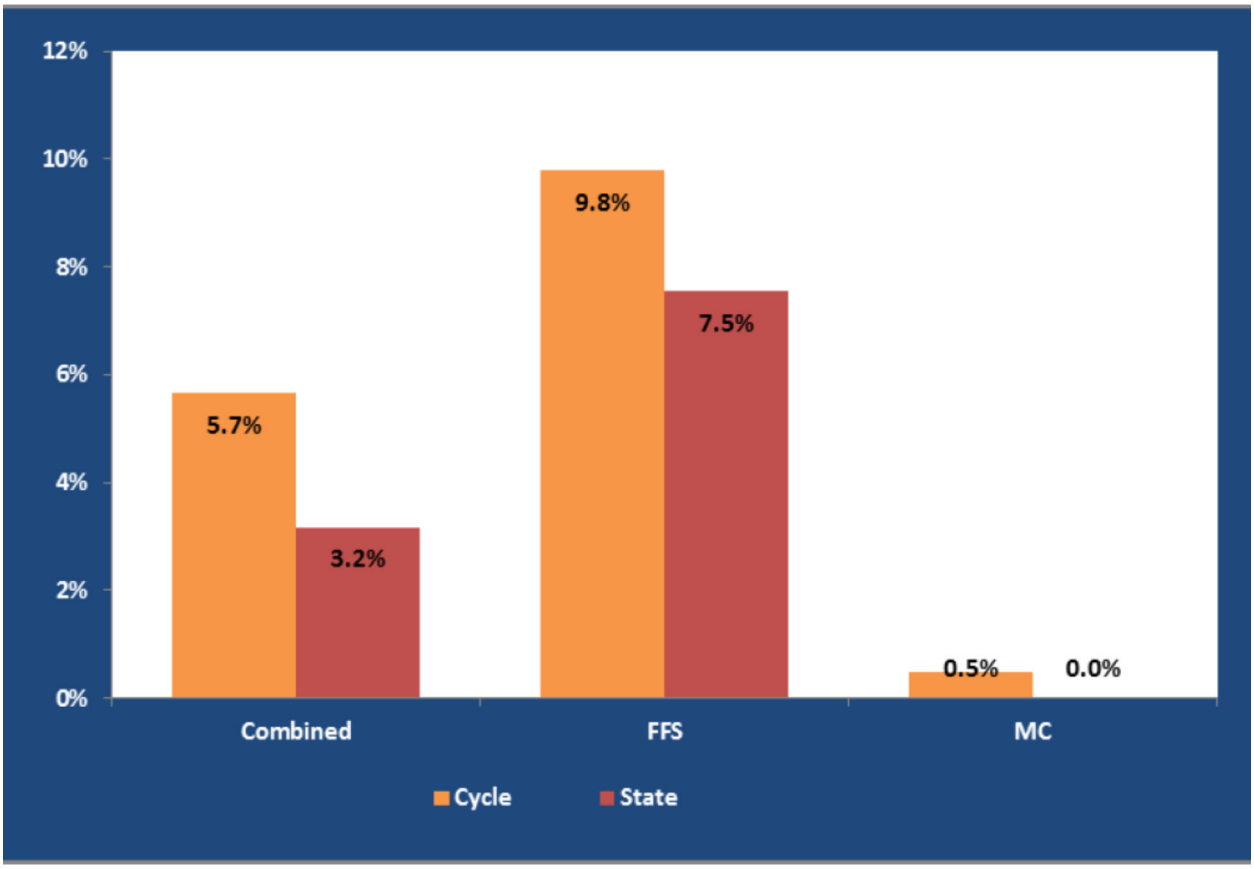
The last PERM audit for Pennsylvania was in 2015. It is important to note that one of the three PERM components -- eligibility determinations and any resulting improper payments -- was not measured in the audit. Eligibility components of PERM were put on hold beginning with 2014 due to the changes in requirements and expanded eligibility made through the Patient Protection and Affordable Care Act of 2010, known as the Affordable Care Act (ACA). The 2015 PERM audit only reviewed FFS claims and managed care capitation payments.[112]

According to the U.S. Department of Health and Human Services 2015 Payment Error Rate Measurement for Pennsylvania Summary Report, "the FFS component improper payment rate measured under PERM is usually higher than the managed care component improper payment rate, primarily due to non-compliance with HIPAA transaction standards requiring National Provider Identifiers (NPI) to be included on electronically submitted claims and new regulations under ACA, such as risk-based screening of providers prior to enrollment. Additionally, the FFS improper payments include errors cited when providers fail to comply with record requests or fail to maintain documentation required by state policies. For the managed care measurement, PERM only reviews the payments made by states to managed care organizations and not claims submitted by providers for services rendered. Therefore, the managed care measurement does not include some errors observed in the FFS component, such as violations of claim transaction standards and provider failure to submit requested medical records."[113]

The following chart shows the 2015 error rates reported for Pennsylvania (labeled "State") and the overall error rates for all 17 states audited in Cycle 1 (labeled "Cycle"). Pennsylvania was lower on all three improper payment rates (FFS, Managed Care and Combined) when compared to the overall Cycle 1 error rates.

[112]United States Department of Health and Human Services. *Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report.* November 16, 2016. p. 1. http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.
[113] Ibid, p. 4.

Cycle 1 States vs. Pennsylvania Combined and Component Improper Payment Rates:



As the above figure from the Report shows, Pennsylvania's Error Payment Rate for FFS is 7.5% while the Cycle 1 FFS error rate is 9.8%. The improper payment rate for managed care is 0.5% while Pennsylvania's is 0.0% (again, it is important to note the claims submitted by providers for services rendered are not reviewed, therefore the measurement rate does not include some errors measured in FFS).[114] Pennsylvania had a combined Medicaid improper payment rate of 3.2 percent compared to 5.7 % for the Cycle. While DHS would submit Pennsylvania achieved a successful audit outcome in part due to its lower combined improper payment rate than the Cycle, we suggest an error over 3% is not one to cause for celebration. Five states had combined error rates below Pennsylvania – their combined improper payment rates ranged from 0.3% to 2.9%.

To understand the possible fiscal impact of this error rate, we look at the total amount of the sample dollars in error which is an estimate of the total dollars paid incorrectly by the state across the program. The Report shows Pennsylvania's projected dollars in error is $694.1 million for FFS. While Medicaid is one state program, states have yet to fully engage to

[114] United States Department of Health and Human Services. *Fiscal Year 2015 Pennsylvania Medicaid Payment Error Rate Measurement (PERM) Cycle 1 Summary Report.* November 16, 2016. p. 3. http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_278846.pdf.

eliminate improper payments which can reduce costs and provide more freed up state dollars to reallocate to other critical programs such as education funding or the Department of Corrections.

The following table summarizes the Report findings in the Fee-For Service component of Pennsylvania's 2015 PERM audit.

Medicaid Program Component	State				Cycle			
	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error	% of Total Projected Dollars in Error	Sample # of Errors	Sample Dollars in Error	Projected Dollars in Error ($Millions)	% of Total Projected Dollars in Error
Medicaid FFS	24	$48,938	$694,150,441	100.0%	1,563	$4,067,319	$7,579	96.1%
Medicaid Managed Care	0	$0	$0	0.0%	15	$8,752	$306	3.9%
Note: Details do not always sum to the total due to rounding.								

Pennsylvania PERM Audit: Fee-For-Service

Sample Medicaid Findings and Projected Dollars in Error

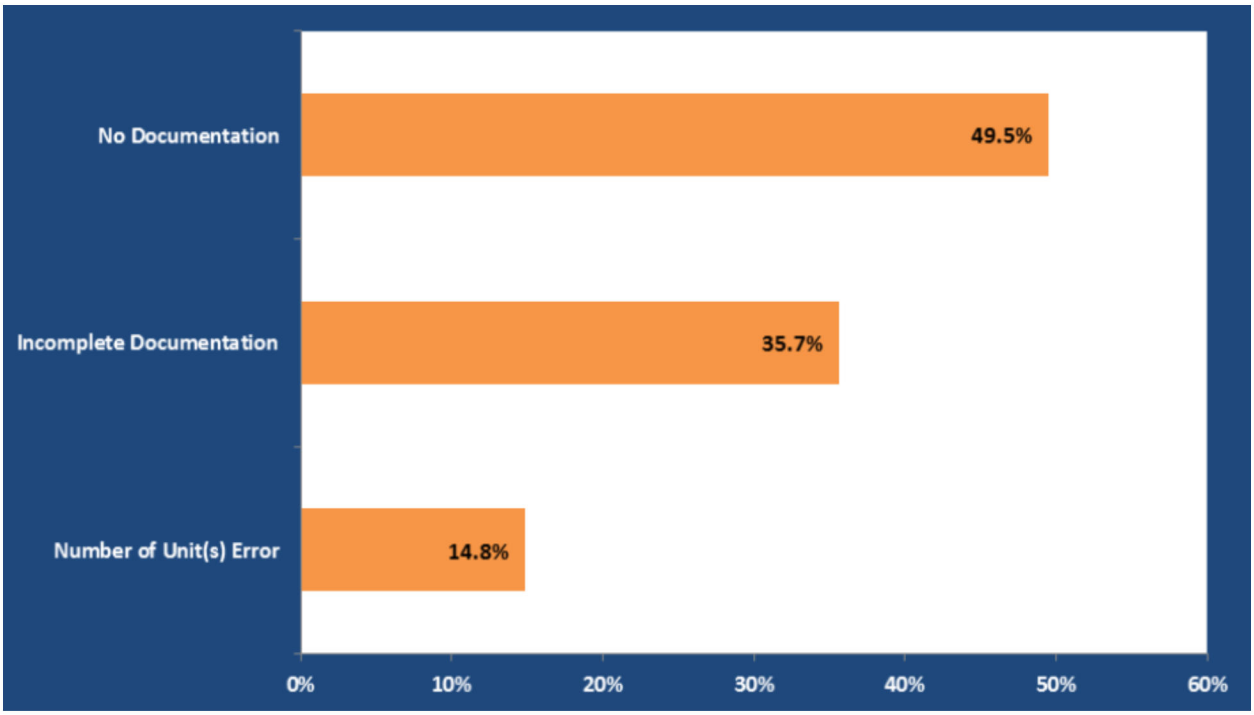
	Number of Errors in Sample	Sample Dollars in Error	Projected Dollars in Error	Percent of Projected Dollars in Error
Total FFS Errors	**24**	**$48,936**	**$694,150,441**	**100%**
Medical Review Errors	5	$8,152	$79,874,662	11.5%
Data Processing Errors	19	$40,786	$614,275,779	88.5%

Source: Pennsylvania PERM Medicaid FY 2015 Findings, Table 1 (page 5) and Table 2 (pages 5-6)

The audit reviewed a sample of FFS claims and found 24 errors with resultant improper payments totaling $48,936. Based on these findings, the Report projected $694 million payments may have been made in error across Pennsylvania's Fee-For-Service program which includes inpatient, outpatient and long-term care services. (The projected dollars in error is calculated by multiplying the improper payment rate in the sample by the projected payment amounts listed on reports Pennsylvania filed with the Centers for Medicare & Medicaid Services.)

- Errors discovered in the Medical Review accounted for nearly $80 million (or 11.5 percent) of total projected dollars in error. All errors were associated with long-term care claims (i.e., nursing facility, intermediate care facilities /group homes for individuals with intellectual disabilities, and home health services).
- Data Processing errors made up the lion's share of projected improper payments, accounting for $614 million (or 88.5 percent) of the total projection.

The Medical Review errors included: no supporting documentation to support the payment claim submitted to DHS, incomplete documentation to support the payment claim, and the incorrect number of units were billed. The following chart from the Report shows the percentage of Medical Review improper payments by error type. For example, almost half of the projected $80 million dollars in error is attributed to claims that had no supporting documentation and more than one-third is due to claims with incomplete documentation.



It is both interesting and cause for concern to realize some of the error types given regarding the medical review errors that resulted in improper payments **echo the very issues detailed in the Attorney General's Grand Jury's Report regarding proper documentation**. Providers billed for the wrong recipient, providers shared that the recipient was not seen, the state could not locate the provider and the wrong units of service were billed. These are all provider information errors.

Findings from the Data Processing Review show 99.7% of improper Fee for Service payments are a result of provider information/enrollment errors. The majority of the errors are cited because providers were not screened using ACA risk based criteria as set forth 42 CFR 455.414, 42 CFR 455.436 and 42 CFR 450.[115] Another strong sampling of the errors cited were because they did not include the provider's NPI**. These are the same issues contained in the Attorney General's Grand Jury Report detailing how provider fraud is being carried out in MA.** In total, the Pennsylvania Medicaid FFS data processing review error type review shows projected dollars in error for overpayments to be $612.4 million.

[115] Ibid p. 15.

State Level Improper Payments Law

As discussed earlier in this report, the payment of errors measurement conducted by CMS for managed care is not a complete picture. It only reviews the payments made by states to managed care organizations and not claims submitted by providers for services rendered. Therefore, we conclude the Commonwealth does not have an accurate picture of how many payments are improper. The argument that the MCOs independently maintain program integrity mechanisms does not assist us in being able to measure payment errors or detect forms of fraud, waste or abuse. We simply are unable to determine the amount of improper payments made to providers through the MCOs. After realizing comprehensive reviews are not occurring and error payments remain unknown, despite the fact that federal law may require MCOs to establish a Fraud, Waste, and Abuse Unit,[116] we support a stronger review and audit of payments made to providers through MCOs.

Given the amount of payment errors made and disclosed through the PERM audit, primarily for FSS as the Managed Care review was unable to examine some of the causes leading to increases in improper payments made through FSS, **the Commonwealth should create a more efficient means to reduce costs attributed to errors of payment through the development of its own baseline analysis of improper payments across state agencies.**

Seeking the benefit of being able to provide more needed services to the most vulnerable, a cooperative team involving the Office of Inspector General, the Auditor General and the Treasury could create a Pennsylvania specific improper payment review for programs and services across every agency that is allocated taxpayer dollars. An improper payment elimination plan should be developed for each state agency with the target of achieving between 0 and 0.03 improper payment rate. Within five years of adopting an improper payment elimination plan for an agency, an audit should be completed by the Legislative Budget and Finance Committee to verify the effectiveness of the improper payment elimination plan. Going forward, reports of error should be performed every five years for every agency.

Considering the number of contracts, payments, and agreements between varies state agencies and non-public entities, take for example the level of payments made through the Department of Corrections, it would be beneficial for a review of improper payments at the state level for all agencies and payments made by those agencies. Not having error payment rate to reference is not the same as the error payment not occurring. The Commonwealth needs to have an adequate and thorough understanding of the amounts of improper or error payments made across the board in order to protect the integrity of government programs, services, and the taxpayers who provide the funding for agencies to continue operating.

[116] 42 CFR §438.608 (a)(1)(vii).

Other Wrongful Payments: Office of Inspector General

The ACA and federal regulations prohibit federal payments for health-care-acquired conditions and authorize States to identify other provider-preventable conditions (PPCs) that would prohibit Medicaid payments.[117] State plans require state agencies to meet federal requirements related to nonpayment of PPCs. Furthermore, federal regulations require contracts with MCOs to comply with the prohibition of payments for PPCs.[118] Ultimately, the state is responsible for ensuring our contracts with MCOs comply with both federal and state requirements.

The Office of Inspector General conducted an audit for the time period between October 1, 2013 through September 30, 2015. The purpose of the audit was "to determine whether the Pennsylvania Department of Human Services (State agency) ensured that its MCOs complied with Federal and State requirements prohibiting payments to providers for inpatient hospital services related to treating certain PPCs."[119] The Office of Inspector General has conducted similar audits on at least 11 other states since 2016 (New York, Massachusetts, Rhode Island, Louisiana, Nevada, Iowa, Missouri, Oklahoma, Illinois, Washington, and Idaho).

The audit only reviewed 10 physical health MCOs and 2 private-sector behavioral health MCOs. The state agency contracts with 32 county governments who subcontract with private sector behavioral health organizations were not included in the audit. The audit found the state was not ensuring contracts complied with both federal and state requirements prohibiting payments for inpatient hospital services related to PPCs. In fact, the audit reveals MCOs paid providers $43.5 million for 576 claims involving PPCs. This is problematic since those payments were included in the calculation of capitation payment rates for 2016, 2017, and 2018. The audit suggests the Commonwealth did not have proper internal controls in place to ensure compliance. Specifically, there was no policy or procedure to determine whether an MCO complied or if the payment rates were based on services covered in the state plan. In addition, because of lacking information it could not be determined on whether MCOs were paying for additional services related to treating the PPCs. [120]

It is worth noting, that in a response to the Office of Inspector General, the Department of Human Services suggests the $43.5 million amount represents payments post-PPC adjustments

[117] United States Department of Health and Human Services, Office of Inspector General. Pennsylvania Did Not Ensure That Its Managed-Care Organizations Complied With Requirements Prohibiting Medicaid Payments For Services Related To Provider-Preventable Conditions. August 2019. P. 4.
[118] Ibid, p. 5.
[119] Ibid, p. 1.
[120] Ibid, p. 6.

and unallowable expenditures. The Office of Inspector General disputes this statement and stands by its Report.[121]

Under federal regulations, payments are not denied when they contain a PPC, but rather the payment is reduced to the amount attributed to the PPC. This was not done according to the audit. Instead, payments were paid in full. There were no reductions in payments to providers for any of the 576 claims containing PPCs. Likewise, there were no policies or procedures in place that would have allowed the MCO determine a reduced payment for claims that included PPCs.[122]

The audit unveiled the lack of proper monitoring by the state agency to ensure MCOs were compliant and the absence of a provision in the contract to require MCOs be compliant with federal requirements. The lack of oversight provided an avenue for a missed opportunity for the state to impose sanctions on the MCOs for compliance failure. There is no provision that allows the state agency to recoup funds from the MCOs.

In all, seven recommendations were made in the audit. Most involved greater oversight by the state agency. For the purposes of this report, the reliance on the state to allow the MCOs to police themselves in making payments only further supports our request for measures to be taken to reduce improper payments and other wrongful payments. These involve audits that were conducted and unknown. We are not certain how widespread such errors are actually being committed and paid.

United States Treasury: Do Not Pay Program

In 2002, the U.S. Treasury started the Do Not Pay program[123] which was codified in federal law with the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).[124] The Do Not Pay program uses data analytics to verify eligibility and to identify and prevent fraud and waste associated with improper payments. Its purpose is to reduce improper payments by providing national agencies, state agencies or local governments who are disbursing federal funds access to critical information to identify fraud and prevent improper payments. It is a portal that provides information collected previously from agencies or publicly available information.[125]

---

[121] Ibid, p. 14.
[122] Ibid, p. 7.
[123] U.S. Department of the Treasury. *Do Not Pay*. https://fiscal.treasury.gov/dnp/.
[124] U.S. Government Printing Office. 112th Congress 2D Session. *H.R. 4053.* December 17, 2012. https://fiscal.treasury.gov/files/dnp/IPERIA.pdf.
[125] Bureau of the Public Debt, U.S. Department of the Treasury. Do Not Pay. Privacy Impact Assessment (PIA). June 15, 2012. p. 4. https://www.treasurydirect.gov/DoNotPayPIA.pdf.

Data sources are constantly being added. The federal agencies providing information to the system include the Social Security Administration, General Services Administration, Department of Treasury and the Department of Health and Human Services. Publicly available sources (both on the internet or purchased from third-party providers, and others) are collected and used. [126] Those who use the system will use the reports to identify payments that need to be investigated to determine if the payments are indeed improper. [127]

In discussing the federal program with the Pennsylvania Treasury, we were informed that Treasury does not currently actively participate in this program. Treasury further explained 90 percent of the contracts it comes across are from vendors approved by the Department of General Services.

While the Department of General Services also indicated they do not use the Do Not Pay program, they indicated that they utilize the Contractor Responsibility Program. This program was mandated by Executive Order 1990-3 by Governor Robert P. Casey to be administered by the Office of the Budget, with the assistance of the Department of General Services, Office of General Counsel, and Office of Inspector General.[128] Under the Executive Order, the program was designed to "identify, evaluate, and sanction appropriately, contractors that do not meet the standards of responsibility, which render deficient performance, or that engage in wrongdoing, or other activity adversely affecting their fitness to contract with Commonwealth agencies.[129]

According to the Management Directive for the program, dated October 25, 2010, agencies are required to only enter into contracts with responsible contractors.[130] Agencies are prohibited from awarding, renewing, extending, amending or assigning contracts to persons who are currently suspended or disbarred. In determining if a contractor is deemed responsible, agencies access the Contractor Responsibility Program (CRP) System which is an internet-based system to collect and disseminate information on contractor obligations; suspensions and debarments and performance issues.[131] The CPR system is administered by the Office of the Administration.

In determining if a contractor is deemed responsible, some of the evaluating factors considered include suspension or disbarment, obligations to the Commonwealth; capacity to perform the task; performances of past or current contracts; financial stability; and any other information, act, or omission indicating they are not responsible.[132]

The contractor is required to certify they are not suspended or disbarred by the Commonwealth, the federal government, or any governmental entity, they have no tax liabilities or other

[126] Ibid. p. 5.
[127] Ibid. p. 7.
[128] PA Office of the Budget. Contractor Responsibility Program. https://www.budget.pa.gov/Programs/Pages/ContractorResponsibilityProgram.aspx.
[129] Executive Order 1990-3. June 29, 1990. https://www.oa.pa.gov/Policies/eo/Documents/1990_3.pdf.
[130] Management Directive. Commonwealth of Pennsylvania Governor's Office. Contractor Responsibility Program. 215.9 Amended. October 25, 2010, p. 6. https://www.oa.pa.gov/Policies/md/Documents/215_9.pdf.
[131] Ibid. p. 3.
[132] Management Directive. Commonwealth of Pennsylvania Governor's Office. Contractor Responsibility Program. 215.9 Amended. October 25, 2010. p12-13.

Commonwealth obligations, and they have filed timely appeals or are in a deferred payment plan if such liabilities exist. If during the time of the contract such liabilities arise, the contractor is required to inform the contracting agency.[133] The typical time span of a contract is two years with the possibility of being extended an additional year for up to three extensions. It appears that the only CPR system reviews conducted are during the awarding of the contracts and upon contract renewals.

A CRP Oversight Committee comprising of members of the Administration is tasked with monitoring, maintaining, and evaluating the program. Agency heads and the Office of General Counsel have the ability to waive any contract provision regarding contractor responsibility.[134]

In addition to the CRP program, the Governor's office has established the Keystone Offset Program (KOP). Through the KOP, the existing tools in the CRP are leveraged against payments to collect certain eligible, delinquent debt owed to the Commonwealth.

MA Providers

Instead, for providers who wish to participate in the MA program, DHS uses an enrollment process that "screens" providers for participating in the program. Providers are required to be licensed and registered by the appropriate state agency. Providers can complete an on-line application and submit supporting documentation. Each provider enrolls in the MA program based on their provider type (physician, nurse, mental health and substance abuse provider, case manager…etc.) and each has different requirements. All providers must be screened according to the ACA screening requirements.[135]

Providers are assigned a categorical risk level (limited, moderate, high). Those assigned as "high" risk are required by the ACA to obtain fingerprint-based criminal background checks which include a Federal Bureau of Investigation criminal background check and a Pennsylvania State Police Criminal Record check.[136] These are implemented through the DHHS regulations at 42 CFR 455, Subpart E-Provider Screening and Enrollment. This section also requires a person with 5% or more direct or indirect ownership interest in a "high" risk provider to submit a set of fingerprints. Failure to do so results in the termination or denial of the application.

The screening requirements of the ACA require all providers to undergo a federal database check. These checks are also to be done on a monthly basis as well as a check against pertinent licensing database. Databases include the Provider Enrollment, Chain and Ownership System (PECOS); Social Security Administration Database; OIG-US Office of Inspector General's List of Excluded Individuals/Entities (LEIE); MEDI-CHECK- Pennsylvania Precluded Provider Database; System for Awards Management (SAMS); and the National Plan & Provider

[133] Ibid. p. 7.
[134] Ibid. p. 8.
[135] Department of Human Services. Welcome to the Pennsylvania (PA) Department of Human Services (DHS). Medical Assistance (MA) and Children's Health Insurance Program (CHIP) On-line Provider Enrollment Application. https://provider.enrollment.dpw.state.pa.us/.
[136] Pennsylvania Department of Human Services, Medical Assistance Bulletin. 99-17-03. March 6, 2017. http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_259400.pdf.

Enumeration System (NPPES). In addition, site visits are conducted on "moderate" and "high" categorical risk providers to verify the information submitted is accurate and determine enrollment requirements are met. A revalidation of enrollment is conducted on every provider every five years. The department does not participate in the U.S. Treasury's Do Not Pay program.

In addition, the department has established the Department of Human Services' Bureau of Program Integrity (BPI) to identify and eliminate fraud, waste and abuse within the MA program. A toll-free fraud hotline (1-844-DHS-TIPS) is established to report suspected cases of fraud. Members of the public may use the tip line to report suspected fraud related to the provision or receipt of public assistance benefits.[137] The bureau not only monitors potential health care fraud and abuse, but it also manages the federally mandated cost containment program and administers the Estate Recovery Program and the Health Insurance Premium Payment Program.

The law requires DHS to publish an annual report on its activities relating to fraud prevention. The report for fiscal year 2017-2018 shows 282 calls were made to report incidents of suspected fraud.[138] The Bureau determined 178 of those calls required further investigation. In addition, 796 reports of suspected fraud were reported via the website and the united states mail, which resulted in 117 investigations. The department reclaimed $842,626.20 from providers as a result of the investigations and reports of fraud.[139]

Based on these reclamations, the existence of the Do Not Pay Program and the Commonwealth's nonparticipation, and the levels of improper payments known and reported by the federal government, we believe efforts should be taken to examine or re-examine the utilization of the Do Not Pay program by all agencies and Commonwealth entities that spend taxpayer dollars, especially those who have contracting relationships. A full review of improper payments throughout state agencies has never been performed. We suggest building upon what is currently in place so such reviews can finally be performed.

Likewise, the system of provider screening should be expanded and built upon to be used on a continuous basis for processing payment reviews. We suggest a better data analytical system be developed to review these payments, on a continual basis, before actual disbursements are made. The Office of the State Treasurer could develop further state specific analytics to enhance the federal Do Not Pay program or develop one that meets or exceeds the federal program. Not utilizing this program to further protect taxpayer dollars is a concern, especially in light of the amount of reported fraud, abuse and waste within the MA program.

[137] Pennsylvania Department of Human Services, Report of Tips of Suspected and Confirmed Provider Fraud Received by the Medical Assistance Fraud Hotline. Act 132 of 2014. 2017-2018 Fiscal Year.
[138] Section 1418(b) of Act 132 of 2014 amended Act 132 of June 13, 1967 (P.L. 31, No. 21).
[139] Pennsylvania Department of Human Services, Report of Tips of Suspected and Confirmed Provider Fraud Received by the Medical Assistance Fraud Hotline. Act 132 of 2014. 2017-2018 Fiscal Year.

Notification of RY 2019 Medicaid Improper Payment Rates

State: **Pennsylvania**
Date: November 26, 2019

The Improper Payments Information Act (IPIA) of 2002[1] requires federal agencies to annually review programs susceptible to significant improper payments to estimate the amount of improper payments, report those estimates to Congress, and submit a report on actions the agency is taking to reduce the improper payments.

Medicaid and the Children's Health Insurance Program (CHIP) were identified as programs at risk for significant improper payments. CMS measures Medicaid and CHIP improper payments through the Payment Error Rate Measurement (PERM) program. Under PERM, reviews are conducted in three component areas (Fee-For-Service [FFS], managed care, and eligibility) for both the Medicaid program and CHIP. The results of these reviews are used to produce national program improper payment rates, as well as state-specific program improper payment rates. The PERM program uses a 17-state, three-year rotation cycle for measuring improper payments, so every state is measured once every three years. Pennsylvania is a Cycle 1 state, measured in Reporting Year (RY) 2019[2], and will be measured again in RY 2022[3].

This letter is an official notice of Pennsylvania's RY 2019 Medicaid program and component improper payment rates, as well as preliminary Medicaid sample sizes and target Medicaid improper payment rates for Pennsylvania's next PERM cycle.

[1]Amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).
[2]Please note that RY 2019 is comprised of reviews of payments made July 1, 2017 – June 30, 2018.
[3]Please note that RY 2022 is comprised of reviews of payments made July 1, 2020 – June 30, 2021.

Pennsylvania Medicaid Improper Payment Rates for RY 2019

Table 1 displays RY 2019 samples sizes, improper payment rates, and confidence intervals for each component.[4]

Table 1: Pennsylvania RY 2019 Medicaid Improper Payment Rates[5]

Component	RY 2019 Sample Size	Improper Payment Rate Estimate	Lower Confidence Interval (95%)	Upper Confidence Interval (95%)
Overall	**1,478**	**14.24%**	**11.49%**	**16.99%**
Fee-For-Service	761	8.74%	6.13%	11.35%
Managed Care	40	0.00%	0.00%	0.00%
Eligibility	677	11.36%	8.67%	14.06%

Please note that improper payments do not necessarily represent expenses that should not have occurred. For example, instances where information required for payment was missing from the claim and/or states did not follow the appropriate process for enrolling providers are cited as improper payments. However, if the missing information had been on the claim and/or had the state complied with the enrollment requirements, then the claims may have been payable. For a breakout of Pennsylvania's improper payments representing claims where CMS determined that the Medicaid payment should not have been made or should have been made in a different amount and are considered a known monetary loss to the program (i.e., not medically necessary, made for a non-covered service, paid to a provider not enrolled in the program), please see Pennsylvania's cycle summary report.

RY 2019 Next Steps

Your state must develop a corrective action plan to address all errors and deficiencies identified during the RY 2019 PERM cycle and CMS expects to recover the federal share on a claim-by-claim basis from the FFS and managed care overpayments found in error. **There will be no eligibility recoveries or disallowances in RY 2019. However, if eligibility disallowances had been in effect for this cycle and if your state had not met the good faith effort requirement established by section 1903(u) of the Social Security Act (i.e., complying with the Medicaid Eligibility Quality Control and corrective action plan requirements outlined in 82 FR 31158), the total extrapolated dollars available for disallowance would be $908,011,385.**

[4] A confidence interval is a range around a measurement that conveys the precision of that measurement. If multiple samples were drawn and reviewed, the results would fall within the ranges shown 95% of the time.

[5] The eligibility component sample is derived from the FFS and managed care universes.

Pennsylvania Preliminary RY 2022 Medicaid Sample Size Estimates

Table 2 displays your state's estimated component sample sizes for RY 2022. Your state's previous Medicaid improper payment rates, expenditures, and payment variation were reviewed to establish the RY 2022 sample sizes.

Table 2: Pennsylvania Preliminary RY 2022 Medicaid Sample Size

Component	RY 2022 Medicaid Sample Size
Overall	**1,338**
Fee-For-Service	586
Managed Care	77
Eligibility	675
Note: The Overall sample size is based on the total number of reviews for the state. Some claims may be sampled for multiple reviews.	

Note that the sample sizes for each component in Table 2 are preliminary. Your state's sample size will be finalized by CMS at the beginning of the RY 2022 cycle.

Pennsylvania Medicaid Target Improper Payment Rates for RY 2022

OMB guidance requires agencies to set targets for future erroneous payment rates. National Medicaid targets are negotiated by the Department of Health & Human Services, OMB, and CMS. CMS calculates state-specific improper payment rate targets to allow CMS to partner with states to meet the national Medicaid improper payment rate target. Table 3 shows Pennsylvania's target improper payment rates for the next cycle.

Table 3: Pennsylvania RY 2022 Medicaid Target Improper Payment Rates

Pennsylvania	FFS	Managed Care	Eligibility	Overall
Target RY 2022 Rate	5.12%	0.00%	3.00%	4.84%

For the RY 2022 targets, states are asked to reduce their FFS and managed care component improper payment rates by 50 percent of the difference between the current RY 2019 rate and an anchor rate (anchor rates are currently set at 1.5 percent for FFS, and 1 percent for managed care). If the current rate is below the anchor, the RY 2022 target is the same as the current rate. Eligibility targets are set at 3 percent for every state, as the 3 percent threshold for state eligibility-related improper payments in any year is established by section 1903(u) of the Social Security Act.

DNP STATE FACT SHEET

Do Not Pay® Business Center

The U.S. Department of the Treasury, the Bureau of the Fiscal Service (Fiscal Service) operates a resource dedicated to preventing and detecting improper payments—the Do Not Pay® Business Center (DNP). DNP is authorized and governed by the Payment Integrity Information Act of 2019 (PIIA), and several Office of Management and Budget (OMB) memoranda and circulars. The authorities generally belong to OMB, which delegated the operational aspects to the Department of the Treasury.

PIIA gives DNP the authority to work directly with State Agencies that manage federally funded state-administered programs such as, but not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Unemployment Insurance. Establishing a relationship with DNP can assist with your current pre-award and pre-payment verification of beneficiaries, providers, and vendors.

The Working System and DNP together create one element of the larger multi-agency government-wide DNP® Initiative and centrally provides a variety of data matching and data analytics services to support federally funded state-administered programs in their efforts to strengthen internal controls and payment integrity initiatives.

Goals of Do Not Pay®

- Verify eligibility of a vendor, grantee, loan recipient, or beneficiary to receive federal payments.
- Save time by providing accurate and actionable information about payments.
- Save money with cutting-edge techniques to monitor the integrity of payments.
- Reduce errors by assisting agencies in identifying, preventing, and detecting improper payments.

Databases You Can Search

- American InfoSource (AIS) Obituary Death Data - Commercial
- American InfoSource (AIS) Probate Death Data - Commercial
- Department of Defense (DOD) Death Data - Public
- Department of State (DOS) Death Data - Public
- Death Master File (DMF) - Public
- List of Excluded Individuals & Entities (LEIE) - Public & Restricted
- Office of Foreign Assets Control (OFAC) - Public
- System for Award Management (SAM) Exclusion Records - Public & Restricted

Components of Do Not Pay®

Web-based Portal

The DNP Portal lets you search multiple data sources at ***NO COST***. Portal users can: Search for a single person or entity, batch their searches, and set up the Portal to regularly monitor the databases for specific individuals or entities.

Data Analytics

Data Analytics provides ***FREE*** advanced payment analysis services to federal agencies and federally funded state administered programs to help combat improper payments.

Agency Support

Works with agencies to onboard, determine and target the best DNP processes and data sources to meet agencies' program needs.

Contact Us:

jon.ortiz@fiscal.treasury.gov | 855-837-4391 | fiscal.treasury.gov/dnp/states

The U.S. Department of the Treasury, the Bureau of the Fiscal Service assists federal agencies with the prevention, collection, and resolution of debts owed to government agencies. Additionally, we provide debt collection services to the states. Debt Management Services (DMS) is the business area responsible for administering programs and services related to improper payments, receivables management, and delinquent debt collection.

July 2021

DNP Data Analytics Services

DNP provides free advanced payment analysis services to help combat improper payments.

Analyze payment data for indicators that a payment is being made in error or is vulnerable to abuse

Develop risk scoring to help agencies prioritize and manage reviewing and investigating cross-matches

Screen payees for eligibility such as identifying deceased beneficiaries

Our Experience:

The right payment to the right recipient at the right time for the right purpose.

DNP provides services to:

Federal Agencies

Federally funded state-administered programs

Office of Inspectors General (OIG)

Council of Inspectors General on Integrity and Efficiency (CIGIE)

Pandemic Response Accountability Committee (PRAC)

Special Inspector General for Pandemic Recovery (SIGPR)

Data Analytics Data Sources

In addition to data sources available in the Portal, Analytics also has access to:

Internal Revenue Service's Tax-Exemption Lists

Contains records of organizations eligible and ineligible to receive tax-deductible charitable contributions and grants targeting tax-exempt entities.

- ⇒ 990-N (e-Postcard) - Authorized organizations with under $50,000 in contributions
- ⇒ Publication 78 - Authorized organizations with over $50,000 in contributions

Inquiries

For additional information about data analytics for federally funded state-administered programs and the Do Not Pay® Business Center, email Jon Ortiz at jon.ortiz@fiscal.treasury.gov

Excerpt From Performance Audit Report
Medicaid Provider Eligibility - Issued 2/2021

EXECUTIVE SUMMARY

PURPOSE

The purpose of this audit was to determine whether the Medicaid Provider Enrollment process ensures that only qualified providers are approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program.

The audit scope included the **initial enrollment** of providers, **re-verification** of providers, and **ongoing discipline checks** of professional licenses for state fiscal year 2019.

BACKGROUND

Medicaid is a joint federal and state funded program that provides health insurance coverage to eligible low-income parents, children, seniors, and people with disabilities. Medicaid pays providers (such as doctors and pharmacies) for services provided to eligible beneficiaries.

To combat potential provider fraud, waste, and abuse, the federal Centers for Medicare and Medicaid Services (CMS) issued requirements for states to follow when screening and enrolling providers. Compliance with the requirements is crucial for screening out providers at risk of committing fraud or providing services without professional credentials (e.g. a medical license). For example, the Government Accountability Office (GAO) reported that "**States' non-compliance with provider screening and enrollment requirements contributed to over a third of the $36.3 billion estimated improper payments** in Medicaid in 2018."[1]

The NC Department of Health and Human Services' (Department) Division of Health Benefits (Division) is responsible for screening and enrolling Medicaid providers in accordance with CMS requirements. The Division outsources most of the provider enrollment process to General Dynamics Information Technology – GDIT (Contractor), **although the Division has ultimate responsibility**.

KEY FINDINGS

The Medicaid Provider Enrollment process did not ensure that only qualified providers[2] were approved to provide services to Medicaid beneficiaries and to receive payments from North Carolina's Medicaid program. Specifically, the Division:

- Did not identify and remove enrolled providers from the Medicaid program who had their professional license suspended or terminated.[3]
- Allowed all providers who had professional license limitations to remain enrolled in the Medicaid program.

---

1 GAO, CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements, October 2019.

2 Doctors, pharmacies, hospitals, mental health counselors, durable medical equipment suppliers, and personal care services are all examples of providers.

3 Includes providers with Non-Practice Agreements (NPAs). An NPA is an agreement between a state licensing board and a licensee in which the licensee cannot practice or perform any act that requires that license in North Carolina while the agreement is in effect.

EXECUTIVE SUMMARY (CONCLUDED)

- Did not ensure that its contractor verified all professional credentials during the Medicaid provider enrollment re-verification process.[4]
- Did not require its contractor to verify provider ownership information during the Medicaid provider enrollment re-verification process.

As a result, there was an increased risk that providers whose actions posed a threat to patient safety were enrolled in Medicaid and could receive millions of dollars in improper payments[5] from the State.

KEY RECOMMENDATIONS

- The Division should immediately remove all providers who have suspended or terminated professional licenses from the Medicaid program.
- The Division should immediately remove all providers from the Medicaid program who have professional license limitations and pose threats to the safety of beneficiaries.
- The Division should remove all providers who do not have the appropriate professional credentials required by the State Plan[6] from the Medicaid program.
- The Division should verify the accuracy of all provider ownership disclosures so that background checks can be performed.[7] When providers submit inaccurate information but are still allowed to enroll, the Division should document the reasons why termination or denial of enrollment is not in the best interests of the Medicaid program.

MATTERS FOR FURTHER CONSIDERATION

- The Division should improve its documentation supporting the approval of higher-risk providers.[8] The Division should also consider increasing the oversight of these same providers.
- The Division should consider increasing its oversight of the enrollment of providers who operate under Local Management Entities/Managed Care Organizations (LME-MCOs).[9]

The key findings and recommendations in this summary may not be inclusive of all the findings and recommendations in this report.

---

4 The Medicaid re-verification process is separate from the initial enrollment process. While the Division directly source verifies credentials during the initial enrollment process, it does not in the re-verification process.

5 Any payment that should not have been made or that was made in an incorrect amount due to administrative error, fraud, waste, or abuse.

6 An agreement between a state and the federal government describing how that state administers its Medicaid program. It gives an assurance that a state will abide by federal rules and may claim federal matching funds for its program activities. The State Plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state.

7 Providers are required to disclose all owners, managing employees, or others with controlling interest (collectively referred to as ownership information).

8 When adverse actions such as a criminal history or a professional license limitation of a provider are identified in the screening and enrollment process, General Dynamics Information Technology (GDIT) sends these "flagged, higher-risk" provider applications to the Division for further review and to approve or deny the provider to participate in NC Medicaid.

9 LME/MCOs are political subdivisions of the State that contract with the Division to provide managed care behavioral health services (mental health, substance abuse, and developmental disability) for Medicaid beneficiaries through a network of licensed practitioners and provider agencies.

United States Government Accountability Office

Report to Congressional Committees

March 2020

PAYMENT INTEGRITY

Federal Agencies' Estimates of FY 2019 Improper Payments

GAO-20-344

March 2020

PAYMENT INTEGRITY

Federal Agencies' Estimates of FY 2019 Improper Payments

GAO Highlights

Highlights of GAO-20-344, a report to congressional committees

Why GAO Did This Study

Improper payments—payments that should not have been made or that were made in incorrect amounts—continue to be an area of fiscal concern in the federal government. Improper payments have been estimated to total almost $1.7 trillion government-wide from fiscal years 2003 through 2019.

From fiscal year 2003 through 2016, a government-wide estimate and rate had been included in government-wide financial reports based on the programs and activities that reported estimates. However, financial reports for fiscal years 2017 and 2018 did not include a government-wide improper payment estimate or rate. Agency-reported improper payment estimates are posted on the Office of Management and Budget's Paymentaccuracy.gov website.

IPERA requires IGs to annually determine and report on whether executive branch agencies complied with six IPERA criteria, such as conducting risk assessments and publishing and meeting improper payment reduction targets.

This report summarizes (1) federal agencies' reported improper payment estimates for fiscal years 2018 and 2019, and reasons for substantial changes between years, and (2) CFO Act agencies compliance with IPERA criteria for fiscal year 2018, as determined by their IGs, and overall compliance trends for fiscal years 2016 through 2018. GAO summarized (1) improper payment estimates from agency financial reports and Paymentaccuracy.gov and (2) information on CFO Act agencies' IPERA compliance reported in IGs' fiscal year 2018 IPERA compliance reports and prior GAO reports.

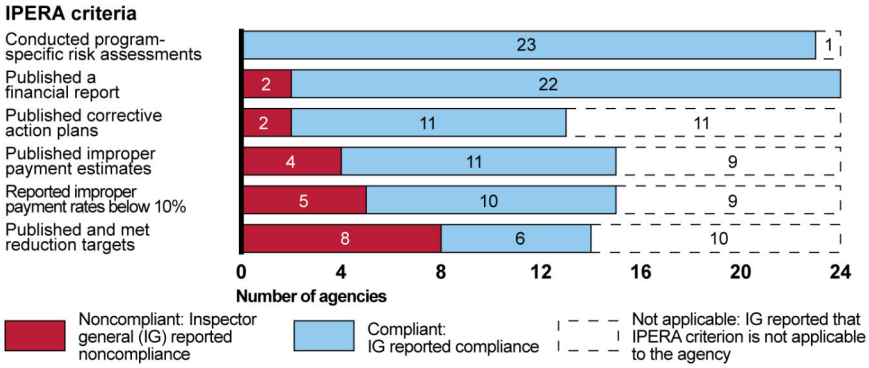
View GAO-20-344. For more information, contact Beryl H. Davis at (202) 512-2623 or davisbh@gao.gov.

What GAO Found

Agency-reported improper payment estimates for fiscal year 2019 totaled about $175 billion, based on improper payment estimates reported by federal programs, an increase from the fiscal year 2018 total of $151 billion. Of the $175 billion, about $121 billion (approximately 69 percent) was concentrated in three program areas: (1) Medicaid, (2) Medicare, and (3) Earned Income Tax Credit. About $74.6 billion (approximately 42.7 percent) of the government-wide estimate was reported as monetary loss, an amount that should not have been paid and in theory should or could be recovered. However, the federal government's ability to understand the full scope of its improper payments is hindered by incomplete, unreliable, or understated agency estimates; risk assessments that may not accurately assess the risk of improper payment; and agencies not complying with reporting and other requirements in the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

Eight years after the implementation of IPERA, half of the 24 Chief Financial Officers Act of 1990 (CFO Act) agencies—whose estimates account for over 99 percent of the federal government's reported estimated improper payments—complied with IPERA overall for fiscal year 2018, as reported by their inspectors general (IG). Based on the IGs' fiscal year 2018 compliance reports, agencies were most frequently reported as noncompliant with the requirement to publish and meet annual targets for improper payment reduction. Out of the 14 agencies for which this requirement was applicable, eight agencies were noncompliant. The second most-frequently reported area of noncompliance related to the requirement for agencies' reported improper payment rates to be below 10 percent for programs that published estimates. Out of the 15 agencies for which this requirement was applicable, five agencies were noncompliant.

Chief Financial Officers Act of 1990 Agencies' Fiscal Year 2018 Compliance with IPERA Criteria, as Reported by Their IGs



Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' fiscal year 2018 Improper Payments Elimination and Recovery Act of 2010 (IPERA) compliance reports. | GAO-20-344

The IGs reported that 21 programs were noncompliant with IPERA for each of the past 3 fiscal years (2016–2018). These programs represented about $78 billion, or approximately 52 percent of the $151 billion government-wide reported improper payment estimates for fiscal year 2018.

Contents

Figures

Abbreviations

AFR	agency financial report
CFO Act	Chief Financial Officers Act of 1990
CIGIE	Council of the Inspectors General on Integrity and Efficiency
DOD	Department of Defense
EITC	Earned Income Tax Credit
HHS	Department of Health and Human Services
IG	inspector general
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPIA	Improper Payments Information Act of 2002
OMB	Office of Management and Budget
PAR	performance and accountability report
PERM	Payment Error Rate Measurement
SSA	Social Security Administration
TANF	Temporary Assistance for Needy Families
Treasury	Department of the Treasury
VA	Department of Veterans Affairs

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

March 2, 2020

Congressional Committees

Improper payments—payments that should not have been made or that were made in incorrect amounts—continue to be an area of fiscal concern in the federal government. Improper payments have been estimated to total almost $1.7 trillion government-wide from fiscal years 2003 through 2019.[1] We have reported that improper payment estimates themselves may not be reliable because the federal government is unable to determine the full extent to which improper payments occur and reasonably ensure that appropriate actions are taken to reduce them.[2] From fiscal years 2003 through 2016, a government-wide improper payment estimate and rate had been included in the government-wide financial reports based on the programs and activities that reported estimates. However, government-wide financial reports for fiscal years

[1]As required by the Improper Payments Information Act of 2002 (IPIA), Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002), *codified as amended at* 31 U.S.C. § 3321 note, certain agencies were required to start reporting improper payment estimates beginning for fiscal year 2003. Under IPIA, as amended, an improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Office of Management and Budget (OMB), *Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement*, OMB Memorandum M-18-20 (Washington, D.C.: June 26, 2018), effective for fiscal year 2018 reporting, also provides that when an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment should also be considered an improper payment. Since the conclusion of fiscal year 2019, Congress has passed the Payment Integrity Information Act of 2019 (PIIA), S. 375, 116th Cong. This bill would repeal IPIA, IPERA, and IPERIA and would enact a new Subchapter in Title 31 of the U.S. Code, containing substantially similar provisions. Under PIIA, some details would change; however, the core structure of executive agency assessment, estimation, and reporting of improper payments would remain consistent with the statutory framework in effect during fiscal year 2019, as described in this report.

[2]GAO, *Financial Audit: Fiscal Years 2018 and 2017 Consolidated Financial Statements of the U.S. Government*, GAO-19-294R (Washington, D.C.: Mar. 28, 2019).

2017 and 2018 did not include a government-wide improper payment estimate or improper payment rate.[3]

The Improper Payments Elimination and Recovery Act of 2010 (IPERA), among other things, requires federal agencies' inspectors general (IG) to annually determine and report on whether the agencies under their jurisdiction have complied with IPERA criteria.[4] IGs' annual IPERA compliance reports help reasonably ensure that improper payment estimates are accurate, reliable, and complete and that Congress has information on agencies' efforts to address improper payments. We previously reported on agencies' compliance with IPERA for fiscal years 2011 through 2017, as reported by the agencies' IGs.[5]

We performed our work under the authority of the Comptroller General to conduct evaluations on his own initiative and to assist Congress with its oversight responsibilities.[6] This report (1) summarizes federal agencies' reported improper payment estimates for fiscal years 2018 and 2019,[7]

[3]GAO-19-294R, and GAO, *Financial Audit: Fiscal Years 2017 and 2016 Consolidated Financial Statements of the U.S. Government*, GAO-18-316R (Washington, D.C.: Feb. 15, 2018).

[4]IGs are required to issue compliance reports under IPERA, Pub. L. No. 111-204, § 3, 124 Stat. 2224, 2232 (July 22, 2010), *codified at* 31 U.S.C. § 3321 note. Per OMB Memorandum M-18-20, the compliance reports are due on May 15 following the IGs' review of the agencies' annual agency financial reports or performance and accountability reports. The most recent IG compliance reports available were issued in 2019 for agencies' fiscal year 2018 compliance with IPERA criteria.

[5]GAO, *Improper Payments: CFO Act Agencies Need to Improve Efforts to Address Compliance Issues*, GAO-16-554 (Washington, D.C.: June 30, 2016); *Improper Payments: Additional Guidance Could Provide More Consistent Compliance Determinations and Reporting by Inspectors General*, GAO-17-484 (Washington, D.C.: May 31, 2017); and *Improper Payments: Additional Guidance Needed to Improve Oversight of Agencies with Noncompliant Programs*, GAO-19-14 (Washington, D.C.: Dec. 7, 2018).

[6]31 U.S.C. § 717(b).

[7]Although the improper payment estimates were reported in agencies' fiscal year 2019 financial reports, the payments included in the population from which the estimates were derived did not always occur in fiscal year 2019. For example, the Social Security Administration's fiscal year 2019 improper payment estimates are based on payment data from October 2017 through September 2018.

and the reasons they identified for substantial changes between years,[8] and (2) discusses the extent to which Chief Financial Officers Act of 1990 (CFO Act) agencies complied with the six IPERA criteria for fiscal year 2018, and overall IPERA compliance trends evident for fiscal years 2016 through 2018, as reported by their IGs.[9]

To summarize federal agencies' improper payment estimates for fiscal years 2018 and 2019, we compiled improper payment estimates from agency financial reports (AFR) or performance and accountability reports (PAR) and the Office of Management and Budget's (OMB) Paymentaccuracy.gov website.[10] We summarized and compared the estimates to identify any substantial changes that occurred between the 2 fiscal years. For such changes, we reviewed the agency's AFR and PAR to determine the reason(s), if any, that the agency identified.

To determine the extent to which CFO Act agencies complied with the six criteria listed in IPERA for fiscal year 2018, we reviewed the IPERA compliance reports that the agencies' respective IGs issued. We summarized compliance information from the fiscal year 2018 reports and used information from our prior reports on IPERA compliance to identify compliance trends in fiscal years 2016 through 2018. We corroborated the results of our analysis with the CFO Act agencies and their IGs. Based on the CFO Act agencies' AFRs and PARs and their IGs' IPERA compliance reports for fiscal years 2016 through 2018, we identified the agency programs reported as noncompliant for 3 or more consecutive years as of fiscal year 2018 and the related estimate of improper

[8]For the purpose of this report, we define "substantial change" as a change in (1) the improper payment estimate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than $1 billion or (2) the improper payment rate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than 5 percent and the fiscal year 2019 improper payment estimate is over $100 million.

[9]The CFO Act, Pub. L. No. 101-576, 104 Stat. 2838 (Nov. 15, 1990), among other things, established chief financial officers to oversee financial management activities at 23 major executive departments and agencies. The list now includes 24 entities, which are often referred to collectively as CFO Act agencies, and is *codified as amended at* 31 U.S.C. § 901.

[10]An official U.S. government website managed by OMB, www.Paymentaccuracy.gov contains, among other things, information about current and historical rates and amounts of improper payments.

payments associated with those programs for fiscal year 2018.[11] We focused on the 24 CFO Act agencies because the improper payment estimates for those agencies accounted for over 99 percent of the federal government's reported estimated improper payments for fiscal year 2018.

We conducted this performance audit from July 2019 to March 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Improper Payments Information Act of 2002 (IPIA), as amended by IPERA and the Improper Payments Elimination and Recovery Improvement Act of 2012,[12] requires executive branch agencies, among other things, to (1) review all programs and activities and identify those that may be susceptible to significant improper payments (commonly referred to as conducting a risk assessment), (2) publish improper payment estimates for those programs and activities that the agency identified as being susceptible to significant improper payments, (3) implement corrective actions to reduce improper payments and set reduction targets, and (4) report on the results of addressing the foregoing requirements.

IPERA also requires executive agencies' IGs to annually determine and report on whether their respective agencies complied with six IPERA-related criteria. If an agency does not meet one or more of the six IPERA criteria for any of its programs or activities, the IG considers the agency to be noncompliant overall. The six criteria are as follows:

1. **publish a financial report** in the form and including all content required by OMB—typically an AFR or a PAR—for the most recent fiscal year, and post that report on the agency website;

[11]Per IPERA and OMB Memorandum M-18-20, an agency with a program or activity that is reported noncompliant for 3 or more consecutive fiscal years is required to submit to Congress either (1) a reauthorization proposal for the program or activity or (2) the proposed statutory changes necessary to bring the program or activity into compliance.

[12]Pub. L. No. 112-248, 126 Stat. 2390 (Jan. 10, 2013).

2. **conduct a program-specific risk assessment**, if required, for each program or activity that conforms with IPIA, as amended;[13]
3. **publish improper payment estimates** for all programs and activities deemed susceptible to significant improper payments;[14]
4. **publish corrective action plans** for those programs and activities assessed to be susceptible to significant improper payments;
5. **publish and meet annual reduction targets** for all programs and activities assessed to be at risk for significant improper payments; and
6. **report a gross improper payment rate of less than 10 percent** for each program and activity for which an improper payment estimate was published.

As described above, not all criteria are applicable to every agency. For example, if an agency publishes a financial report and conducts a risk assessment and determines that none of its programs or activities are susceptible to significant improper payments, then the remaining criteria would not be applicable.

OMB plays a key role in implementing laws related to improper payment reporting. As required by statute, OMB has established guidance for federal agencies on estimating, reporting, reducing, and recovering improper payments. Such guidance includes OMB Circular A-123 Appendix C, *Requirements for Payment Integrity Improvement*, which also includes guidance to IGs on determining agency compliance with

[13]IPIA, as amended, requires that agencies conduct program and activity risk assessments at least once every 3 fiscal years. In addition, per OMB Memorandum M-18-20, for programs that are deemed not susceptible to significant improper payments, agencies must perform a risk assessment at least once every 3 fiscal years unless there is a significant change in legislation, a significant increase in the program's funding level, or both. A program for which an improper payment estimate is being reported does not need an additional improper payment risk assessment.

[14]Under IPIA, as amended, "significant improper payments" are defined as gross annual improper payments (i.e., the total amount of overpayments and underpayments) in a program exceeding either (1) both 1.5 percent of program outlays and $10 million of all program or activity payments made during the fiscal year reported or (2) $100 million (regardless of the improper payment percentage of program outlays). OMB may also determine on a case-by-case basis that certain programs that do not meet this threshold would still be subject to improper payments reporting. In addition, statutes for disaster relief funding have established a lower threshold for certain disaster relief improper payment reporting requirements.

IPERA.[15] The Council of the Inspectors General on Integrity and Efficiency (CIGIE) also published guidance in July 2019 to assist IGs who are required to conduct an annual improper payment review under IPERA.[16]

We continued to report improper payments as a material weakness in internal control in our audit report on the U.S. government's consolidated financial statements for fiscal years 2018 and 2017 because of the federal government's inability to determine the full extent to which improper payments occur and reasonably ensure that appropriate actions are taken to reduce them.[17] We have also reported that estimation of improper payments is key to understanding the extent of the problem and to developing effective corrective actions to address it.[18] However, the government's ability to understand the full scope of its improper payments is hindered by incomplete, unreliable, or understated estimates; risk assessments that may not accurately assess the risk of improper payment; and noncompliance with criteria listed in IPERA. For example, we previously reported that issues and inconsistencies we identified in selected agencies' processes for estimating improper payments may affect the quality of their estimates.[19] In addition, certain IGs have reported issues with their agencies' reported improper payment estimates that were caused by insufficient sampling methods and flawed estimation methodologies for calculating and reporting improper payment estimates.

[15]OMB Memorandum M-18-20.

[16]Council of the Inspectors General on Integrity and Efficiency, *Guidance for Improper Payments Elimination and Recovery Act Compliance Reviews* (July 2019). CIGIE is an independent entity established within the executive branch to address integrity, economy, and effectiveness issues that transcend individual government agencies and aid in establishing a professional, well-trained, and highly skilled workforce in the offices of inspectors general.

[17]GAO-19-294R. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis.

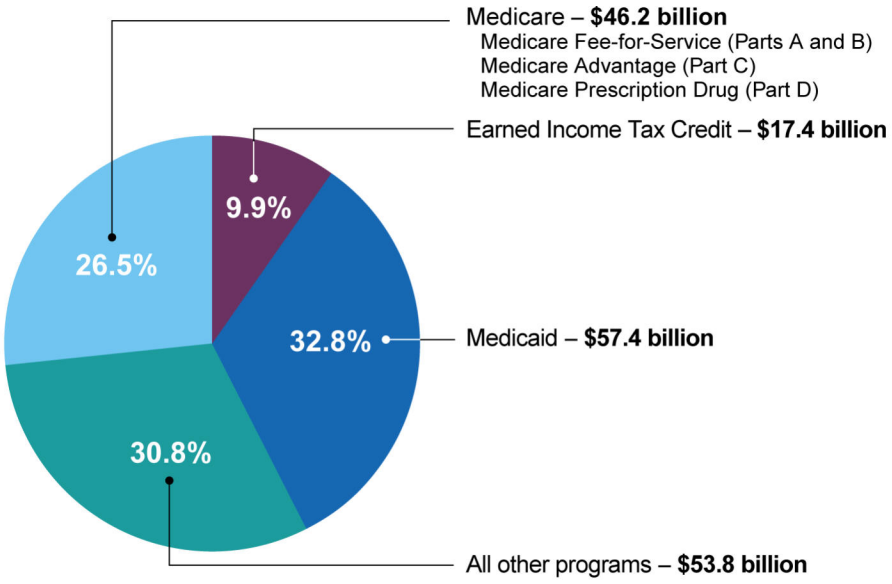
[18]GAO, *Improper Payments: Actions and Guidance Could Help Address Issues and Inconsistencies in Estimation Processes*, GAO-18-377 (Washington, D.C.: May 31, 2018).

[19]GAO-18-377.

Federal Agencies' Estimates of Fiscal Year 2019 Improper Payments Totaled $175 Billion

Based on agencies that reported improper payment estimates in their AFRs and PARs, government-wide estimated improper payments for fiscal years 2019 and 2018 totaled about $175 billion and $151 billion, respectively. See appendix I for the reported amounts by agency and program for fiscal years 2019 and 2018. As shown in figure 1, of the $175 billion for fiscal year 2019, about $121 billion (approximately 69 percent) is concentrated in three program areas: (1) Medicaid, totaling about $57.4 billion (approximately 32.8 percent);[20] (2) Medicare (comprised of three reported programs: Fee-for-Service (Parts A and B), Advantage (Part C), and Prescription Drug (Part D)), totaling about $46.2 billion (approximately 26.5 percent); and (3) Earned Income Tax Credit (EITC), totaling about $17.4 billion (approximately 9.9 percent).

Figure 1: Programs with the Largest Percentage of Total Reported Government-Wide Estimates of Improper Payments for Fiscal Year 2019



Source: GAO analysis of Office of Management and Budget data and fiscal year 2019 agency financial reports. | GAO-20-344

[20]The Department of Health and Human Services (HHS) estimates improper payments for the Medicaid program across three components: (1) fee-for-service, (2) managed care, and (3) eligibility. In fiscal year 2019, HHS reported improper payment rates for each of these components but did not report separate improper payment amounts.

Key information contained in agency AFRs and PARs regarding the types and causes of fiscal year 2019 estimates of improper payments, and reasons for significant changes in reported estimates from fiscal year 2018, are summarized as follows:

- The $175 billion total reported government-wide estimates for fiscal year 2019 is broken down per OMB's Paymentaccuracy.gov Data Call Instructions by type as follows:[21]
  - overpayments, totaling about $79.1 billion (approximately 45.2 percent);
  - underpayments, totaling about $12.9 billion (approximately 7.4 percent);
  - unknown, totaling about $74.1 billion (approximately 42.4 percent); and
  - technically improper due to statute or regulation, totaling about $8.7 billion (approximately 5 percent).
- About $74.6 billion (approximately 42.7 percent) of the government-wide estimates was reported as monetary loss.[22]
- About $151.2 billion (approximately 86.6 percent) of the reported government-wide improper payment estimates for fiscal year 2019 related to root causes that occurred in the three areas below. See appendix II for details on the root causes that agencies identified for their reported improper payment estimates for fiscal year 2019.
  - **Insufficient documentation to determine payment accuracy.** About $74.1 billion (approximately 42.4 percent) resulted from situations where the agency lacked supporting documentation necessary to verify the accuracy of the payments.

[21]The Fiscal Year 2019 OMB Paymentaccuracy.gov Data Call Instructions provides specific instructions on the improper payment estimation breakout by type to provide agencies with guidance in addition to that provided in OMB, *Financial Reporting Requirements*, OMB Circular No. A-136 (revised June 28, 2018) at II.4.5, on reporting estimates for programs or activities that are identified as susceptible to improper payments. "Unknown" is the estimated amount within the agency's improper payment estimate that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation. "Technically improper due to statute or regulation" represents a payment made to the right recipient for the right amount but the payment process failed to follow applicable regulation and statute.

[22]According to OMB Circular No. A-136, "monetary loss" represents an amount that should not have been paid and in theory should or could be recovered.

- **Administrative or process error.** About $39.1 billion (approximately 22.4 percent) resulted from incorrect data entry, classifying, or processing of applications or payments.
- **Inability to authenticate eligibility.** About $38 billion (approximately 21.8 percent) resulted from the agency not being able to authenticate eligibility criteria.

- The fiscal year 2019 total reported government-wide estimated improper payments, among programs that reported estimates, increased by about $24 billion from the fiscal year 2018 total reported. While decreases in estimated improper payments were reported for several programs, these were offset by increases for certain other programs. Between fiscal years 2018 and 2019, six programs had an increase and five programs had a decrease of over $1 billion in estimated improper payments. Appendix III provides information on all the programs that had a substantial change in estimated improper payments between fiscal years 2018 and 2019 and the reasons for those changes as reported in agency AFRs.[23] Examples of substantial changes in improper payments and the reasons for such changes that agencies provided in their AFRs include the following:
  - Department of Health and Human Services (HHS) reported an increase in the total estimated improper payments for the Medicaid program in excess of $21.1 billion for fiscal year 2019. The majority of the increase in the total estimated improper payments for the Medicaid program was due to HHS's reintegration of the eligibility component of the Payment Error Rate Measurement (PERM) for Medicaid for fiscal year 2019. From fiscal years 2015 through 2018, HHS did not estimate improper payments attributed to eligibility determinations, but did include a proxy estimate, which was the last reported rate in fiscal year 2014 for the eligibility component, while HHS worked to update this component.

    For fiscal year 2019, HHS estimated improper payments attributed to eligibility determinations in 17 states (about one-third of all states). HHS's national eligibility estimated improper payment rate still includes a proxy estimate for 34 remaining states that have

[23]For the purpose of this report, we define "substantial change" as a change in (1) the improper payment estimate between fiscal years 2018 and 2019 that is equal to or greater than $1 billion or (2) the improper payment rate between fiscal years 2018 and 2019 that is equal to or greater than 5 percent and the fiscal year 2019 improper payment estimate is over $100 million.

not yet been measured since the reintegration of the PERM eligibility component.

HHS reported that most eligibility errors identified through the new measurement process were due to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements.[24] HHS also reported that these insufficient documentation situations were related primarily to income or resource verifications. HHS's fiscal year 2019 AFR noted that another significant cause for estimated Medicaid improper payments is errors resulting from state noncompliance with provider screening and enrollment requirements.

- The Department of the Treasury (Treasury) began reporting improper payment estimates for fiscal year 2019 for two programs deemed newly susceptible to significant improper payments. Specifically, Treasury reported about $7.2 billion and $2.1 billion in improper payment estimates for Additional Child Tax Credit and American Opportunity Tax Credit, respectively.[25]
- In addition, HHS reported a decrease in the total estimated improper payments for the Medicare Fee-for-Service (Parts A and B) program of about $2.7 billion. According to HHS's fiscal year 2019 AFR, the decrease in the estimate is due to a reduction in estimated improper payments for home health; Medicare Fee-for-Service Part B; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies claims.

As stated earlier, the federal government's ability to understand the full scope of its improper payments is hindered by incomplete, unreliable, or

[24]Generally, state Medicaid agencies must renew beneficiaries' Medicaid coverage by redetermining their eligibility every 12 months. A state Medicaid agency must also promptly redetermine eligibility when it receives information about a change in a beneficiary's circumstances that may affect eligibility.

[25]In April 2018, the Internal Revenue Service implemented GAO's recommendation to develop a comprehensive operational strategy to address compliance issues with refundable tax credits such as the Additional Child Tax Credit and American Opportunity Tax Credit. In the recommendation, we stated that the strategy could include use of error rates and amounts. See GAO, *Refundable Tax Credits: Comprehensive Compliance Strategy and Expanded Use of Data Could Strengthen IRS's Efforts to Address Noncompliance*, GAO-16-475 (Washington, D.C.: May 27, 2016).

understated agency estimates and risk assessments that may not accurately assess the risk of improper payment. For example,

- certain federal programs and activities that agencies determined to be at risk for significant improper payments did not report estimates of improper payments for fiscal year 2019, including the Premium Tax Credit and Temporary Assistance for Needy Families programs, and
- as we previously reported, the Department of Defense (DOD) lacks quality assurance procedures to ensure the completeness and accuracy of the payment populations from which it develops improper payment estimates.[26]

CFO Act Agencies' Reported Compliance with IPERA

Half of the CFO Act Agencies Were Reported as Compliant for Fiscal Year 2018

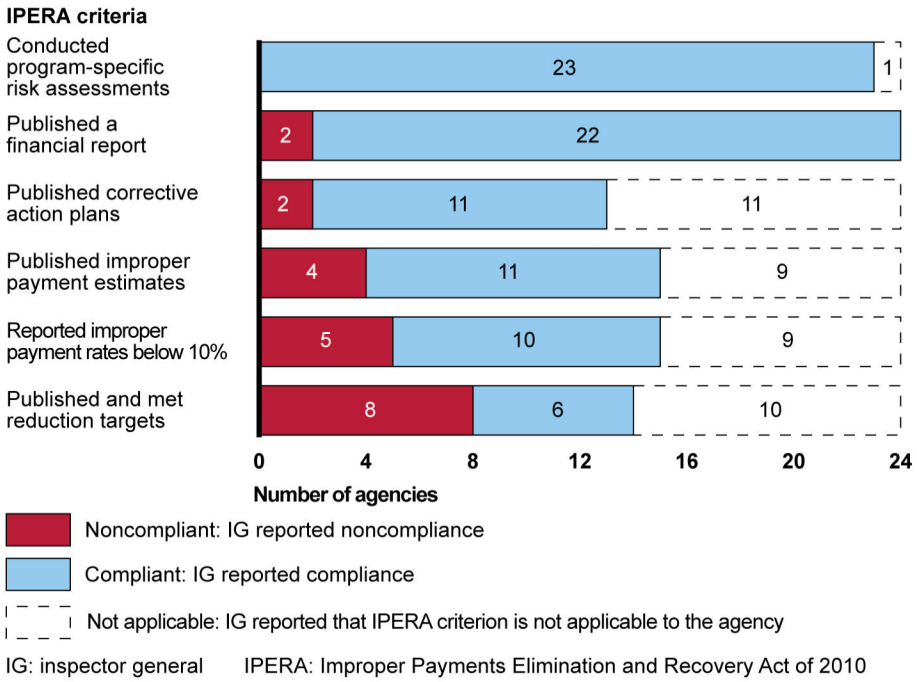
Eight years after the implementation of IPERA, half of the 24 CFO Act agencies were compliant with IPERA overall for fiscal year 2018, as reported by their IGs. See appendix IV for each CFO Act agency's overall compliance with IPERA. With regard to the six IPERA criteria, as shown in figure 2, IGs reported all agencies as compliant with the requirement to conduct program-specific risk assessments if it was applicable to the agency. In addition, 22 of 24 agencies (92 percent) met the requirement to publish a PAR or AFR.

Based on the IGs' fiscal year 2018 compliance reports, agencies were most frequently reported as noncompliant with the IPERA requirement to publish and meet annual targets for improper payment reduction. Out of the 14 agencies for which this requirement was applicable, IGs for eight

[26]In May 2013, we reported on major deficiencies in DOD's process for estimating fiscal year 2012 improper payments in the Defense Finance and Accounting Service Commercial Pay program, including deficiencies in identifying a complete and accurate population of payments; see GAO, *DOD Financial Management: Significant Improvements Needed in Effort to Address Improper Payment Requirements*, GAO-13-227 (Washington, D.C.: May 13, 2013). The foundation of reliable statistical sampling estimates is a complete, accurate, and valid population from which to sample. As of June 2019, DOD's efforts to establish and implement key quality assurance procedures to ensure the completeness and accuracy of sampled populations were still in progress.

agencies (57 percent) reported that their agencies were noncompliant.[27] The second most-frequently reported area of noncompliance related to the IPERA requirement for agencies' reported improper payment rates to be below 10 percent for programs that published estimates. Out of the 15 agencies for which this requirement was applicable, IGs for five agencies (33 percent) reported that their agencies were noncompliant. See appendix IV for additional details on each CFO Act agency's compliance with the six IPERA criteria for fiscal year 2018, as reported by their IG.

Figure 2: Chief Financial Officers Act of 1990 Agencies' Fiscal Year 2018 Compliance with IPERA Criteria, as Reported by Their IGs



IG: inspector general IPERA: Improper Payments Elimination and Recovery Act of 2010

Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' fiscal year 2018 IPERA compliance reports. | GAO-20-344

In addition, IGs for certain CFO Act agencies reported quality issues in their agencies' reporting of improper payment data. Although the issues did not result in noncompliance with the related IPERA criterion, the IGs noted these as areas that need improvement. For example, one agency

[27]Although Treasury reported an improper payment estimate for its EITC program, according to the Treasury IG's IPERA compliance report, Treasury and OMB developed a series of EITC supplemental measures for use in lieu of reduction targets. As such, the Treasury IG determined that the requirement to publish and meet reduction targets was not applicable.

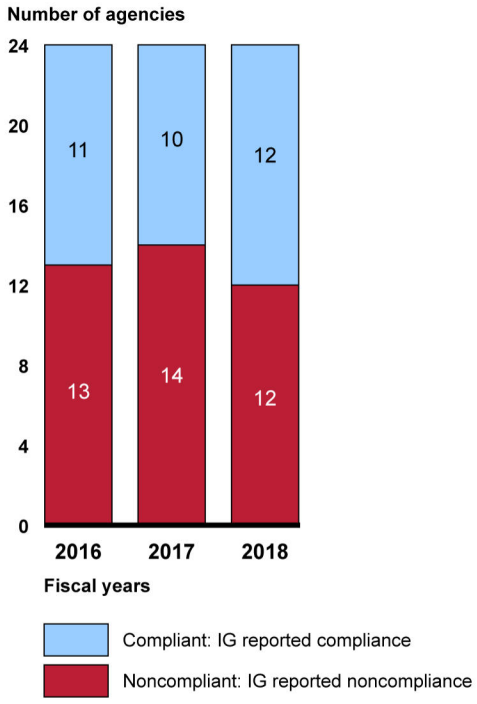
reported inaccurate amounts for identified and recaptured improper payments in its AFR. However, the IG reported that the agency was compliant with the IPERA criterion for publishing financial information in a PAR or AFR. Another agency's IG reported that its agency did not accurately evaluate its corrective actions' effectiveness in recapturing improper payments. However, the IG reported that the agency was compliant with the IPERA criterion to publish corrective action plans. As we stated above pertaining to the IGs' determination of compliance with IPERA criteria, these determinations are based on whether the agency met the requirements and is not a judgment on the quality of the work conducted in order to meet those requirements.

Trends in Reported Overall IPERA Compliance for Fiscal Years 2016 through 2018

As stated above, IGs for 12 of the 24 CFO Act agencies reported that their agencies were compliant with IPERA overall for fiscal year 2018. As shown in figure 3, this is an increase from 10 agencies reported as compliant for fiscal year 2017, and 11 agencies reported as compliant for fiscal year 2016. The improvement in IPERA compliance is attributable to the Departments of Commerce and Education, which were reported by their IGs as noncompliant in fiscal year 2017 but compliant in fiscal year 2018.[28] No agencies that IGs reported as compliant in fiscal year 2017 were reported as noncompliant in fiscal year 2018.

[28]The change in overall IPERA compliance from fiscal years 2016 through 2017 is attributable to the Department of Commerce, which was reported as compliant in fiscal year 2016 but noncompliant in fiscal year 2017.

Figure 3: Chief Financial Officers Act of 1990 Agencies' IPERA Compliance for Fiscal Years 2016 through 2018, as Reported by Their IGs



IG: inspector general IPERA: Improper Payments Elimination and Recovery Act of 2010

Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' fiscal year 2018 IPERA compliance reports and prior GAO reports. | GAO-20-344

In addition, the IGs reported that 21 programs within these agencies were noncompliant with IPERA for each of the past 3 fiscal years (2016–2018). Improper payment estimates for these programs totaled about $78 billion, representing approximately 52 percent of the $151 billion government-wide reported improper payment estimates for fiscal year 2018. As shown in table 1, this includes improper payment estimates for Medicaid of about $36 billion and for EITC of about $18 billion.

Table 1: Reported Improper Payment Estimates for Chief Financial Officers Act of 1990 Agency Programs That Their Inspectors General Reported as Noncompliant with IPERA for 3 or More Consecutive Years as of Fiscal Year 2018

Agency	Program	Estimated improper payments reported for fiscal year 2018 (millions of dollars)
Department of Agriculture	Food and Nutrition Services School Breakfast Program - Total Program	469.3
	Food and Nutrition Services Special Supplemental Nutrition Program for Women, Infants, and Children - Total Program	194.2
Department of Defense	Civilian Pay	85.0
	Defense Finance and Accounting Service Commercial Pay	15.0
	Department of Defense Travel Pay	365.3
	Military Health Benefits	91.2
	Military Pay	305.8
	Military Retirement	314.4
Department of Health and Human Services	Children's Health Insurance Program	1,389.6
	Foster Care	29.8
	Medicaid	36,249.7
	Temporary Assistance for Needy Families	Not reported
Department of Labor	Unemployment Insurance	3,743.5
Department of the Treasury	Earned Income Tax Credit	18,443.5
Department of Veterans Affairs	Beneficiary Travel	216.0
	Civilian Health and Medical Program of Veterans' Affairs	85.3
	Purchased Long Term Services and Support	2,059.1
	Supplies and Materials	829.2
	Community Care	7,998.1
General Services Administration	Rental of Space	16.7
Social Security Administration	Supplemental Security Income	4,757.4
Total		**77,658.2**

Legend: IPERA = Improper Payments Elimination and Recovery Act of 2010.

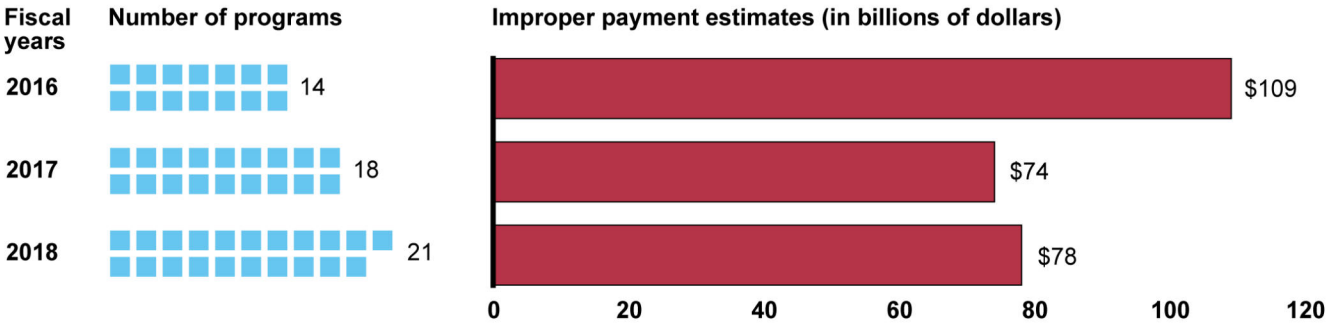
Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' IPERA compliance reports for fiscal years 2016 through 2018, Office of Management and Budget data, and agencies' data. | GAO-20-344

Note: Total does not agree because of rounding.

As shown in figure 4, the number of programs reported as noncompliant with IPERA for 3 or more consecutive years has increased since fiscal year 2016. Specifically, the number of programs reported as noncompliant for 3 or more consecutive years increased from 14 programs in fiscal year 2016 to 18 programs in fiscal year 2017 and 21 programs in fiscal year 2018. The reported improper payment estimates

for these programs totaled about $109 billion for fiscal year 2016, $74 billion for fiscal year 2017, and $78 billion for fiscal year 2018. The total improper payment estimates for programs reported as noncompliant for 3 or more consecutive years decreased for fiscal 2017 primarily because the Medicare Fee-for-Service program, with about $41 billion of improper payments in fiscal year 2016, was reported as compliant beginning fiscal year 2017.

Figure 4: Improper Payment Estimates for Chief Financial Officers Act of 1990 Agency Programs Reported as Noncompliant with IPERA for 3 or More Consecutive Years, Fiscal Years 2016 through 2018



IPERA: Improper Payments Elimination and Recovery Act of 2010

Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' IPERA compliance reports for fiscal years 2016 through 2018, Office of Management and Budget data, and agencies' data. | GAO-20-344

Agency Comments

We provided a draft of this report to OMB and CIGIE for review and comment. CIGIE stated that it had no comments. OMB did not provide any comments.

We also provided the full draft for review and comment to agencies and respective IG offices we met with throughout the course of this work. In addition, we sent summary facts to other agencies that had substantial changes in reported improper payment estimates between fiscal years 2018 and 2019 (as shown in app. III), and provided the full draft for review and comment, upon request, to those agencies. We received written comments from the U.S. Agency for International Development, which is reproduced in appendix V. The Department of Health and Human Services, Department of Veterans Affairs, and the Social Security Administration's Office of Inspector General provided technical comments, which we incorporated in the report as appropriate. The remaining agencies and IG offices informed us that they had no comments.

We are sending copies of this report to the appropriate congressional committees, the Director of the Office of Management and Budget, the Chairman of the Council of the Inspectors General on Integrity and Efficiency, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-2623 or davisbh@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

Beryl H. Davis
Director, Financial Management and Assurance

List of Committees

The Honorable John N. Kennedy
Chairman
The Honorable Chris Coons
Ranking Member
Subcommittee on Financial Services and General Government
Committee on Appropriations
United States Senate

The Honorable Thomas R. Carper
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Gerald E. Connolly
Chairman
Subcommittee on Government Operations
Committee on Oversight and Reform
House of Representatives

Appendix I: Reported Improper Payment Estimates and Rates by Agency and Program for Fiscal Years 2019 and 2018

Table 2 details the improper payment estimates and rates that federal agencies reported to the Office of Management and Budget or in their agency financial reports or performance and accountability reports for fiscal years 2019 and 2018.[1] In addition, as shown in the table 2, 17 programs had a substantial change in their reported improper payment estimates or rates between fiscal years 2018 and 2019.[2] The reasons for the changes, as reported in the agency financial reports, are detailed in appendix III.

Table 2: Reported Improper Payment Estimates and Rates by Agency and Program for Fiscal Years 2019 and 2018

Dollars in millions

	Fiscal year 2019		Fiscal year 2018	
Agency and program	Estimate (dollars)	Rate (percent)[a]	Estimate (dollars)	Rate (percent)
Consumer Product Safety Commission	**0.2**		**29.1**	
Non-Payroll	0.2	0.6	29.1	95.0
Corporation for National and Community Service	**91.9**		**76.0**	
AmeriCorps	39.0	16.5	40.1	16.4
The Foster Grandparent Program	25.7	27.8	18.2	20.8
The Retired and Senior Volunteer Program	16.2	37.3	7.0	17.3
The Senior Companion Program	11	28.3	10.7	28.2
Department of Agriculture	**6,762.0**		**6,104.8**	
Food and Nutrition Services Supplemental Nutrition Assistance Program	4,021.7	6.8	4,007.8	6.3
Food and Nutrition Services National School Lunch Program	1,142.4	9.1	1,155.4	9.4
Food and Nutrition Services School Breakfast Program	461.4	10.5	469.3	11.0
Food and Nutrition Services Special Supplemental Nutrition Program for Women, Infants, and Children - Total Program	68.4	2.0	194.2	5.4
Food and Nutrition Act Child and Adult Care Food Program	3.7	0.5	3.9	0.5

[1]The estimated improper payment rate is the estimated amount in improper payments divided by the amount in program outlays for a given program in a given fiscal year.

[2]For the purpose of this report, we define “substantial change” as a change in (1) the improper payment estimate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than $1 billion or (2) the improper payment rate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than 5 percent and the fiscal year 2019 improper payment estimate is over $100 million.

Dollars in millions

Agency and program	Fiscal year 2019 Estimate (dollars)	Fiscal year 2019 Rate (percent)[a]	Fiscal year 2018 Estimate (dollars)	Fiscal year 2018 Rate (percent)
Farm Service Agency Livestock Forage Disaster Program	87.5	17.9	42.1	11.9
Farm Service Agency Noninsured Crop Disaster Assistance Program	42.5	23.1	26.6	16.4
Natural Resources Conservation Service Farm Security and Rural Investment Act Programs	37.0	1.3	21.3	0.8
Risk Management Agency Federal Crop Insurance Corporation Program Fund	282.5	3.00	184.2	1.8
Forest Service Capital Improvement and Maintenance (Harvey)	0.0	0.0	Not reported	Not reported
Farm Service Agency Hurricane Harvey - Emergency Conservation Program	3.0	15.9	Not reported	Not reported
Farm Service Agency Agriculture Risk and Price Loss Coverage[b]	612.0	16.1	Not reported	Not reported
Department of Defense	**8,680.2**		**1,193.1**	
Civilian Pay	96.7	0.1	85.0	0.1
Defense Finance and Accounting Service Commercial Pay	19.3	0.0	15.0	0.0
Department of Defense Travel Pay	366.5	4.8	365.3	4.6
Military Health Benefits	411.5	1.7	91.2	0.4
Military Pay[b]	7,450.3	7.3	305.8	0.3
Military Retirement	287.4	0.4	314.4	0.5
U.S. Army Corps of Engineers Commercial	47.8	0.2	15.0	0.1
U.S. Army Corps of Engineers Travel Pay	0.9	0.4	1.2	0.5
Department of Education	**1,133.2**		**6,055.3**	
Direct Loan[b]	483.1	0.5	3,752.9	4.0
Pell Grant[b]	646.1	2.2	2,302.4	8.2
Temporary Emergency Impact Aid for Displaced Students	3.9	2.4	Not reported	Not reported
Immediate Aid to Restart School Operations	0.0	0.0	Not reported	Not reported
Department of Health and Human Services	**106,671.7**		**86,462.3**	
Child Care and Development Fund	324.7	4.5	302.0	4.0
Children's Health Insurance Program[b]	2,736.4	15.8	1,389.6	8.6
Foster Care	7.1	4.9	29.8	7.6
Medicaid[b]	57,358.1	14.9	36,249.7	9.8
Medicare Fee-For-Service (Parts A and B)[b]	28,908.8	7.3	31,617.9	8.1
Medicare Advantage (Part C)[b]	16,728.6	7.9	15,554.3	8.1

Dollars in millions

Agency and program	Fiscal year 2019 Estimate (dollars)	Fiscal year 2019 Rate (percent)[a]	Fiscal year 2018 Estimate (dollars)	Fiscal year 2018 Rate (percent)
Medicare Prescription Drug (Part D)	607.9	0.8	1,318.9	1.7
Department of Homeland Security	**76.6**		**70.6**	
Customs and Border Protection - Refund and Drawback	Not reported	Not reported	0.4	0.0
Federal Emergency Management Agency - Assistance to Firefighters Grant Program	Not reported	Not reported	4.1	1.3
Federal Emergency Management Agency - Flood Risk Map & Risk Analysis	0.0	0.0	0.3	0.2
Federal Emergency Management Agency - Homeland Security Grant Program	Not reported	Not reported	6.3	0.7
Federal Emergency Management Agency - National Flood Insurance Program	0.3	0.0	0.2	0.0
Federal Emergency Management Agency - Public Assistance Program	26.7	0.7	33.1	1.0
Federal Emergency Management Agency - Vendor Pay	44.6	1.0	26.1	1.7
Immigration and Customs Enforcement - Enforcement and Removal Operations	Not reported	Not reported	0.3	0.0
Federal Protective Services (Payroll)	4.9	2.4	Not reported	Not reported
Department of Housing and Urban Development	**80.5**		**85.8**	
Community Planning and Development/Disaster Relief Appropriations Act	Not reported	Not reported	14.7	0.7
Federal Housing Administration/Single Family Insurance Claims	72.6	0.9	16.4	0.2
Ginnie Mae - Contractor Payments	7.8	5.1	54.7	22.7
Department of Labor	**2,928.7**		**3,817.8**	
Federal Employees' Compensation Act	73.6	2.4	74.4	2.4
Unemployment Insurance	2,855.2	10.6	3,743.5	13.1
Department of Transportation	**395.7**		**1,006.0**	
Federal Highway Administration Highway Planning and Construction	395.7	0.9	997.0	2.2
Federal Transit Administration Emergency Relief Program - Disaster Relief Appropriations Act	Not reported	Not reported	9.0	1.7
Department of the Treasury	**26,627.0**		**18,443.5**	
Earned Income Tax Credit[b]	17,351.6	25.3	18,443.5	25.1
American Opportunity Tax Credit[b]	2051.9	26.0	Not reported	Not reported
Additional Child Tax Credit[b]	7,223.5	15.2	Not reported	Not reported

Dollars in millions

Agency and program	Fiscal year 2019 Estimate (dollars)	Fiscal year 2019 Rate (percent)[a]	Fiscal year 2018 Estimate (dollars)	Fiscal year 2018 Rate (percent)
Department of Veterans Affairs	**11,990.4**		**14,735.1**	
Beneficiary Travel	180.2	18.8	216.0	23.5
Civilian Health and Medical Program of the Department of Veterans Affairs	20.6	1.6	85.3	6.9
Communications, Utilities, and Other Rent[b]	683.2	43.4	998.7	65.5
Compensation	53.8	0.1	399.2	0.6
Education - Chapter 33	56.9	0.5	74.0	0.7
Medical Care Contracts and Agreements	654.1	65.9	635.9	64.0
Pension	284.6	5.4	375.5	6.9
Prosthetics	60.3	2.1	1,020.7	39.7
Purchased Long Term Services and Support[b]	2,125.3	93.1	2,059.1	100.0
Supplies and Materials[b]	629.1	22.3	829.2	31.5
State Home Per Diem Grants	28.1	2.1	43.4	3.5
Community Care[b]	7,212.9	92.3	7,998.1	100.5
Dependency and Indemnity Compensation	1.0	0.0	Not reported	Not reported
Disaster Relief Fund	0.1	0.4	Not reported	Not reported
Environmental Protection Agency	**22.5**		**0.3**	
Grants	22.5	1.3	0.3	0.0
Federal Communications Commission	**285.4**		**296.6**	
Telecommunications Relay Service	2.0	0.2	0.3	0.0
Universal Service Fund - High Cost	0.7	0.0	1.2	0.0
Universal Service Fund - Lifeline[b]	108.9	9.3	227.0	18.5
Universal Service Fund - Schools & Libraries	139.7	6.3	68.0	2.6
Universal Service Fund Rural Health Care Program	34.2	11.5	Not reported	Not reported
General Services Administration	**Not reported**	**Not reported**	**16.7**	
Rental of Space	Not reported	Not reported	16.7	0.3
Office of Personnel Management	**339.4**		**355.5**	
Total Program Retirement	284.4	0.4	284.1	0.4
Federal Employees Health Benefits - ALL carriers	54.9	0.1	71.4	0.1
Railroad Retirement Board	**Not reported**	**Not reported**	**89.8**	
Railroad Medicare	Not reported	Not reported	89.8	10.5
Small Business Administration	**522.3**		**936.4**	
7(a) Guaranty Purchases	31.4	3.6	22.2	3.2
7(a) Guaranty Approvals	358.7	2.2	519.4	2.8

Dollars in millions

Agency and program	Fiscal year 2019 Estimate (dollars)	Fiscal year 2019 Rate (percent)[a]	Fiscal year 2018 Estimate (dollars)	Fiscal year 2018 Rate (percent)
504 Certified Development Company Guaranty Approvals	26.7	0.6	118.1	2.6
Disaster Loan Disbursements	103.1	6.3	274.4	8.9
Disbursements for Goods & Services	Not reported	Not reported	2.3	1.9
Supplemental Disaster Relief Administrative Funds - Travel	2.3	2.9	Not reported	Not reported
Supplemental Disaster Relief Administrative Funds - Payroll	0.3	0.1	Not reported	Not reported
Social Security Administration	**8,180.0**		**10,915.3**	
Old-Age, Survivors and Disability Insurance[b]	2,651.3	0.3	6,157.8	0.7
Supplemental Security Income	5,528.8	9.7	4,757.4	8.4
Total	**174,787.5**	**5.1**	**150,689.8**	**4.6**

Source: GAO analysis of Office of Management and Budget data and agency financial reports for fiscal years 2019 and 2018. | GAO-20-344

Note: Totals may not agree because of rounding.

[a]The estimated improper payment rate is the estimated amount of improper payments divided by the amount in program outlays for a given program in a given fiscal year.

[b]This program had a change in (1) the reported improper payment estimate between fiscal years 2018 and 2019 that is equal to or greater than $1 billion or (2) the improper payment rate between fiscal years 2018 and 2019 that is equal to or greater than 5 percent and the fiscal year 2019 improper payment estimate is over $100 million.

Appendix II: Agency-Reported Root Causes for Improper Payment Estimates for Fiscal Year 2019

Table 3 shows the government-wide agency-reported improper payment estimates and rates for fiscal year 2019, grouped by Office of Management and Budget (OMB) improper payment root cause categories.[1]

Table 3: Agency-Reported Fiscal Year 2019 Improper Payment Estimates, by Office of Management and Budget Root Cause Category

Dollars in billions		
Office of Management and Budget root cause category	**Reported fiscal year 2019 improper payment estimates (dollars)**	**Percentage**
Insufficient documentation to determine	74.1	42.4
Administrative or process errors	39.1	22.4
Inability to authenticate eligibility	38.0	21.8
Program design or structural issue	14.1	8.0
Medical necessity	5.4	3.1
Failure to verify data	3.5	2.0
Other reason	0.6	0.3
Total	**174.8**	**100.0**

Source: GAO analysis of Office of Management and Budget data and fiscal year 2019 agency financial reports. | GAO-20-344

OMB defines the root cause categories as follows:

- **Insufficient documentation to determine:** For this category, there is a lack of supporting documentation necessary to verify the accuracy of a payment identified in the improper payment testing sample. For example, a program does not have documentation to support a beneficiary's eligibility for a benefit, and without that particular documentation, the agency is unable to discern that the payment was for the correct amount or went to the right recipient.
- **Administrative or process errors:** In this category, errors were caused by incorrect data entry, classifying, or processing of applications or payments. For example, an eligible beneficiary receives a payment that is too high or too low because of a data entry mistake (such as transposing a number) or an agency enters an incorrect invoice amount into its financial system.
- **Inability to authenticate eligibility:** In this category, an improper payment is made because the agency is unable to authenticate

[1]Office of Management and Budget, *Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement*, OMB Memorandum M-18-20 (Washington, D.C.: June 26, 2018).

eligibility criteria. These types of errors include but are not limited to (1) inability to access data and (2) data needed do not exist.

- **Program design or structural issue:** For this category, improper payments result from the design of the program or a structural issue. For example, a scenario in which a program has a statutory (or regulatory) requirement to pay benefits when due, regardless of whether all the information has been received to confirm payment accuracy.
- **Medical necessity:** For this category, a medical provider delivers a service or item that does not meet coverage requirements for medical necessity (for example, providing a power wheelchair to a patient whose medical record does not support meeting coverage requirements for a power wheelchair).
- **Failure to verify data:** In this category, the agency (federal, state, or local), or another party administering federal dollars, fails to verify appropriate data to determine whether a recipient should be receiving a payment, even though such data exist in government or third-party databases. In these situations, the data needed exist, and the agency or other party administrating federal dollars had access to them but did not check the payment against those data prior to making the payment.
- **Other reason:** This category covers when the improper payment does not meet any of the above categories.

Appendix III: Programs with Substantial Changes in Reported Improper Payment Estimates or Rates from Fiscal Year 2018 to Fiscal Year 2019

Table 4 shows the 17 programs that had a substantial change in the improper payment estimates or rates between fiscal years 2018 and 2019, and the reasons for those changes, as reported in the agency financial reports.[1]

Table 4: Programs with Substantial Changes in Improper Payment Estimates or Rates between Fiscal Years 2018 and 2019

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
Department of Health and Human Services (HHS)/Medicaid	57,358.1	36,249.7	21,108.4	5.1	HHS reintegrated the eligibility component of the Payment Error Rate Measurement (PERM) for Medicaid.[a] HHS's fiscal year 2019 agency financial report noted that another significant cause of improper payments for the Medicaid program is errors resulting from state noncompliance with provider screening and enrollment requirements.
Department of the Treasury (Treasury)/Additional Child Tax Credit	7,223.5	0.0	7,223.5	15.2	Treasury did not report an estimate for fiscal year 2018. Treasury's fiscal year 2019 agency financial report stated that this program was newly identified as susceptible to significant improper payments.

[1]For the purpose of this report, we define "substantial change" as a change in (1) the improper payment estimate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than $1 billion or (2) the improper payment rate between fiscal year 2018 and fiscal year 2019 that is equal to or greater than 5 percent and the fiscal year 2019 improper payment estimate is over $100 million.

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
Department of Defense (DOD)/ Military Pay	7,450.3	305.8	7,144.5	7.0	DOD's fiscal year 2019 agency financial report stated that DOD implemented a revised sampling plan and testing methodology for the Military Pay program, which included reviewing military service member entitlements paid with available supporting documentation. DOD also stated that the increase is a direct result of the revised testing methodology.
Social Security Administration (SSA)/Old-Age, Survivors and Disability Insurance	2,651.3	6,157.8	(3,506.6)	(0.4)	SSA's fiscal year 2019 agency financial report did not disclose a reason.
Department of Education/Direct Loan	483.1	3,752.9	(3,269.8)	(3.5)	The Department of Education's fiscal year 2019 agency financial report stated that the department implemented a new statistically valid estimation methodology for fiscal year 2019. The fiscal year 2018 estimate was based on a nonstatistical estimation methodology.
HHS/Medicare Fee-For-Service (Parts A and B)	28,908.8	31,617.9	(2,709.1)	(0.9)	HHS's fiscal year 2019 agency financial report stated that the estimate decreased from the prior year's reported estimate because of a reduction in improper payments for home health; Medicare Fee-For-Service Part B; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies claims.

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
Treasury/ American Opportunity Tax Credit	2,051.9	0.0	2,051.9	26.0	Treasury did not report an estimate for fiscal year 2018. Treasury's fiscal year 2019 agency financial report stated that this program was newly identified as susceptible to significant improper payments.
Department of Education/Pell Grant	646.1	2,302.4	(1,656.3)	(6.0)	The Department of Education's fiscal year 2019 agency financial report stated that the department implemented a new statistically valid estimation methodology for fiscal year 2019. The fiscal year 2018 methodology was based on a nonstatistical estimation methodology.
HHS/Children's Health Insurance Program	2,736.4	1,389.6	1,346.8	7.3	HHS reintegrated the eligibility component of PERM for the Children's Health Insurance Program.[a] HHS's fiscal year 2019 agency financial report noted that another significant cause of improper payments for the Children's Health Insurance Program is states not following the appropriate process for screening and enrolling providers.
HHS/Medicare Advantage (Part C)	16,728.6	15,554.3	1,174.3	(0.2)	Although the improper payment estimate increased, the improper payment rate decreased. HHS's fiscal year 2019 agency financial report stated that Medicare Advantage organizations' submission of more accurate diagnoses for payment primarily drove the decrease in the improper payment rate.

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
Treasury/Earned Income Tax Credit	17,351.6	18,443.5	(1,091.9)	0.2	Treasury's fiscal year 2019 agency financial report did not disclose a reason. However, we noted a decrease in outlays of $4.9 billion in fiscal year 2019, which likely contributed to the decrease in the improper payment amount.
Department of Veterans Affairs (VA)/Community Care	7,212.9	7,998.1	(785.2)	(8.2)	VA's fiscal year 2019 agency financial report did not disclose a reason. However, it stated that the VA Community Care program implemented corrective actions, such as ensuring the remaining Medicare Fee Schedules were updated in VA's Fee Basis Claims System, as well as implementing the VA MISSION Act in June 2019. In addition, the VA Community Care program incorporated corrective actions on the use of Community Care Networks and Veteran Care Agreements under the VA MISSION Act to ensure that authority is properly delegated or contracted rates are established for payments.
Department of Agriculture/Farm Service Agency Agriculture Risk and Price Loss Coverage	612.0	0.0	612.0	16.1	The Department of Agriculture did not report an estimate for fiscal year 2018. The department's agency financial report stated that this is the first year that improper payment estimates are being reported for this program.

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
VA/ Communications, Utilities, and Other Rents	683.2	998.7	(315.6)	(22.1)	VA's fiscal year 2019 agency financial report did not disclose a reason. However, it stated that in order to address the program or structural error root cause for improper payments in this program, in September 2019, VA removed unneeded instructions from regulations, thereby removing requirements imposing additional burdensome documentation.
VA/Supplies and Materials	629.1	829.2	(200.1)	(9.3)	VA's fiscal year 2019 agency financial report did not disclose a reason. However, it stated that in order to address the program or structural error root cause for improper payments in this program, in September 2019, VA removed unneeded instructions from regulations, thereby removing requirements imposing additional burdensome documentation.
Federal Communications Commission/ Universal Service Fund - Lifeline	108.9	227.0	(118.1)	(9.2)	The Federal Communications Commission's fiscal year 2019 agency financial report did not disclose a reason. In addition, the commission stated that it became aware of additional instances of noncompliance in this program and the actual improper payment rate may be higher than what was reported.

Dollars in millions

Department/ program	Fiscal year 2019 reported improper payment estimate (dollars)	Fiscal year 2018 reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment estimate (dollars)	Increase/(decrease) in reported improper payment rate (percent)	Reason for increase or decrease as reported in the agency financial report
VA/Purchased Long Term Services and Support	2,125.3	2,059.1	66.2	(6.9)	VA's fiscal year 2019 agency financial report did not disclose a reason. However, it stated that VA implemented corrective actions, including (1) developing new fact sheets for providers on common billing errors, (2) providing monthly staff training on avoiding ineligible vendors and incorrect rates by verifying approved vendor list prior to authorization, and (3) incorporating corrective actions on the use of Community Care Networks and Veteran Care Agreements under the VA MISSION Act to ensure that authority is properly delegated or contracted rates are established for payments.

Source: GAO analysis of Office of Management and Budget data and agency financial reports for fiscal years 2019 and 2018. | GAO-20-344

[a]From fiscal years 2015 through 2018, HHS did not estimate improper payments attributed to eligibility determinations for Medicaid and the Children's Health Insurance Program; however, HHS did include a proxy estimate, which was the last reported rate in fiscal year 2014 for the eligibility component, while it worked to update this component. For fiscal year 2019, HHS estimated improper payments attributed to eligibility determinations in 17 states. HHS's national eligibility improper payment rate for fiscal year 2019 still includes a proxy estimate for 34 remaining states that have not yet been measured since the reintegration of the PERM eligibility component.

Appendix IV: Fiscal Year 2018 CFO Act Agencies' IPERA Compliance as Reported by Their Inspectors General

Figure 5 details the Chief Financial Officers Act of 1990 (CFO Act) agencies' overall compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA), as well as the agencies' compliance with each of the six IPERA criteria for fiscal year 2018, as reported by their inspectors general.

Figure 5: Fiscal Year 2018 Chief Financial Officers Act of 1990 Agencies' Compliance with IPERA as Reported by Their Inspectors General

Agency	Overall compliance	Published a financial report	Conducted program-specific risk assessments	Published improper payment estimates	Published corrective action plans	Published and met reduction targets	Reported improper payment rates below 10%	Total non-compliance
Department of Agriculture	X	✓	✓	✓	✓	X	X	2
Department of Commerce	✓	✓	NA	NA	NA	NA	NA	0
Department of Defense	X	✓	✓	X	X	X	✓	3
Department of Education	✓	✓	✓	✓	✓	✓	✓	0
Department of Energy	✓	✓	✓	NA	NA	NA	NA	0
Department of Health and Human Services	X	✓	✓	X	X	X	✓[a]	3
Department of Homeland Security	X	X	✓	✓	✓	X	✓	2
Department of Housing and Urban Development	X	✓	✓	X	NA	✓	X	2
Department of the Interior	✓	✓	✓	NA	NA	NA	NA	0
Department of Justice	✓	✓	✓	NA	NA	NA	NA	0
Department of Labor	X	✓	✓	✓	✓	✓	X	1
Department of State	✓	✓	✓	NA	NA	NA	NA	0
Department of Transportation	X	✓	✓	✓	✓	X	✓	1
Department of the Treasury	X	✓	✓	✓	✓	NA	X	1
Department of Veterans Affairs	X	✓	✓	✓	✓	X	X	2
Environmental Protection Agency	✓	✓	✓	✓	NA	✓	✓	0
General Services Administration	X	X	✓	X	✓	✓	✓	2
National Aeronautics and Space Administration	✓	✓	✓	NA	NA	NA	NA	0
National Science Foundation	✓	✓	✓	NA	NA	NA	NA	0
Nuclear Regulatory Commission	✓	✓	✓	NA	NA	NA	NA	0
Office of Personnel Management	✓	✓	✓	✓	✓	✓	✓	0
Small Business Administration	X	✓	✓	✓	✓	X	✓	1
Social Security Administration	X	✓	✓	✓	✓	X	✓	1
U.S. Agency for International Development	✓	✓	✓	NA	NA	NA	NA	0
Noncompliant agencies	12	2	0	4	2	8	5	
Compliant agencies	12	22	23	11	11	6	10	
Not applicable	0	0	1	9	11	10	9	

✓ agency's inspector general reported compliant
X agency's inspector general reported noncompliant
NA agency's inspector general reported that criterion is not applicable to the agency

IPERA: Improper Payments Elimination and Recovery Act of 2010

Source: GAO analysis of Chief Financial Officers Act of 1990 agencies' fiscal year 2018 IPERA compliance reports. | GAO-20-344

[a]All Department of Health and Human Services (HHS) programs were reported as compliant with the IPERA criterion for the reported improper payment rates to be below 10 percent, except for the Temporary Assistance for Needy Families (TANF) program. HHS's inspector general did not make a compliance determination for TANF and noted that an improper payment estimate was not published because of statutory limitations.

Appendix V: Comments from the U.S. Agency for International Development

USAID
FROM THE AMERICAN PEOPLE

February 13, 2020

Beryl H. Davis
Director, Financial Management and Assurance
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20226

Dear Ms. Davis:

I am pleased to provide the formal response of the U.S. Agency for International Development (USAID) to the draft report produced by the U. S. Government Accountability Office (GAO) titled, *PAYMENT INTEGRITY: Federal Agencies' Estimates of [Fiscal Year] FY 2019 Improper Payments* (GAO-20-344)

The GAO's draft report identifies USAID as one of 12 Departments and Agencies subject to the Chief Financial Officers Act of 1990 that are in overall compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA) for Fiscal Year (FY) 2018, as reported by their Inspectors General.

USAID has a rigorous payment process supported by an extensive core financial system and procedural controls that have led to a consistently low rate of erroneous payments, as audited annually by the USAID Office of Inspector General. As a result, the Office of Management and Budget has granted USAID relief from a number of reporting requirements, which demonstrates our continued prudent and diligent stewardship of taxpayer dollars. USAID published our rate of improper payments (0.038 percent) in our *Agency Financial Report* for FY 2019, available at: www.usaid.gov/results-and-data/progress-data/agency-financial-report/fy-2019.

I am transmitting this letter for inclusion in the GAO's final report. Thank you for the opportunity to respond to the draft report, and for the courtesies extended by your staff while conducting this engagement. We appreciate the opportunity to participate in the evaluation of our compliance with IPERA.

Sincerely,

Fredrick Nutt
Assistant Administrator
Bureau for Management

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
www.usaid.gov

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Beryl H. Davis, (202) 512-2623 or davisbh@gao.gov

Staff Acknowledgments

In addition to the contact named above, Matt Valenta (Assistant Director), Cherry Vasquez (Auditor in Charge), Pat Frey, Jason Kelly, Jim Kernen, Anne Thomas, Judy Tsan, and Landon Western made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/fraudnet/fraudnet.htm

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548

Benefit Accuracy Measurement State Data Summary
Improper Payment Information Act Performance Year 2020

The Benefit Accuracy Measurement (BAM) program is designed to determine the accuracy of paid and denied claims in three major Unemployment Insurance (UI) programs: regular State UI, Unemployment Compensation for Federal Employees (UCFE), and Unemployment Compensation for Ex-Servicemembers (UCX). State Workforce Agencies (SWAs) select weekly random samples of paid and denied claims. Independent state BAM investigators audit these paid and denied claims to determine whether the claimant was properly paid or properly denied benefits. The results of the BAM statistical samples are used to estimate accuracy rates for the populations of paid and denied claims. The BAM program provides continuous feedback on the state and federal methods of administration.

Based on the errors identified and information gathered through the BAM program, states are able to develop plans and implement corrective actions to improve accurate administration of state law, rules, and procedures. The major objectives of the BAM program are to:

- Assess the accuracy of UI payments;
- Estimate the UI improper payment rate as required by Federal Law;
- Promote improvements in program accuracy and integrity; and
- Encourage more efficient administration of the UI program.

The basis for determining payment and denial accuracy are federal and state laws, administrative codes and rules, and official policies. The system is designed to be comprehensive in coverage by including all areas of the UI claims processes where errors may occur. As a quality assurance program, BAM is a diagnostic tool for Federal and SWA staff to use in identifying systemic errors and their causes and to correct and track solutions to these problems.

This report is designed to provide information gathered by the BAM program for the performance year (PY) 2020 and offer some analysis of this information. Generally, the performance year for reporting is 12-month period from July 1, Year through June 30, Year+1. For example for PY 2019, the performance year for reporting is from July 1, 2018 through June 30, 2019.

For PY 2020, this analytical report uses the BAM data for the nine month period from July 2019 through March 2020[1] and is aligned with the reporting period used by the UI program in the U.S. Department of Labor's (Department) Agency Financial Report (AFR). In this analytical report, rates are shown at a national level, which is the sum of the 52 SWAs. The SWAs consist of the 50 states, Puerto Rico, and the District of Columbia. Each SWA's data are provided in separate linked documents. The United States Virgin Islands is exempt from operating a BAM program.

[1] The BAM program was suspended for the quarter April1, 2020 through June 30, 2020 due to operational flexibilities provided to states in response to the pandemic situation.

Under 20 CFR 602.21(g), the Department's Employment Training Administration (ETA) compiles and releases the BAM program results each year on behalf of the states. The Department accomplishes this requirement by the release of annual results on its Web site: https://www.dol.gov/general/maps and the associated data page https://www.dol.gov/general/maps/data.

Improper Payments Information Act of 2002 and the subsequent statutory amendments (the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012)[2] require agencies to examine the risk of erroneous payments in all programs and activities they administer. Federal law defines the term improper payment as: "(A)…any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and (B) includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts."[3] Agencies are required to review all programs and activities they administer and identify those that may be susceptible to significant erroneous payments. IPERIA defines "significant improper payments" as gross annual improper payments (i.e., the total amount of overpayments and underpayments) in the program exceeding (1) both 1.5 percent of program outlays and $10,000,000 of all program or activity payments made during the year reported or (2) $100,000,000 (regardless of the improper payment percentage of total program outlays)[4]. The UI program meets both of these criteria. Additionally, IPERA codifies the requirement for valid statistical estimates of improper payments such as those generated by the BAM program, and compels actions to reduce improper payments. Since the SWAs make all UI payment decisions, the Department requires SWAs to review their BAM program improper payment estimates and report their planned activities to prevent, detect, reduce, and recover improper payments in an UI Integrity Action Plan (ET Handbook No. 336, see, Appendix V).[5]

The Department reports the overpayment and the underpayment rates to the Office of Management and Budget (OMB) as part of its IPIA[6] reporting. The IPIA PY 2020 (IPIA 2020) includes the period July 2019 through March 31, 2020 (Batch Range 201927 through 202013). It is extremely important that the BAM programs in each SWA accurately measure the level of improper payments in its state so that performance can be properly evaluated against the state and national targets. BAM is critical to assessing improvements in program accuracy and integrity and encouraging more efficient administration of the UI program.

UI benefit payments included in BAM sample for the IPIA 2020 PY decreased to $20.45

---

[2] These Laws were replaced March 2, 2020 by Public Law 116–117 which is referred to as ''Payment Integrity Information Act of 2019" (PIIA).
[3] Appendix C to OMB Circular A-123,issued June 26, 2018, p.8
[4] Appendix C to OMB Circular A-123, issued June 26, 2018, p.10
[5] Unemployment Insurance Program Letter (UIPL) No. 15-19 ; and ET Handbook No. 336
[6] U. S. Department of the Treasury PaymentAccuracy.gov Web Page: https://www.paymentaccuracy.gov

billion[7] compared to $26.18 billion during the IPIA 2019 PY. IPIA 2020 BAM paid claims results are based on 17,232 valid sample cases[8]. This represents a completion rate of 97.50 percent. BAM investigators completed claimant interviews in 14,983 or 86.95 percent of the completed cases. The remaining audits were completed based on information obtained from agency records, the claimants' former employers, and third-party sources, such as labor unions and private employment agencies. As this linked document shows (IPIA_2020_Method_Claimant_Information_Obtained.xlsx in sheet titled "Response & Nonresponse Errors"), investigators are able to identify payment accuracy issues in cases, in which interviews are not completed. This limits nonresponse bias.

Readers are strongly cautioned that it may be misleading to compare one state's payment accuracy rates with another state's rates. No two states' written laws, regulations, and policies specifying eligibility conditions are identical, and differences in these conditions influence the potential for error. States have developed many different ways to determine monetary entitlement to UI. Additionally, nonmonetary requirements are, in large part, based on how a state interprets and enforces its law. Two states may have identical laws but may interpret them quite differently. States with stringent or complex provisions tend to have higher improper payment rates than those with simpler, more straightforward provisions (See the 2020 "Comparison of State Unemployment Laws," https://oui.doleta.gov/unemploy/comparison/2020-2029/comparison2020.asp).

Because the BAM data are based on relatively small samples, the estimated improper payment rate is subject to sampling and non-sampling errors. Sampling errors are errors that arise in a data collection process as a result of taking a sample from a population rather than using the whole population. Therefore, integrity rates are shown at a 95 percent confidence level with an interval, expressed as plus or minus percentage points. The actual rate is expected to lie within the interval 95 percent of the time. The rate and intervals are constructed from repeated samples of the same size and selected in the same manner as the BAM sample requires.

Non-sampling errors are errors or biases that arise in a data collection process as a result of factors other than taking a sample. These errors can include, but are not limited to, timeliness of data collection, data entry errors, biased questions in fact-finding, biased decision making, and inappropriate analysis and conclusions completed by state investigators or false or inaccurate information provided by survey respondents.

The Department's approved improper payment rate computation methodology can be found in UIPL 09-13 Change 1 (issued January 27, 2015). Corrective action and integrity plans for Fiscal Year (FY) 2021 are based on this computation methodology. IPERA requires an improper payment rate of less than 10 percent for each program and activity for which an estimate was published under the IPIA.

In this report, the Department uses six analytical measures to assess SWA payment accuracy and estimate the risk of erroneous denial of benefits. Individual SWA rates reflect state laws, administrative codes or rules, and policies. National results reflect the 52 SWAs' findings.

---

[7] In the fourth quarter of IPIA 2020, the period of BAM program suspension, states paid $64.36 billion.
[8] States sampled 17,681 payments and deleted 8 payments as being out of the scope of the review, BAM investigators completed 17,232 of the remaining 17,673 valid cases.

The Analytical Measures (Rates):

1. **Overpayment Rate** - The overpayment rate is defined in UIPL No. 09-13, Change 1. It is the total weighted amount of payments determined to be overpaid divided by the weighted dollar amount paid in the BAM sample population. The rate includes fraud, nonfraud recoverable, and nonfraud nonrecoverable overpayments. All causes and responsible parties are included in this rate.

2. **Underpayment Rate** – The underpayment rate is defined in UIPL No. 9-13, Change 1. It is the total weighted amount of payments determined to be underpaid divided by the weighted dollar amount paid in the BAM sample population. All causes and responsible parties are included in this rate. It includes errors where additional payment is made to the claimant. It excludes those errors that are technically proper due to finality rules or technically proper due to rules other than finality.

3. **Improper Payment Rate** – This rate includes UI benefits overpaid plus UI benefits underpaid divided by the total amount of UI benefits paid. Overpayments, underpayments, and total UI benefits paid are estimated from the BAM survey results of paid UI claims in the regular state UI, UCFE, and UCX programs. Overpayments and underpayments determined to be technically proper under state UI law for finality and other reasons are excluded from the measure.

4. **Agency Responsibility Rate** - This rate includes overpayments for which the SWA was either solely responsible or shared responsibility with claimants, employers, or third parties, such as labor unions or private employment referral agencies. The rate includes fraud, nonfraud recoverable overpayments, and nonfraud nonrecoverable overpayments. It excludes payments that are technically proper due to finality or other rules.

5. **Fraud Rate** - The definition of unemployment compensation (UC) fraud varies from state to state – there is no federal definition of fraud in the UC program. Generally, fraud involves a knowing and willful act and/or concealment of material facts to obtain or increase benefits when benefits are not due. However, states vary on the level of evidence required to demonstrate a knowing and willful act or the concealment of facts. An overpayment which is classified as a fraud overpayment in one state might be determined to be a nonfraud overpayment in another state. Often fraud determinations include looking at a pattern of action or the claimant's certification of erroneous information under the penalty of perjury. States also differ on the implementation of fraud administrative penalty determinations. In some states, a fraud determination becomes effective on the date of the fraudulent act. In other states, the administrative penalty takes effect on the determination date. Since fraud determination criteria and thresholds vary throughout the SWAs, the individual state rates reflect these differences. The rate includes all causes and responsible parties.

6. **Improper Denial Rates** - BAM estimates the percentage of claimants improperly denied benefits. This rate includes three subcategories. These subcategories are monetary denials, separation denials, and nonseparation denials. The BAM program

does not assign a dollar estimate to improper denial rates; however, improper denials are corrected when permitted by law.

For a detailed listing of these rates for each state, click on the following link (Please note that excel spreadsheets may have several worksheets or tabs of data): IPIA_2020_Integrity_Rates_All_States.xlsx

I. Paid Claims Accuracy

The Code of Federal Regulations (20 CFR 602) requires states to conclude all findings of inaccuracy as detected through quality control (QC) (now known as BAM) investigations with appropriate official actions in accordance with the applicable State and Federal laws and to classify its findings in benefit payment cases as proper payments, underpayments, or overpayments, and in benefit denial cases as proper or improper denials or underpayments. The classification system for payment accuracy includes seven codes. The classification system for denials includes six codes.

For each paid UI week investigated, referred to as the Key Week (KW), BAM investigators record whether the payment was proper or improper and, if technically proper or improper, the type of erroneous payment. Payment errors on the key week are weighted and used to generate improper payment estimates. The coding of BAM audit findings is required to be consistent with the laws, rules, and written policies of each SWA[9]. BAM captures 110 data elements for each sampled payment or denial.

The BAM data set includes demographic information and before and after investigation elements for eligibility conditions. Data for nine of these elements are completed only for improper and technically proper payments or erroneous denials. The Department uses these elements to produce the various integrity rates listed. (ET_395_Handbook_5th_Edition_BAM_State_Operations_Guidance).

Each integrity rate represents a different view of the BAM data set. The BAM data construct provides multiple perspectives; and payment errors may be included or excluded for a specific rate (See IPIA_2020_Methodology_and_Program_Description).

The fraud rate and the agency responsible rate are subsets of the overpayment rate. Also, the data structure allows for the development of individual overpayment cause rates, which excludes the impact of other erroneous payments. The chart below summarizes five paid claim accuracy (PCA) rates, which are used for communicating overpayment estimates. The improper payment rate listed in the chart is based on performance data for IPIA 2020. BAM investigators have 120 days from the end of the quarter to complete their audits and record the outcomes; this rate includes these cases.

For a detailed listing of these rates for each state, click on the following link (the spreadsheet may have several pages or worksheets):

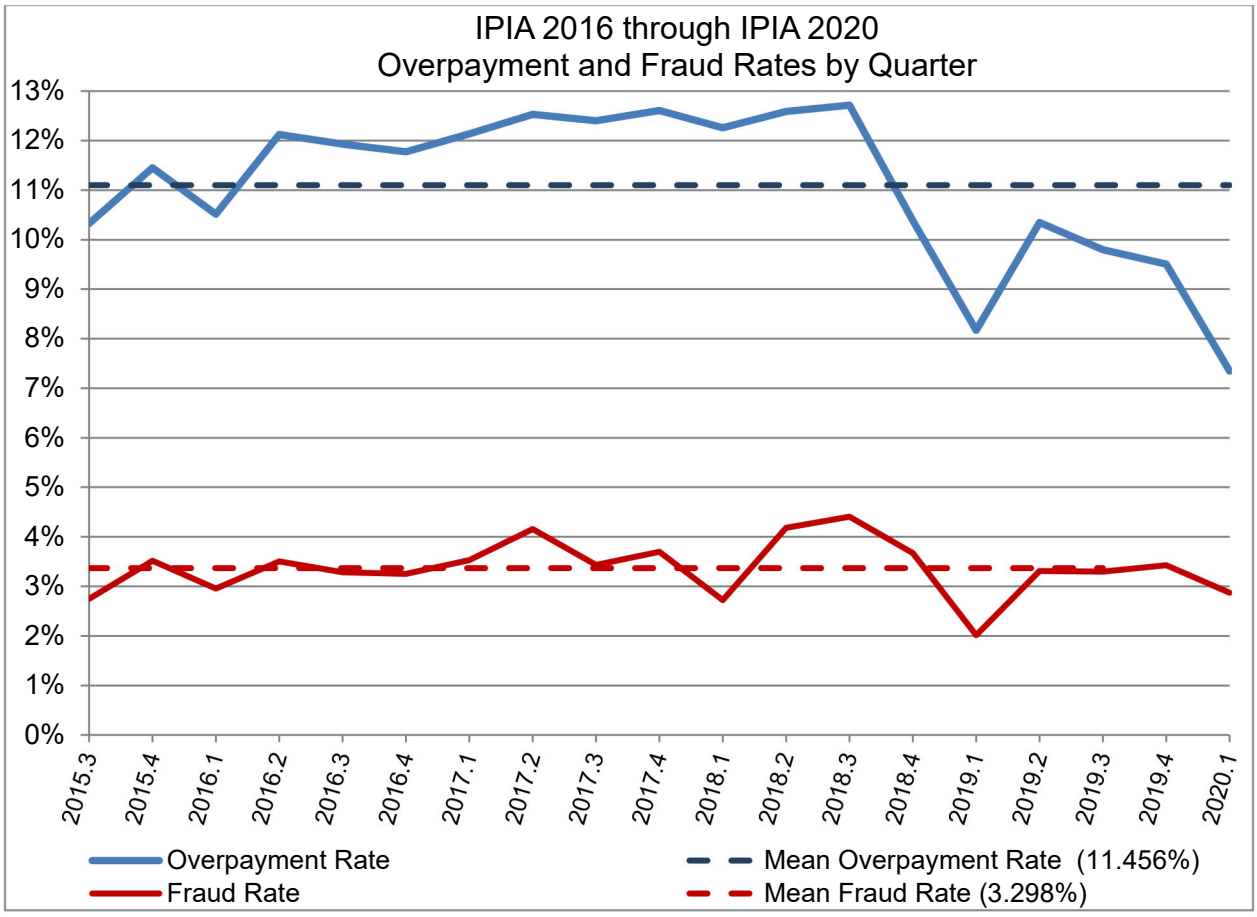
[9] Comparison of State Unemployment Laws, https://oui.doleta.gov/unemploy/comparison/2020-2029/comparison2020.asp

IPIA_2019_-_IPIA_2020_Integrity_Rate_Changes.xlsx

Overpayment Time Series

The following chart displays the overpayment and fraud rates by calendar quarter. For the period IPIA 2016 to IPIA 2020, the average revised overpayment rate was 11.456 percent.

Reviewers should be aware that state level rates show a higher degree of volatility from one quarter to the next. The quarterly volatility is in part due to the small sample sizes pulled at the state level; the probability of sampling a given number of weeks with payment errors; and seasonal factors. This volatility demonstrates that SWAs should be cautious in making performance assumptions and judging corrective actions effectiveness based on one single calendar quarter of data.



For a detailed listing of these and other rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_16_IPIA_20_Overpayment_Rate_by_Quarter_&_State.xlsx

Overpayment by Cause and Integrity Rate

UI initial and continuing eligibility requirements are complex. Benefit payments are limited to weekly benefit amounts and overall maximum benefit amounts. Benefits are restricted to a specific time period (benefit year). Claimant turnover is high with finite benefit duration and opportunities to return to employment. Eligibility is determined on a week by week basis. Each week is an opportunity for a new improper payment. Eligibility and payment decisions are made by state government agencies using state specific information technology (IT) systems. Errors can occur at any of the process points discussed below.

Federal law establishes certain requirements for the UC program. The Social Security Act (SSA) and the Federal Unemployment Tax Act (FUTA) set broad coverage provisions, some benefit provisions, the Federal tax base and rate, and administrative requirements. One of the major functions of the Federal government is to ensure conformity and substantial compliance[10] of state laws, regulations, rules, and operations with Federal law. As a condition of receiving administrative grants, each state's methods of administration must ensure payment when due.[11] The Department has always interpreted "when due" in Section 303(a)(1), SSA, to require accuracy to ensure that payments are not made when they are not due.[12]

All state laws must provide or be interpreted in such a manner that a claimant must meet week-to-week eligibility requirements to receive benefits. Claimants certify their weekly eligibility status when claiming benefits. Generally, claimants must be able to work, be available for work, register for employment services, report when directed to the state agency, and actively seek work. Some states provide dependent allowances in certain instances. Finally, claimants may be subject to a reduction in benefit amounts payable based on any benefit year earnings (partial employment) or deductible income received (i.e., pension payments, vacation pay, severance payments).

As a statistical survey, the BAM program uses standardized questionnaires to gather information to determine improper payments and their causes. The surveys include claimant, employer, and third party interviews and are designed to identify potential eligibility or payment issues. When a potential eligibility or payment issue is identified that could affect the key week accuracy, the investigator must pursue and resolve the issue. In making determinations of eligibility, a BAM investigator must comply with the Secretary's Standard for Claim Determinations and apply all facets of federal and state law, administrative code, and official policy to the case findings to determine whether a key week payment is proper or improper (20 CFR 602.21(c)(4)). Although the legal basis for determining whether a payment is proper or improper may be different from state to state, the causes of errors are common across the nation.

[10] See https://unemploymentinsurance.doleta.gov/unemploy/conformity.asp
[11] Section 303, Social Security Act. https://www.ssa.gov/OP_Home/ssact/title03/0303.htm
[12] UIPL No. 04-01 (October 27, 2000) https://wdr.doleta.gov/directives/attach/UIPL4-01.cfm

The BAM program relies on a standardized coding system to categorize improper payments[13] into major categories. The table below displays the common error cause codes and UI improper payment terminology.

Error Cause Codes	Cause Group Description
100 - 119; 150 -159	Benefit Year Earnings (BYE)
120 – 149	Deductible Income a.k.a. Sev./Vac./SSI/Pension
200 – 259	Base Period Wage Issues (BPW)
300 – 329	Separation Issues (SEP)
400 – 419	Able & Available Issues (A&A)
420 – 429	Work Search Issues (WS)
460 – 469	Employment Service Reg. (ES Reg)
430 - 459; 470 – 489	Other Eligibility Issues
500 – 519	Dependents' Allowances
600 – 639	Other Issues a.k.a. All Other Causes

(See IPIA_2020_Methodology_and_Program_Description for inclusion or exclusion from to develop the various rates).

UIPL No. 29-20[14] requires states to analyze their BAM data to identify the top root causes for improper payments and to develop strategies that will be effective in reducing or recovering improper payments. The following chart displays the percent of the dollars overpaid by integrity rate and cause category. The distribution of the causes for UI overpayments and the total amount overpaid varies considerably among the three overpayment integrity rates. The elements included or excluded from the various rates influence this cause distribution.

IPIA 2020 Overpayments (OP) by Cause and Integrity Rates Percent of the Estimated Dollars Overpaid			
Cause	Overpayment Rate	Fraud Rate	Agency Responsible Rate
Benefit Year Earnings	37.443%	60.817%	11.903%
Work Search	24.686%	4.937%	11.784%
Separation Issues	18.122%	23.770%	37.401%
Able+Available	7.820%	4.238%	3.560%
Base Period Wage Iss.	3.863%	0.054%	10.956%
Other Eligibility	2.894%	2.728%	8.557%
Other Issues	2.660%	3.456%	12.225%
ES Registration	1.386%	0.000%	1.085%
Sev./Vac./SSI/Pension	0.784%	0.000%	2.516%
Dependent Allow	0.340%	0.000%	0.014%
Total $ Overpaid by Rate	$1,783,417,629	$647,716,984	$185,073,856

[13] https://wdr.doleta.gov/directives/attach/ETHandbook_395_Ch5_acc.pdf, Chapter V, pp. V-5 through V-7
[14] https://wdr.doleta.gov/directives/corr_doc.cfm?DOCN=7540

An analysis of the top three causes nationally – Benefit Year Earnings, Work Search, and Separations -- is outlined below.

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Integrity_Rates_by_Cause.xlsx

Benefit Year Earnings Issues

Cause Benefit Year Earnings	Overpayment Rate	Fraud Rate	Agency Responsible Rate
Estimated Amount Overpaid due to BYE errors	$667,771,765	$393,922,278	$22,029,524
Estimated Total $ Overpaid by Rate	$1,783,417,629	$647,716,984	$185,073,856
Percent of BYE Overpaid to Total $ Overpaid	37.443%	60.817%	11.903%

As displayed in the IPIA 2020 Overpayment by Cause and Integrity Rates table (page 8), unreported or misreported benefit year earnings (BYE) were the leading cause of UI overpayments in the 2020 reporting period. BYE errors account for more than half (60.817 percent) of UI fraud overpayments and more than a third (37.443 percent) of the overpayments included in the Overpayment Rate. However, BYE errors represent a smaller portion (11.903 percent) of the Agency Responsible rate.

The UI system is designed to maintain and to encourage claimant attachment to the workforce overall and to their previous employers when feasible. The system does this by allowing partial benefit payments, which are reduced for BYE in each week earned. Weekly benefit amounts may be reduced as a result of wages, commissions, bonuses, tips or gratuities, odd jobs or self-employment income, and through Short-Time Compensation programs (also known as Workshare).[15] Because UI benefits only replace a portion of the claimant's previous base period wages[16], states have devised various earnings disregard and benefit reduction provisions.[17] Ultimately, these payment adjustments require accurate reporting of these earnings. Generally, claimants are required to report income when earned (not when paid) and claimants are required to report gross earnings, not net earnings. This benefit year earnings reporting procedure is part of the continued claims taking process (See claim filing methods by state IPIA_2020_Claim_Filing_Methods.xlsx) and is generally automated.

The BAM program collects data for several important UI eligibility criteria before and

[15]Short-Time Compensation (STC) provides partial UC benefits to individuals whose usual hours of work are reduced to avert the layoff of workers. STC is a program that allows an employer to request UI agency approval of a plan that provides the STC benefits to those workers whose hours are reduced. For more information on STC, see https://stc.workforcegps.org/
[16] See Wage Replacement Ratios in the IPIA_2020_Base_Period_Wages_Report.xlsx spreadsheet
[17] 2020 Comparison of State Laws; Chapter 3 Monetary Entitlement; Table 3-8; pp. 3-19 to 3-21; https://oui.doleta.gov/unemploy/pdf/uilawcompar/2020/monetary.pdf

after the investigation. Claimant earnings and adjustments to the claimant's weekly benefit amount (WBA) for the paid week investigated by BAM (referred to as the key week) can produce useful information related to BYE improper payments. The following table summarizes the earnings before and after data for BAM investigations. The table compares the information at the time the claimant received benefits to the findings after the investigation.

IPIA Period July 1, 2019 through March 31, 2020 Key Week Benefit Year Earnings (BYE) Analysis		
17,232		Completed BAM Reviewed Cases
1,377	7.99%	Of the 17,232 cases completed, 1,377 initially reported key week BYE
		Claimant Over Reported Earnings
170	12.35%	Of the 1,377 cases with earnings, 170 had BYE over reported
	$44.18	Average amount BYE over reported in the key week
	$18.00	Median amount BYE over reported in the key week
110 of 170	$33.98	Average benefit amount paid increased because BYE over reporting
		Claimant Accurately Reported Earnings
764	55.48%	Of the 1,377 cases, 764 had BYE amounts accurately reported
	$206.29	Average amount of BYE accurately reported in the key week
	$172.00	Median amount of BYE accurately reported in the key week
539 of 764	$127.94	Average amount in benefit's paid reduced with accurate BYE reporting
		Claimant Under Reported Earnings
443	32.17%	Of the 1,377 cases with earnings, 443 had BYE under reported
	$121.29	Average amount BYE of under reported in the key week
	$43.00	Median amount BYE of under reported in the key week
335 of 443	$79.52	Average amount Benefit paid decreased because BYE under reporting
		Claimant Reported No Earnings
15,855	92.01%	Of the 17,232 cases, 15,855 had no BYE initially reported
		Claimant Failed to Report Earnings
554	3.43%	Of the 15,855 cases, 554 not initially reporting BYE actually had BYE
	$454.71	Average unreported or concealed BYE amount in the key week
447 of 554	$343.00	Median unreported or concealed BYE amount in the key week
	$250.11	Average amount Benefit paid decreased because failure to report BYE

In IPIA 2020, the BAM program reviewed 17,232 key weeks. From these 17,232 paid weeks, 15,855 or 92.01 percent of the weeks selected had no benefit year earnings reported at the time of payment. From these 17,232 paid weeks, 1,377 or 7.99 percent of the weeks investigated had benefit year earnings reported at the time of payment. Slightly more than 55.48 percent (764 weeks) of the 1,377 key weeks with benefit year earnings initially reported actually had the earnings reported accurately. However, in 433 of weeks with initially earnings reported, representing 32.17 percent of the key weeks investigated, had under reported earnings (claimant earned more than reported), and 170 weeks (12.35 percent) of the weeks had over reported earnings (claimant earned less than what they reported).

Additionally, investigators found 544 weeks or 3.43 percent of the 15,855 weeks with no benefit year earnings initially reported actually had earnings income, which should have been reported.

To address UI improper payments caused by BYE issues, ETA published enhanced Recommended Operating Procedures in UIPL No. 13-19, to provide SWAs with updated best practices on cross-matching with the National Directory of New Hires and the State Directory of New Hires. Also, in partnership with National Association of State Workforce Agencies' UI Integrity Center, ETA conducted research to determine if there are other tools in the market that can provide for earlier detection of UI improper payments, such as through use of financial data.

Work Search Issues

Cause Work Search Issues	Overpayment Rate	Fraud Rate	Agency Responsible Rate
Estimated Amount Overpaid due to Work Search errors	$440,257,199	$31,979,109	$21,808,840
Estimated Total $ Overpaid by Rate	$1,783,417,629	$647,716,984	$185,073,856
Percent of Work Search Overpaid to Total $ Overpaid	24.686%	4.937%	11.784%

The Middle Class Tax Relief and Job Creation Act of 2012 (Public Law 112-96) amended Section 303(a) of the Social Security Act, by adding paragraph a(12) which requires that a claimant must actively seek work. The provision now states: "A requirement that, as a condition of eligibility for regular compensation for any week, a claimant must be able to work, available to work, and actively seeking work." [18] UIPL No. 05-13 at p. 3; (issued January 10, 2013) provides that "Federal Unemployment Compensation (UC) law establishes strictly limited circumstances under which states may not hold UC claimants to the work search requirement." Because Federal UC law does not specifically define "actively seeking work," states have discretion in establishing requirements. Therefore, readers are cautioned to not make any state to state comparisons.

As displayed in the IPIA 2020 Overpayment by Cause and Integrity Rates table above, work search issues were the second leading cause for overpayments in the 2020 reporting period, but they are not a significant cause of fraud overpayments. Additionally, work search overpayments do not represent a significant portion of improper payments for which the agency had full or partial responsibility.

Almost 25 percent of UI improper payments are the result of work search errors. However, work search errors are currently the primary driver in the reduction of UI improper payment rate. UI claimants are required to certify weekly that they have met the state's work search requirements and to document their work search in accordance

[18] https://www.ssa.gov/OP_Home/ssact/title03/0303.htm#ftn16

with the state's law.

States vary with regard to their work search requirements. In many states, claimants must make a minimum number of employer contacts, employment applications, and/or work search activities each week. Within a state there may be differences in the number of work search activities required based on local labor market characteristics, while in other states the number of contacts is standard throughout the state. Some states have expanded work search requirements that allow certain activities, such as attending job search seminars or career networking, to be considered acceptable work search activities. Depending on the occupation, some states require claimants to contact the employer in person. As a condition of eligibility, many states require a claimant to maintain a log, record, or other documentation of weekly work search activities and provide the record for verification purposes. In other states the claimant must provide information about their work search activities when requested.

As a result of these diverse work search eligibility requirements and enforcement standards, there is tremendous variability in work search error rates among states. A lower error rate could reflect a higher rate of work search compliance within the state, which in turn could be due either to greater search efforts by claimants or to less stringent requirements for work search. Other variables include the circumstances such as where the SWA considers claimants' lack of compliance in work search or reporting as constituting an improper payment; or varying SWA standards for verification of claimant provided contacts/activities.

UI program structural issues also contribute to a higher work search improper payment rate. Federal law requires that when an issue is detected, the state agency must provide the claimant notice and an opportunity to provide information. As part of the "payment when due" policy described above, there is a presumption in UI that the claimant will continue to be eligible once initial eligibility is determined and should, therefore, be paid. If an eligibility issue associated with work search (or any other eligibility issue) is detected, there is a requirement to pay for a claimed week no later than the end of the week following the week in which an issue is detected. The time it takes to work through the necessary due process steps prevents states from stopping the payment before it must be paid. In this circumstance, for sound policy reasons, states are legally required to make payments that have the potential to later be considered improper under the Federal definition.

The BAM investigator must review a sufficient number of work search actions to determine whether the claimant met state requirements. The BAM program assigns one of three classifications to each of the actions reviewed. These are:

(1) Acceptable - documentation exists in the BAM file that through new and original fact finding or through the review of state records, such employer contacts, employment applications, or state approved work search activities were made by claimant and were acceptable within state's written law/policy on active search for work.

(2) Unverifiable - the investigator is unable to establish sufficient information to make a judgment of whether the work search activities were either acceptable or unacceptable within the state's written law/policy on work search.

(3) Unacceptable - written documentation exists in the BAM file that through new and original fact finding or through the review of state records, such contacts or activities were not made at all by the claimant or were made but are unacceptable within the framework of state's written law or policy or the work search activity occurred outside of the week investigated.

Work search activities classified as acceptable or unverifiable count towards meeting the state's work search requirement. For performance year 2020, the BAM work search improper payment estimates are based on verification activities representing 17,232 key weeks with an average of 2.02 work search verifications per week totaling 34,816 actions reviewed. Overall, 95.19 percent of the claimant's work search activities met state requirements. This includes those contacts and/or work search activities which are classified as acceptable or unverifiable. Work search contacts, employment applications, and activities deemed unacceptable do not satisfy a count towards meeting the state's numeric requirements.

The BAM dataset includes a number of cases (1,223) where work search was required with zero work search actions found as being acceptable or unverifiable. The cases were found as being properly paid. This includes 539 instances of nonresponse where the cases had no acceptable or unverifiable work search activities. States address such failures or lack of evidence differently. Furthermore, work search documentation requirements vary from state to state. For example, 364 cases with no acceptable or unverifiable evidence of work search were found overpaid. Another 262 of such cases were classified as technically proper payments.[19]

Additionally, states' continued claim processes vary. Some states continued claim systems are capable of capturing detailed work search information at the time a week is claimed. In these states, work search information is available to immediately evaluate when the claimant fails to meet the state's work search requirements.

Finally, one other category where claimants are held ineligible for benefits due to work search issues involves situations where the claimant provided information that initially exempts the individual from work search requirements, but after verification, the exemption is invalid. For example, the claimant stated that they were a member of a union with a hiring hall and they obtained their employment through union referrals or that they had a definite recall date, thereby meeting the work search requirement. However, the investigator's verification with the union found that the claimant was not in good standing or the investigator's verification with the employer found that the claimant had no definite recall date. In such a situation, the claimant might be held ineligible for a failure to conduct an active work search because the exemption was invalid.

For a detailed listing of work search compliance for each state, click on the following link (note: the spreadsheet has multiple tabs or worksheets):
IPIA_2020_Work_Search_Verification_Outcomes.xlsx

Separation Issues

[19] ETA Handbook No. 395, 5th Edition, pages V4 and V5.

Cause : Separation Issues	Overpayment Rate	Fraud Rate	Agency Responsible Rate
Estimated Amount Overpaid due to Separation errors	$323,197,169	$153,961,790	$69,220,020
Estimated Total $ Overpaid by Rate	$1,783,417,629	$647,716,984	$185,073,856
Percent of Separation Overpaid to Total $ Overpaid	18.122%	23.770%	37.401%

As displayed in the IPIA 2020 Overpayment by Cause and Integrity Rates table (page 9), issues involving the claimant's reasons for separating from work (separation issues) are the third leading cause of UI overpayments. They account for 18.12 percent of the overpayment rate and 23.77 percent of the fraud overpayments. Separation issues are the leading cause (37.40 percent) of the amount overpaid for which the agency had full or partial responsibility.

Overpayments attributable to separation issues involve inadequate or inaccurate claimant and/or employer regarding the reason for the claimant's separation from employment. They involve claimants who are initially determined eligible, but due to later information of a disqualifying job separation (such as quitting a job without good cause or being discharged for misconduct under the state UI law) are then determined to be ineligible. The SWAs have the crucial responsibility of identifying and pursuing separation issues, conducting fair and impartial fact finding hearings, and determining whether the employment separation is disqualifying. Separation fact finding hearings involve input from both employers and claimants and the facts may be disputed. In some instances, the SWA contributes to separation improper payments.

Cause	Agency Responsible Rate- Prior Agency Action	Estimated Amount
SEP	(30) SWA Took Incorrect Action	$38,930,168
SEP	(40) SWA Had Documentation - Did Not Resolve Issue	$18,661,800
SEP	(50) Procedures Not Followed Preventing Detection	$6,316,400

The Benefits Timeliness and Quality guide sheets 1 and 2 in the ET Handbook No. 301, 5th Edition show the complexities of fact finding and the central role SWAs play in determining eligibility. However, the process demands employers and claimants provide complete, accurate, and timely facts to separation adjudicators, so the state can appropriately apply the law.

To address UI improper payments caused by separation-related issues, the State Information Data Exchange System (SIDES) was developed by states with funding from the Department and input from states, employers, and third party administrators. It was designed to enable more rapid and accurate communications between SWAs and employers, resulting in better initial eligibility determinations and a reduction in UI improper payments. While SWAs' and employers' participation in SIDES is voluntary, currently, 50 of the 53 SWAs are using SIDES. The Department's Office of Inspector General found SIDES has contributed to reductions in separation-related improper payment rates in SWAs sampled during a recent audit.[20]

[20] https://www.oig.dol.gov/public/reports/oa/2017/04-17-003-03-315.pdf

Overpayment Responsibility by Integrity Rate

The BAM program identifies the party or parties responsible for all payment errors. As with cause, the distribution of overpayment responsibility varies considerably by integrity rate. The BAM investigator attributes responsibility to various parties based on their actions or inaction. Improper payment responsibility may be assigned to one or more parties.

Eligibility for UC is determined on a week-by-week basis. During a continued claim series, a claimant must certify continuing eligibility for each week. The SWA makes continued benefit payments based on the presumption of eligibility and the claimant's ongoing certification that requirements have been met. However, if a question of eligibility arises, the SWA is required to conduct an investigation to establish evidentiary facts and make a subsequent determination of eligibility or ineligibility.[21] Such a determination may affect past, present, or future benefit payments.

Overpayment Responsibility by Integrity Rates

Integrity Rate	Amount Improperly Paid	Claimant Only	Claimant + Employer	Claimant+ Agency	Employer Only	Agency Only	Clmnt+ Empl+ Agy	Employer + Agency	All Others
Over payment	$1,783,417,625	75.709%	11.447%	3.723%	2.551%	3.646%	1.370%	1.232%	0.323%
Fraud	$647,690,894	77.588%	18.141%	1.993%	0.000%	0.045%	2.025%	0.000%	0.208%
Agency Resp	$185,073,856	0.000%	0.000%	38.225%	0.000%	36.468%	13.244%	11.784%	0.279%
Under payment	$90,960,946	29.098%	14.121%	6.408%	34.239%	5.694%	5.772%	1.608%	3.060%

The overpayment rate is the broadest measure of overpayments. Since claimants control much of the information used to establish the presumption of weekly eligibility, it is not surprising that as detailed in the above table, claimants alone were responsible for 75.71 percent of the dollars overpaid included in the overpayment rate. Errors resulting in overpayments that were attributed exclusively to the SWA accounted for 3.65 percent of the amount overpaid. The claimant and the agency were jointly responsible for an additional 3.72 percent of the dollars overpaid, and the claimant and employer were jointly responsible for an additional 11.45 percent of the dollars overpaid. Claimants alone were responsible for 77.59 percent of the fraud overpayments. Claimants and employers were responsible for almost 18.14 percent of fraud overpayments. The claimant and the agency were responsible for most all other fraud.

The agency responsibility rate includes improper payments in which the agency had contributory responsibility. The SWA was solely responsible for 36.47 percent of the amount overpaid included in the agency responsibility rate. The agency and the claimant were responsible for 38.23 percent of this category of overpayments. State agencies shared responsibility with employers for 11.78 percent of the amount overpaid

[21] UIPL No. 04-01, "Payment of Compensation and Timeliness of Determinations during a Continued Claims Series" https://wdr.doleta.gov/directives/attach/UIPL4-01.cfm

in this category; and for the remainder of the agency responsibility overpaid, the state shared responsibility with claimants, employers, or third parties.

For a detailed listing of these rates for each state, click on the following links (note: spreadsheets may have several pages or worksheets):
IPIA_2020_Integrity_Rates_by_Responsibility.xlsx
IPIA_2020_Overpayment_Rate_Cause_and_Responsibility.xlsx

Claimant Action Prior to Sample Selection for Overpayments

Responsibility for improper payments are assigned based on the action that various parties take on the payment. Prior claimant action provides additional details on improper payment responsibility and helps prioritize ways to prevent, reduce, and detect overpayments.

Continuing eligibility for UI is determined on a week-by-week basis. During a continued claim series, a claimant must certify their continuing eligibility for each week. Errors can occur anywhere in this business process. In the case of payment errors, BAM identifies the action that the claimant took prior to the sample selection. BAM assigns a code to indicate action(s) taken by the claimant affecting the payment error issue by recording the following actions:

- Claimant provided adequate and timely information to SWA for determination.
- Claimant provided adequate information to SWA after due date for determination.
- Claimant provided timely but inadequate information to SWA for determination.
- Claimant provided inadequate/incorrect information to SWA after due date for determination.
- Claimant did not respond to SWA request for information.
- SWA did not request the claimant to provide information.

Depending on the cause, BAM often finds claimants responsible for overpayments because they are a principal source of eligibility information. The data further emphasize the importance of verifying separation and earnings information with employers and conducting these verification actions.

For a detailed listing of this rate, click on the following link (note: the spreadsheet may have several pages or worksheets): IPIA_2020_Cause_x_Prior_Claimant_Action.xlsx

Agency Action Prior to Sample Selection for Overpayments

In the case of payment errors, BAM case reviews identify the action that the state agency took before the payment was selected for the BAM sample. Prior agency action provides additional details on improper payment responsibility and helps prioritize ways to prevent, reduce, and detect overpayments. In the case of payment errors, BAM identifies the action that the SWA took prior to the sample's selection.

At the time the SWA made payment, BAM found most overpayments were not detectable through normal agency procedures. BAM found that special agency actions (e.g., crossmatching with the National Directory of New Hires or taking additional steps to secure claimant and/or employer information) were required to prevent or detect these overpayments. The remaining fraud overpayments were distributed among the other prior agency action categories. The table below shows Overpayment Rate by prior agency action.

Overpayment Rate by Prior Agency Action	Percent of Dollars OP	Estimated Amount
Issue Not Detectable by Normal Procedures	87.288%	$1,557,022,679
Identified But Took Incorrect Action	3.826%	$67,404,766
Sufficient Information But Did Not Resolve Issue	3.445%	$61,215,879
In Process of Resolving	2.653%	$47,446,798
Procedures Not Followed Precluding Detection	1.580%	$28,137,956
Detected Thru SDNH/NDNH Crossmatch	1.144%	$20,769,650
Detected Thru Wage Crossmatch	0.034%	$877,700
Agency Provided Incorrect Information	0.031%	$542,199
Total	100.000%	$1,783,417,627

For overpayments included in the overpayment rate, BAM estimates that $1.56 billion or 87 percent of the $1.78 billion of UI benefits overpaid were not detectable through normal agency procedures. BAM results indicate the agency identified the overpayment issue but took the incorrect action in about $67 million or 3.8 percent of dollars overpaid, and the agency had sufficient information but did not resolve the issue for $61 million or 3.4 percent of the amount overpaid. The agency failed to follow its own procedures, which precluded the ability to prevent the overpayment in an additional $28 million or 1.6 percent of the overpayment rate dollars overpaid. At the time BAM selected the sample, the agency had resolved or was in the process of resolving improper payments constituting 2.6 percent of the amount overpaid. Additionally, the agency identified 1.17 percent of these overpayments using crossmatches.

Almost 92 percent of the fraud overpayments were not detectable through normal agency procedures at the time the payment was made. The table below shows fraud overpayments not detectable at the time payment made.

Fraud Overpayments by Cause Classified Not Detectable at Time of Payment			
Fraud Cause	Percent of Dollars Paid	Percent of Dollars OP	Estimated Amount
BYE	1.830%	57.775%	$374,200,869
Sep	0.644%	20.336%	$131,712,958
Work Search	0.157%	4.942%	$32,011,611
A&A	0.119%	3.742%	$24,237,353
Other Issues	0.080%	2.514%	$16,283,149
Other Elig	0.078%	2.459%	$15,928,477
BPW	0.001%	0.033%	$210,688
Total	2.908%	91.801%	$594,585,105

For the Agency Responsible Rate, BAM estimated SWAs were responsible for approximately $185 million in overpayments because they had full or partial responsibility for the overpayment.

Agency Responsible Rate by Prior Agency Action	Percent of Dollars OP	Estimated Amount
State identified issue but took incorrect action.	36.190%	$66,746,540
State had documentation did not resolve the issue	34.287%	$63,384,717
Procedures not followed or forms not completed precluding ability to detect issue	15.135%	$28,168,624
Not detectable by normal procedures	12.697%	$23,616,559
State was in the process of resolving issue	1.082%	$2,023,965
Agency provided incorrect information	0.294%	$542,199
Detected Thru SDNH/NDNH Crossmatch	0.258%	$481,674
Detected Thru Wage Crossmatch	0.059%	$109,573
Total	100.000%	$185,073,851

Of these overpayments, the agency identified the issue but took incorrect action for 36.19 percent of the amount overpaid; the agency had documentation did not resolve the issue for 34.29 percent and did not follow procedures thereby precluding the SWA's ability to detect the payment error for 15.14 percent of the amount overpaid. The remaining overpayments for which the agency had full or partial responsibility were either not detectable through normal procedures at the time the payment was made or the agency had resolved or was in the process of resolving improper payments detected through crossmatches or the error was committed by another SWA. Again, we note there are structural due process requirements in the UI program that prevent stopping payment without an opportunity for the claimant and employer to be heard. These requirements are for good policy reasons and in many cases require the SWA to proceed with payment of benefits that may later be determined to be improper.

For a detailed listing of these rates for each state, click on the following links (note: spreadsheets may have several pages):
IPIA_2020_Integrity_Rates_Cause_x_Prior_Agency_Action.xlsx

Employer Action Prior to Sample Selection for Overpayments

In the case of payment errors, BAM case reviews identify the action that the employer took before the payment was selected for the BAM sample. Prior employer action provides additional details on improper payment responsibility and helps prioritize ways to prevent, reduce, and detect overpayments. As discussed in the previous section, BAM considers a large majority of the overpayments included in the overpayment rate and fraud rate to be undetectable by the agencies during their usual payment administration processes, and thus prohibitively expensive for the agency to prevent. However, BAM detects the majority of its payment errors through the verification of claim information with employers.

Although claimants provide most of the information that agencies use in determining eligibility for UI benefits, employers also provide critical information to the agencies. Employers provide wage information, which is used to calculate the claimants' monetary eligibility and weekly benefit payments. Employers also respond to notices of new initial and additional claims by providing information on the reason for the claimant's separation from work. Employers submit notices of new hires, which agencies use to detect claims filed by individuals who have returned to work. Employers also provide detailed information that may corroborate or contradict claimant-provided information on issues that affect eligibility, such as information concerning availability for work, work search, job refusal, and benefit year earnings.

BAM data show that prior employer action is a critical factor in the agency's ability to prevent or detect many overpayments. BAM assigns a code to indicate action(s) taken by the employer affecting the payment error issue and records the following employer actions:

- Employer provided adequate information to SWA in a timely manner for the payment determination.
- Employer provided adequate information after due date for payment determination.
- Employer provided inadequate/incorrect information in a timely manner for payment determination.
- Employer provided inadequate/incorrect information after due date for payment determination.
- Employer did not respond to request for information.
- Employer did not report claimant as a "New Hire" as required by law.
- Employer, as an interested party, was not requested by agency to provide information for determination.
- Not an employer-related issue.

Because the state agency uses employer-provided information in its eligibility determinations, the accuracy and timeliness of this information affect whether benefits were properly paid. The following table displays prior employer actions for each of the integrity rates. The highlighted cells reflect employers' action that may lead to improper payments.

IPIA 2020 Integrity Rates – Estimated Dollars Overpaid by Prior Employer Action

	Overpayment Rate	Fraud Rate Overpayments	Agency Rate Overpayments
Total Estimated Overpaid	$1,783,417,628	$647,690,891	$185,073,852
Prior Employer action as of the time that the payment was selected for audit			
Not An Employer Related Issue	$551,704,202	$71,038,959	$56,872,186
Agency Did Not Request	$619,523,178	$306,736,207	$22,438,211
Adequate and Timely Information	$297,556,461	$129,991,571	$58,874,402
Did Not Respond to request for info.	$138,534,522	$88,275,920	$15,997,152
Timely Inadequate/Incorrect information	$86,943,791	$7,370,296	$21,328,576
Did Not Report New Hire	$55,784,043	$39,706,504	$2,453,683
Adequate but Not Timely information	$29,522,601	$4,571,434	$6,488,544
Inadequate/Incorrect and Untimely	$3,848,830	$0	$621,098
Estimated dollars overpaid where a different employer action may have produced a different outcome	$314,633,787	$139,924,154	$46,889,053
Percent of Total Dollars overpaid where a different employer action may have produced a different outcome	17.64%	21.60%	25.34%

The highlighted sections show estimated overpayments where a different employer action in response to a claim may have produced a different outcome. BAM estimates that employer actions contribute 17.64 percent of the overpayments included in the overpayment rate, 21.60 percent to the fraud rate dollars overpaid, and 25.34 percent of the overpayments included in the agency responsible rate. Overall, BAM data show that prior employer participation is an essential factor in the prevention or detection of many overpayments.

For a detailed listing of these rates for each state, click on the following links (note: spreadsheets may have several pages or worksheets):
IPIA_2020_Integrity_Rates_Cause_x_Prior_Employer_Action.xlsx

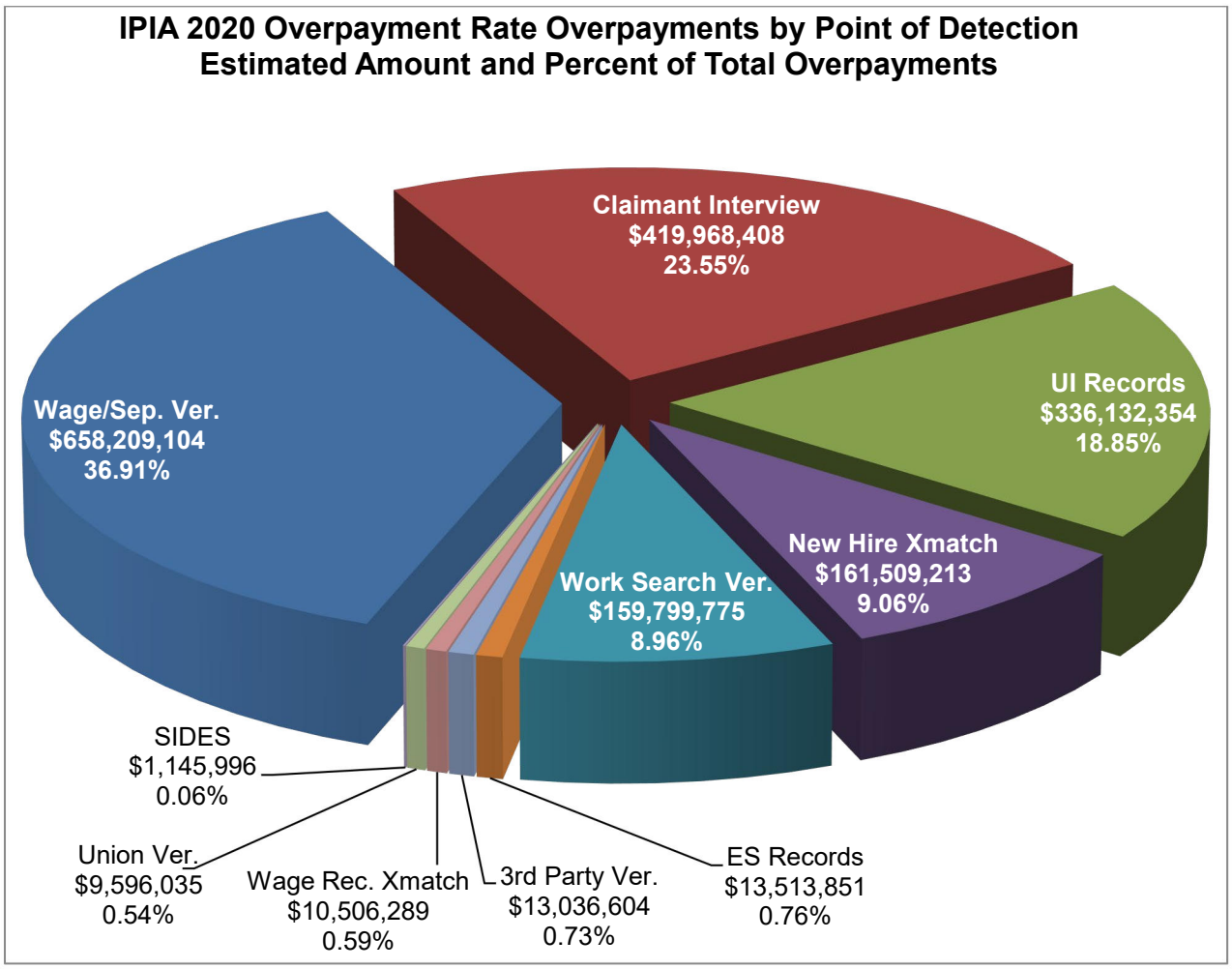
Point of Detection

BAM records the point in its audit process at which it first detects a payment error. BAM detects most payment errors by verifying base period wages, benefit year earnings, and separation information with employers. The data suggest that taking additional steps to secure employer information or to conduct more in-depth claimant interviews may impact overpayment amounts. For example, BAM found significant errors when payment information is corroborated with employers and through extensive claimant interviews.

Within this framework, it is important to note that the BAM audit process differs substantially from normal UI operations in terms of cost, time, and effort. BAM exhausts

all avenues in obtaining information. Normal UI operations make reasonable attempts to obtain information, but must make determinations based on available information in order to make timely payments.[22] Therefore, this procedural difference may contribute to BAM identifying some of these overpayments which are not detected by the agency during the normal claims processes.

BAM also captures whether the agency had identified the overpayment at the time of sample selection. In many cases, the SWA has not taken action on the new hire crossmatch hit when BAM selects its case. This strongly suggests that SWA should review and improve their crossmatch workflow processes and adjust their crossmatch parameters to optimize new hire detections. Aggregate IPIA 2020 Point of Detection data are displayed in the following chart.



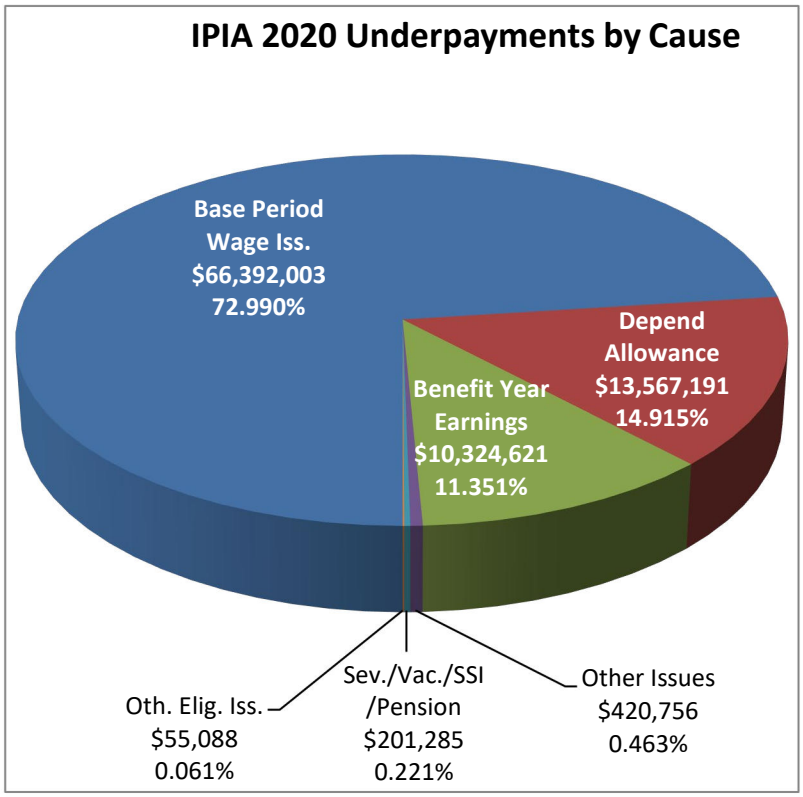
For a detailed listing of these rates for each state, click on the following links (note: spreadsheets may have several pages or worksheets):
IPIA_2020_Integrity_Rates_by_Point_of_Detection.xlsx

[22] UIPL No. 04-01

II. Underpayments

Underpayment Rate

IPIA requires estimates of underpayment rates, in addition to overpayments. BAM estimates that a total of $90.96 million was underpaid in IPIA 2020, compared with $103.7 million in IPIA 2019. IPIA 2019 data excludes technically proper underpayments.



As a percentage of UI benefits paid, the IPIA 2020 national underpayment rate of 0.445 percent is slightly lower than the IPIA 2019 national underpayment rate of 0.396 percent. State underpayments ranged from 0.000 percent in Georgia, Indiana, and Missouri to 1.432 percent in New Jersey.

As with overpayments, the BAM program captures the cause of and responsibility for underpayments. Errors in reporting or recording base period wages accounted for over 72 percent of the amount underpaid and represented 0.33 percent of the amount of UI benefits paid. Employers report employees' wages to SWAs each calendar quarter. SWAs use these wages to establish a claimant's base period, which in turn is used in the calculation of weekly benefit amounts and maximum benefit amounts. Instances in which the weekly benefit amount increases after the BAM investigation represent underpayments used to produce the portion of the estimate.

The base period wage accuracy report shows the impact of misreported wages on benefit payments detailed in the Table below.

Accuracy Finding	Base Period Wages		Weekly Benefit Amount		Maximum Benefit Amount	
	% of Cases	Avg. Error	% of Cases	Avg. Error	% of Cases	Avg. Error
Correct	84.81%		95.31%		93.80	
Understated	8.28%	($8,869)	2.59%	($41)	8.28	($1,648)
Overstated	6.91%	$5,823	2.09%	$50	6.91	$1,314
Total	100.00%		100.00%		100.00%	

(See IPIA_2020_Base_Period_Wages_Report.xlsx for individual state findings. The spreadsheet has several worksheets or tabs and includes worksheets for underpayment cause and responsibility.)

Errors in awarding dependent allowance was the second leading cause in paying the correct benefit amount due under state law. Only thirteen states have dependent allowances provisions and have varying dependents allowance amounts and definitions of a dependent. This issue accounts for 15 percent of all underpayments and 0.07 percent of UI benefits paid

Errors in reporting or recording benefit year earnings (BYE) were the third leading cause of underpayments – accounting for 11.5 percent of all underpayments and 0.05 percent of UI benefits paid. Generally, claimants can work and earn wages while collecting UI benefits as long as they report their earnings. However, weekly UI payments may be adjusted downward based on claimant reported earnings. For many of these underpayments, the claimant may have over reported their weekly earnings and, because of this error, BAM found that UI benefit amount paid was too small.

IPIA Period July 1, 2019 through March 31, 2020 Key Week Benefit Year Earnings (BYE) Analysis		
17,232		Completed BAM Reviewed Cases
1,377	7.99%	Of the 17,232 cases completed, 1,377 initially reported key week BYE
		Claimant Over Reported Earnings
170	12.35%	Of the 1,377 cases with earnings, 170 had BYE over reported
	$44.18	Average amount BYE over reported in the key week
	$18.00	Median amount BYE over reported in the key week
110 of 170	$33.98	Average benefit amount paid increased because BYE over reporting

As with overpayments, the BAM program captures the responsibility for underpayments. The chart below shows the distribution of underpayment responsibility. Employers alone were responsible for almost 34 percent of amount underpaid, which represented 0.15 percent of the amount of UI benefits paid.

BAM Estimated Underpayments by Responsibility IPIA 2020 (CY 2019 Qtr. 3 to CY 2020 Qtr. 1)			
Responsibility	Percent of Dollars Paid	Percent of Dollars UP	Estimated Amount
Employer Only	0.153%	34.239%	$31,276,430
Claimant Only	0.129%	29.098%	$26,361,750
Claimant + Employer	0.062%	14.121%	$12,747,133
Claimant + Agency	0.029%	6.408%	$5,838,516
Agency Only	0.025%	5.694%	$5,193,281
Clmnt+Empl+Agy	0.025%	5.772%	$5,137,444
All Others	0.014%	3.060%	$2,797,305
Employer + Agency	0.008%	1.608%	$1,609,087
Total	0.445%	100.000%	$90,960,946

Claimants alone were responsible for an additional 29 percent of the amount underpaid, which represented 0.13 percent of the amount of UI benefits paid. Because SWAs often send out confirmations to the claimant and base period employers at the time of monetary determination, responsibility for these types of underpayments are highly distributed.

The underpayments estimated from BAM paid claims samples represent underpayments only for those claimants who were originally found eligible for UC by the state.

III. Denied Claims Accuracy

Denied Claims Accuracy (DCA) Rates

Each week, BAM units in the SWAs select samples of denied UI claims from three populations (defined by the type of issue on which a benefit denial was based) -- monetary, separation, and nonseparation. DCA measures the accuracy of disqualifying monetary, separation, and nonseparation determinations for both intrastate and interstate claims.

Unlike the investigation of paid claims, in which all prior determinations affecting claimant eligibility for the compensated week are evaluated, the investigation of denied claims is limited to the issue upon which the denial determination is based. DCA investigators verify facts contained in the case file, obtain any missing information, and conduct new and original fact-finding that may impact the denial determination. The DCA audits record error information in a manner similar to paid claim accuracy: Dollar Amount of Error, Error Issue Action Code, Error Cause, Error Responsibility, Error Detection Point, Prior Agency Action, Prior Employer Action, DCA Action Appealed, and Prior Claimant Action.

DCA Rate Table

The following table summarizes the DCA rates for the three denial categories.

IPIA 2020 US Denied Claims Accuracy Rates

Denial Type	BAM Population of Denials	Improper Denial Rate*	Adjusted Improper Denial Rate**	Over-Payment ****	Proper Denial***
Monetary	547,920	17.68%	14.19%	0.01%	0.77%
Separation	972,218	10.25%	7.05%	0.06%	7.63%
Nonseparation	1,796,096	13.11%	9.36%	0.46%	4.64%

DCA Rate Table Notes:

In several states, the population from which the BAM DCA samples were selected may not include all of the determinations that meet the definition for inclusion in the DCA population. This limits the degree to which inferences about the population can be made from BAM DCA data. States are still in the process of resolving these population issues.

* Improper Denial Rate is the percentage of denied claims that BAM DCA concluded were erroneous, whether or not official agency action was taken to issue payment or increase claimant's WBA, MBA or remaining balance.

** Adjusted Improper Denial Rate excludes erroneous denials that were corrected by the agency and claims for which eligibility was established on appeal prior to DCA case completion.

*** Proper Denial is the percentage of properly denied claims, but BAM identified a procedural error, such as basing the determination on the wrong reason or section of the law or applying an incorrect period of denial.

**** Overpayments are discussed below.

Monetary Denials

IPIA 2020 US Denied Claims Accuracy Rates

Denial Type	BAM Population of Denials	Improper Denial Rate*	Adjusted Improper Denial Rate**	Over-Payment ****	Proper Denial***
Monetary	547,920	17.68%	14.19%	0.01%	0.77%

SWAs determine the monetary[23] eligibility of claimants when they file a new initial claim or a transitional claim (to establish a new benefit year). In IPIA 2020, SWAs determined that 83.57 percent or 13.65 million of the 16.64 million new initial and transitional claims were monetarily eligible.

The BAM program estimates that 17.68 percent of the 547,920 monetary denials included in the BAM DCA population were improper. This compares to an improper denial rate of 15.31 percent in IPIA 2019. These UI claims were denied because the agency had initially determined that the claimant had not earned sufficient wages in covered employment prior to being unemployed or failed to meet other requirements for monetary eligibility, such as sufficient earnings in a minimum number of weeks. The BAM DCA audit identified additional wage credits or an alternate or extended base period for these claimants that had not been included in the original monetary determination or identified other errors in the original determination.

For a small portion of these improper monetary denials, the SWA had identified the additional wages and issued a redetermination establishing eligibility independent of the

[23] See the 2020 Comparison of State Unemployment Laws Chapter 3 for Monetary Entitlement https://oui.doleta.gov/unemploy/pdf/uilawcompar/2020/monetary.pdf

BAM investigation, or the initial denial was reversed on appeal. When the improper monetary denial rate is adjusted for these agency initiated redeterminations or appeals reversals, the improper denial rate for monetary determinations drops to 14.19 percent. This rate is higher than the adjusted improper denial rate of 12.51 percent in IPIA 2019.

In states with alternative base period (ABP) provisions only an estimated 43 percent of monetarily denied claimants living in states with such a legal provision received a determination regarding their alternative base period eligibility. Generally, the ABP provision provides that a claimant use the four most recent completed calendar quarters in the base period, prior to filing the claim for benefits, if the individual is found ineligible for the regular base period (first four of the last five completed quarters). In other words, such state laws allow claimants two methods at becoming monetarily eligible. In 2019, 39 states had ABP provisions in their state laws.

On September 16, 2019, the Department issued guidance setting out requirements for ABPs. UIPL No. 17-19.

The BAM program records the agency's action whether the state redetermined the claimant's monetary eligibility prior to or during the course of the DCA investigation.

Separation Denials

IPIA 2020 US Denied Claims Accuracy Rates

Denial Type	BAM Population of Denials	Improper Denial Rate*	Adjusted Improper Denial Rate**	Over-Payment ****	Proper Denial***
Separation	972,218	10.25%	7.05%	0.06%	7.63%

To be eligible for UC, generally states require claimants to be unemployed due to no fault of their own, discharged for non-disqualifying reasons, or must have voluntarily left employment for a non-disqualifying reason provided in state law (such as workplace harassment, unsafe working conditions, domestic violence, or to relocate with a spouse). Agencies conduct fact-finding investigations when a separation issue has been identified. Separation issues generally involve an act of misconduct (fired) or leaving employment without good cause (quit). During fact-finding, the agency gathers information from the claimant, employer, and relevant third parties through structured interviews. Based on the findings of fact and the application of state laws, SWAs issue a determination on whether the claimant is eligible for benefits.

Separation issues normally are identified when a new initial claim or an additional claim is filed. Generally, separation issues are addressed after a claimant is found monetarily eligible. In IPIA 2020, there were approximately 13.65 million monetarily eligible new initial claims and approximately 3.50 million additional claims. No separation determinations were required for nearly 87.18 percent of these claims, because the reason for separation was lack of work or reduction in workforce. SWAs completed almost 2.20 million separation investigations and found disqualifying circumstances in 1.04 million of these determinations that resulted in denial of benefits.

In IPIA 2020, BAM estimated that 10.25 percent of the 972,218 separation denials included in the BAM DCA population were improper, compared with 11.45 percent estimated for IPIA 2019. When redeterminations and appeal reversals are taken into account, the improper denial rate for separations in IPIA 2020 is adjusted to 7.05 percent, compared with 7.99 percent in IPIA 2019.

Nonseparation Denials

IPIA 2020 US Denied Claims Accuracy Rates

Denial Type	BAM Population of Denials	Improper Denial Rate*	Adjusted Improper Denial Rate**	Over-Payment ****	Proper Denial***
Nonseparation	1,796,096	13.11%	9.36%	0.46%	4.64%

Nonseparation issues include the claimant's ability to work, availability for work, disqualifying and unreported earnings and income during the benefit year, failure to meet work search requirements, and failure to report as required by the SWA to provide information related to the UI claim or to receive reemployment services. There is often a distinction between issues that result in an indefinite disqualification and issues that result in a single or a specific number of weeks of ineligibility. Disqualified claimants have no right to benefits until they requalify, usually by obtaining new work and/or by serving an established disqualification period. In some cases, benefits and wage credits may be reduced. An ineligible worker is prohibited from receiving benefits until the condition causing the ineligibility ceases to exist. Eligibility issues are generally determined on a week-by-week basis. Although nonseparation issues can be detected at various points in the UI claims taking process, these issues generally affect the claimant's eligibility for continued claims of UI.

In IPIA 2020 and the period reviewed, SWAs made payments for 61.39 million weeks. SWAs completed 2.33 million nonseparation determinations and concluded that 2.00 million of those investigations should result in denial of benefits.

For the 1.8 million nonseparation denials included in the DCA population, BAM estimates an improper denial rate of 13.11 percent and when redeterminations and appeals reversals are taken into account, the adjusted improper denials rate is 9.36 percent.

Overpayments and Proper Denials

The BAM program determined that small percentages of the monetary denials (0.01 percent), separation denials (0.06 percent), and nonseparation denials (0.46 percent) resulted in overpayments. Overpayments can occur if the period of disqualification for UI benefits was less than it should have been and the claimant received compensation during the period that they should have been ineligible for benefits. Overpayments can also occur if the claimant received a partial payment that was too large. A partial payment is a reduction in the claimant's weekly benefit amount and is issued when the claimant has earnings or other deductible income (such as pension, vacation, severance, and Supplemental Security Income) for weeks of claimed UI benefits. For

some of these compensated weeks, the BAM audit identified additional income that reduced benefits further or in some cases eliminated eligibility for benefits entirely.

In all three types of denials, the BAM program concluded that the claimant was properly denied but the agency committed a procedural error, such as basing the determination on the wrong reason or section of the law or applying incorrect dates to the period of denial. For example, a claimant may have been denied because of a monetary determination that the claimant had earned insufficient wages in the minimum number of weeks required by state law. The BAM audit determined that the claimant did meet the minimum weeks test, but was still ineligible due to insufficient total wage credits earned in the base period. For separation and nonseparation determinations, these errors typically involve citing the wrong issue or the wrong section of the law in the determination (for example, quit versus fired or availability versus reporting).

For a detailed listing of these denial rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Denied_Claims_Accuracy_&_Error Rates.xlsx

Agency Action for Improper Denials

Not every improper denial results in the agency issuing a payment to the claimant (i.e., increasing the claimant's weekly benefit amount, maximum benefit amount, or dependents' allowance), for example, in some states, determination finality rules apply. In 79 percent of the improper monetary denial cases reviewed as part of the BAM review, the agencies or BAM took action to ensure that benefits were paid. Additionally, in the other types of denials reviewed, 57 percent and 56 percent of the claimants improperly denied for separation and nonseparation issues respectively, received benefits. In some cases, claimants are ineligible for payment due to other disqualifying issues. In other cases, the agency is precluded from taking action because of the time that has elapsed since the denial was issued (determination finality rules) or by other provisions of the law or the claimant requested no payments after being denied.

IPIA reporting period July 1, 2019 through March 31, 2020
(Batch Range 201927 through 202013)

Sample Denial Type	Total Denial Error Rate	Improper Denial Official Action To Pay	Improper Denial No Payment Due Not Entitled	Improper Denial Unable to Take Official Action (finality)	Over-payment Claimant eligible	Proper Denial Wrong Reason or Procedural Error
Monetary	17.68%	14.00%	2.12%	1.65%	0.01%	0.78%
Separation	10.25%	5.89%	2.17%	2.19%	0.06%	7.68%
Nonseparation	13.11%	7.60%	4.02%	1.49%	0.46%	4.64%

BAM investigators record the following agency actions:

- Official Action To Pay - Agency or BAM took action to issue payment;

- No Payment Due - Claimant was not entitled to payment due to other disqualifying issue(s) or the claimant did not file a claim for the week(s), which were improperly denied;
- Unable to Take Official Action - No official action could be taken due to finality or other provisions of state law prohibiting redetermination;
- Overpayment - Claimants received payment for weeks of unemployment to which they were not entitled; and
- Procedural Error - Claimant properly denied, but BAM identified a procedural error on the part of the agency such as applying the wrong section of the law.

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Agency_Action_on_Improper_Denials_By_Denial_Type.xlsx

Cause for Improper Denials

The distribution of the causes of improper denials varies considerably among the three denial types and rates. The elements included or excluded from the various rates are controlled by business process definitions, which influences the distribution. Generally, the improper denial cause is directly related to the sample type. For example, monetary denials are related to the base period wages.

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Improper_Denials_by_Cause.xlsx

Responsibility for Improper Denials

The party responsible for erroneous denials varies by type of denial determination. Employers were solely responsible for 29.13 percent of the erroneous monetary denials due to misreporting or underreporting employees' wages. A small percentage of these improper monetary denials involved employers misclassifying claimants as independent contractors during the base period. Claimants were responsible for another 15.76 percent of the erroneous monetary denials, and agency error accounted for approximately 18.03 percent of the improper monetary denials. States often hold claimants responsible for improper monetary denials because the state sends a notice to the claimant showing the information used. That monetary determination notice instructs the claimant to notify the state if the information used is incorrect. The remainder of the improper monetary denials had shared responsibility between these parties and others.

Responsibility For Improper Denials -- IPIA 2020								
Denial Sample Type	Improper Denial Rate	Percent of the Improper Denial Rate						
		Claimant Only	Agency Only	Employer Only	Employer & Agency	Employer & Claimant	Claimant & Agency	All Others
Monetary	17.68%	29.13%	18.03%	15.76%	2.44%	21.13%	6.96%	6.54%
Separation	10.25%	12.12%	35.67%	7.67%	13.65%	10.95%	10.06%	9.88%
Nonseparation	13.11%	49.56%	28.93%	0.75%	1.56%	5.91%	9.20%	4.09%

The SWAs were solely responsible for 35.67 percent of the incorrect separation denials and 28.39 percent of the improper nonseparation denials. Claimants were solely responsible for approximately 49.56 percent of the erroneous nonseparation denials.

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Improper_Denials_by_Responsibility.xlsx

Improper Denials by Prior Agency Action

Because the SWAs, either solely or jointly with other parties, are responsible for the majority of the erroneous nonmonetary denials and for a significant proportion of the monetary denials, it is instructive to examine agency action prior to the DCA investigation.

Prior Agency Action For Improper Denials -- IPIA 2020
July 1, 2019 through March 31, 2020 (Batch Range 201927 - 202013)
Percent of the Improper Denial Rate

Sample Type	Not Detect	Agency Resolved	Incorrect Action	Not Resolved	Procedure Not Followed	Detected By XMatch	Provided incorrect Info	Other SWA Error
Monetary	55.77%	17.95%	7.09%	11.70%	7.40%	0.00%	0.05%	0.03%
Separation	26.40%	11.06%	43.81%	6.20%	12.40%	0.00%	0.00%	0.00%
Nonseparation	44.03%	19.83%	25.31%	5.17%	5.46%	0.02%	0.06%	0.12%

Agencies had resolved or were in the process of resolving 17.95 percent of the erroneous monetary denials. For improper nonmonetary denials, the agency identified the issue but took the incorrect action for 43.81 percent of the improper separation determinations and 25.31 percent of the erroneous nonseparation determinations.

Although the agency followed its procedures, the issue or information was undetectable for 26.40 percent of the improper separation determinations and 44.03 percent of the erroneous nonseparation determinations. For these claims the agency issued its determination to deny eligibility based on information that, although incomplete, was the best available under normal procedures at the time of its decision.

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Improper_Denials_by_Prior_Agency_Action.xlsx

Separation Denial Issues

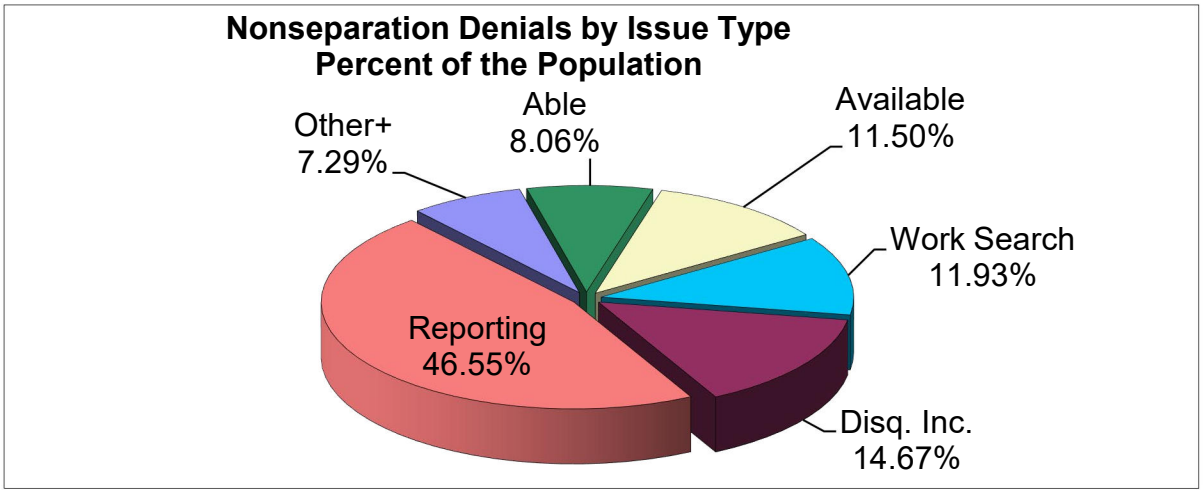
A majority of the separation denials concerned voluntary quits (VQ), representing 55.23 percent of the population. “Other” separation denials include a small number of labor disputes, military separations, or claimants who were still job attached (partial unemployment). Claims that were denied for VQ issues were slightly more likely to be in error (10.29 percent) than denials issued for discharge (10.04 percent). Separation denials that were based on “Other” issues were incorrect at the highest rate (23.08 percent) of separation denial types. The following table displays sample and population classification of these separation denial determinations and improper denial rates by type.

Separation Type	Sample Cases	Population of separation type denial	Percentage of Type in Population	Improper Denials
Voluntary Quit	2,990	536,993	55.23%	10.29%
Discharge	2,549	429,534	44.18%	10.04%
Other	46	5,692	0.59%	23.08%
Total	5,585	972,218	100.00%	
Total % Improper Denials for all Separation Type				10.25%

For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Denied_Claims_Accuracy_Separation_Determinations.xlsx

Nonseparation Denial Issues

The largest category of nonseparation denials in IPIA 2020 concerns claimants failing to report when SWAs require them to provide information related to the UI claim or to receive reemployment services.



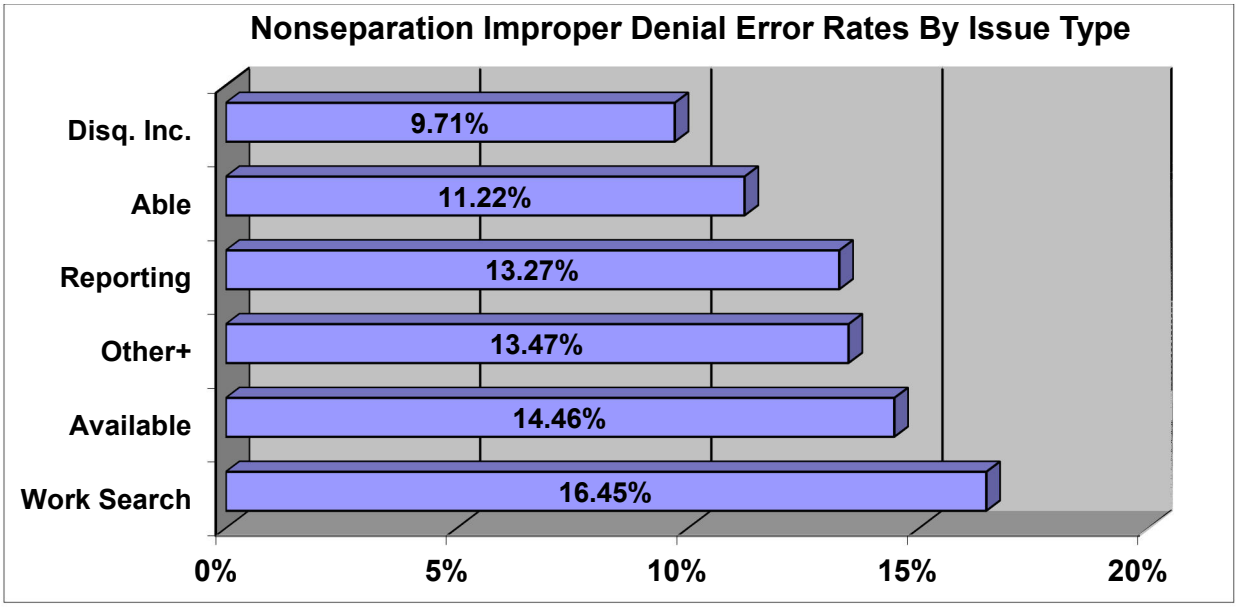
Failing to report is followed by issues involving disqualifying income issues and work search denials. The remaining nonseparation denials are distributed among several issues, such as being available for work, being able to work, and other issues The "Other" nonseparation denial category includes issues such as refusal of suitable work, alien status, athlete, school, and seasonality.

The following table displays sample and population classifications of these nonseparation denial determinations and improper denial rates by type.

Nonseparation Denial Type	Sample Cases	Population of Denials	Percentage of Denial in Population	Percent Improper Denials
Reporting	2,310	836,136	46.55%	13.27%
Disq. Inc.	969	263,436	14.67%	9.71%
Work Search	694	214,206	11.93%	16.45%
Available	594	206,637	11.50%	14.46%
Able	534	144,810	8.06%	11.22%
Other+	488	130,871	7.29%	13.47%
Total	5,589	1,796,096	100.00%	
% Improper				13.11%

+Other includes refusal of suitable work, alien, athlete, school, seasonality issues.

Denials involving being actively seeking work had the highest percent of determinations involving improper denial of benefits (16.45 percent). Denial issues in being available for work had the second highest improper denial rate (14.46 percent). Failure to report denials represent the largest population of nonseparation denials and had an improper denial rate of 13.27 percent. Determinations that denied eligibility because the claimant had disqualifying or deductible income represented the second largest portion of nonseparation denials and had the lowest improper denial rate of 9.71 percent.



For a detailed listing of these rates for each state, click on the following link (note: the spreadsheet may have several pages or worksheets):
IPIA_2020_Denied_Claims_Accuracy_Nonseparation_Determinations.xlsx

Links to Additional BAM Paid and Denied Claims Data and BAM Methodology

Integrity Rates*

- IPIA_2020_Integrity_Rates_all_states.xlsx
- IPIA_2019_-_IPIA_2020_Integrity_Rate_Changes.xlsx

Integrity Rates - Cause / Responsibility*

- IPIA_2020_Integrity_Rates_x_Cause.xlsx
- IPIA_16_IPIA_20_Overpayment_Rate_by_Quarter_&_State.xlsx
- IPIA_2020_Work_Search_Verification_Outcomes.xlsx
- IPIA_2020_Integrity_Rates_by_Responsibility.xlsx
- IPIA_2020_Overpayment_Rate_Cause_and_Responsibility.xlsx

Integrity Rates - Prior Action / Point of Detection*

- IPIA_2020_Integrity_Rates_Cause_x_Prior_Agency_Action.xlsx
- IPIA_2020_Cause_x_Prior_Claimant_Action.xlsx
- IPIA_2020_Integrity_Rates_Cause_x_Prior_Employer_Action.xlsx
- IPIA_2020_Integrity_Rates_by_Point_of_Detection.xlsx
- IPIA_2020_Claim_Filing_Methods.xlsx

Underpayments and Denied Claim Accuracy*

- IPIA_2020_Base_Period_Wages_Report.xlsx
- IPIA_2020_Denied_Claims_Accuracy_&_Error Rates.xlsx
- IPIA_2020_Agency_Action_on_Improper_Denials_By_Denial_Type.xlsx
- IPIA_2020_Improper_Denials_by_Cause.xlsx
- IPIA_2020_Improper_Denials_by_Prior_Agency_Action.xlsx
- IPIA_2020_Denied_Claims_Accuracy_Separation_Determinations.xlsx
- IPIA_2020_Denied_Claims_Accuracy_Nonseparation_Determinations.xlsx
- IPIA_2020_Improper_Denials_by_Responsibility.xlsx

BAM Methodology

- IPIA_2020_Methodology_and_Program_Description
- IPIA_2020_Method_Claimant_Information_Obtained.xlsx
- IPIA_2020_Report_State_Contacts.xlsx
- ET_395_Handbook_5th_Edition_BAM_State_Operations_Guidance
- Code_of_Federal_Regulations-Quality_Control_in_the_Federal_State_UI_System

Other References

- Comparison_of_State_Unemployment_Insurance_Laws_IPIA_2020
- Significant_Provisions_of_State_UI_Laws_IPIA_2020

*** Note: the spreadsheets may have several pages or worksheets**

Prepared by:
U. S. Department of Labor
Employment and Training Administration
Office of Unemployment Insurance
Division of Performance Management (March 2021)

Payment Error Rate Measurement (PERM)
RY 2019 Medicaid Corrective Action Plan
Pennsylvania

Table of Contents

Medicaid Corrective Action Cover Page

This document serves as a template for the state to enter its plan for corrective actions. The template will guide Pennsylvania in reporting the root cause for each error and deficiency found in the RY 2019 measurement and the appropriate corrective actions to resolve them. Please refer to the state's Cycle Summary report for a full analysis and breakdown of the findings that contribute to Pennsylvania's improper payment rate through the PERM program. Please note that the definition of an improper payment is derived from the Improper Payments Information Act (IPIA) of 2002, as amended, and 42 CFR 431.958. Please keep in mind that corrective actions should focus on how to prevent the same improper payment (or deficiency) from occurring again. Please also keep in mind that the Corrective Action Plan (CAP) is not a venue to dispute errors or deficiencies cited. For more information on completing this template, please refer to the CAP template instructions.

A. (State): Pennsylvania **Fiscal Year:** 2019

B. (Date): 2/24/2020

C. State Contact: Jean Lettich
Phone number: 717.772.4616
Email address: jlettich@pa.gov

D. Medicaid Federal Improper Payment Rate: 14.24%
Fee-For-Service Rate: 8.74%
Managed Care Rate: 0.00%
Eligibility Rate: 11.36%

Next Cycle Fee-For-Service Target: 5.12%
Next Cycle Managed Care Target: 0.00%
Next Cycle Eligibility Target: 3.00%

E. Summary of Medicaid Error Causes[1]

Fee-For-Service:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
No Documentation Error (MR1)	1	$30.03	$12.46
Document(s) Absent from Record (MR2)	7	$13,245.87	$56.46
Number of Unit(s) Error (MR6)	4	$201.40	$31.65
Improperly Completed Documentation (MR9)	1	$1,979.86	$12.40
Provider Information/Enrollment Error (DP10)	51	$78,760.55	$436.26
Data Processing Technical Deficiency (DTD)	14	$0.00	$0.00

[1] Multiple errors on a claim are counted separately, which may result in a discrepancy when compared to the Cycle Summary Report results by type of error.

Managed Care:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
There are no Managed Care errors	0	$0.00	$0.00

Eligibility:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	32	$64,921.14	$725.85
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	28	$20,536.11	$873.71
Determination Not Conducted as Required (ER3)	18	$8,307.26	$359.87
Not Eligible for Enrolled Program - Financial Issue (ER4)	3	$5,815.26	$72.91
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	2	$75.46	$31.48
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	2	$623.17	$38.56
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	$365.60	$28.79
Other Errors (ER10)	4	$448.54	$3.16
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	3	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	151	$0.00	$0.00

F. Optional State Medicaid Corrective Action Discussion

Click here to enter text.

RY 2019 Medicaid FFS Federal Improper Payment Rate: 8.74%

As noted in your Cycle Summary Report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Medical Review (MR)[2]

FFS Finding Category #1: No Documentation Error (MR1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Provider responded that he or she did not have the beneficiary on file or in the system	1	$30.03	$12.46
Total	1	$30.03	$12.46

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

[2] No response is needed for No Documentation (MR1) errors that are cited for providers under fraud investigation.

Qualifier #1: Provider responded that he or she did not have the beneficiary on file or in the system

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904F158	$30.03	$12.46

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The provider failed to identify that they had the information on this recipient. The Provider had no direct access to the medical records. The Medical Record Supervisor requested that Children and Youth provide the required documentation. A Request for Records letter was sent to the Law Department for Children and Youth per the Medical Record Supervisor. No response was received from Law Department.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit

procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.

7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and

Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.

15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementa-tion has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle. Request number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainin

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					gs%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	On-going process	OLTL	Conducts periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Detection System (FADS)					reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.

4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (

1920SBAPStatewideTraining.pdf

Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #2: Document(s) Absent from Record (MR2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
One or more documents are missing from the record that are required to support payment	7	$13,245.87	$56.46
Total	7	$13,245.87	$56.46

State may provide additional Data Analysis here (optional)

Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: One or more documents are missing from the record that are required to support payment

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F055	$2,645.50	$7.17
PAM1902F004	$5,613.47	$7.67
PAM1903F035	$3,388.86	$4.03
PAM1903F131	$473.59	$10.71
PAM1903F167	$46.92	$14.22
PAM1904F077	$849.68	$7.09
PAM1904F128	$227.84	$5.57

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Seven (7) instances of MR2 errors-Insufficient Documentation. These errors fell under the Nursing Facility/Intermediate Care Facilities Service Type. Nursing Facility/Intermediate Care Facilities accounted for 23% of total projected dollars in errors and Habilitation/Waiver Programs/School Services accounted for 79% of the total projected dollars in error. The errors

occurred with multiple providers with insufficient documentation to support the claim, missing Individual Education Plans, and failure to submit additional documentation as requested. Two (2) of the errors fell under the Nursing Facility/Intermediate Care Facilities Service Type. The errors occurred from different Providers: one was missing a Progress record within the required 60 day period, and one lacked a signature on a Physician Order. This Provider submitted Interim and Telephone orders which were not signed by the Physician.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

Qualifier #1: Provider failed to Provide a signed Physician order for that Date of Service

PERM ID	Federal Dollars in Error
PAM1901F055	$2,645.50

Qualifier #2: Provider failed to Provide a record with daily documentation of specific tasks performed for that Date of Service

PERM ID	Federal Dollars in Error
PAM1902F004	$5,613.47

Qualifier #3: Provider failed to Provide a progress note for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F035	$3,388.86

Qualifier #4: Provider failed to Provide a time sheets for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F131	$473.59
PAM1904F128	$227.84

Qualifier #5: Provider failed to Provide an Individual Education Plan, record with daily documentation of specific tasks and a physician's order for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F167	$46.92

Qualifier #6: Provider failed to Provide an Individual Service Plan, and a prior Authorization for that Date of Service

PERM ID	Federal Dollars in Error
PAM1904F077	$849.68

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.
7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.

10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.
15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

Implementation and Monitoring: *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or*

next milestone to establish a plan/goal going State has responded that they will conduct provider education on maintaining records and submitting documentation.

- *forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	**Status (Implemented/ Not Implemented/Pending)**	**Implementation Date**	**Estimated Completion Date**	**Responsible Party**	**How state plans to monitor the corrective action**
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or **if** errors **are** still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider **reviews;** Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners,	Pending	Upon request of medical records in the PERM	TBD	BPI	Compare the FY2022 PERM audit with the

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Bulletins, Quick Tips		2022 cycle; date TBD			RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts **quarterly** mandatory newly enrolled provider training sessions for our Home and	Implemented	On-going process	On-going process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Community Based Services (HCBS) waiver providers.					
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.

7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook
Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (

1920SBAPStatewideTraining.pdf

Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #3: Number of Unit(s) Error (MR6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Number of units billed not supported by number of units documented*	4	$201.40	$31.65
Total	4	$201.40	$31.65

State may provide additional Data Analysis here (optional):

This error resulted in an identified total overpayment of $201.40 and accounted for 31% of the total errors identified during the medical records review and 1.3% of the total sample dollars in error. This error fell under the Service Type of Habilitation/Waiver Programs/School Services. Habilitation/Waiver Programs/School Services accounted for 79% of the total projected dollars in error

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Number of units billed not supported by number of units documented*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F115	$37.94	$0.80
PAM1901F126	$83.39	$1.76
PAM1903F095	$10.12	$0.07
PAM1904F167	$69.96	$29.02

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The documentation submitted by the provider did not support the number of units billed for the procedure code. The Provider billed for an incorrect number of units. The submitted documentation supporting the units of the procedure code billed was less than the billed amount. The provider failed to verify that the number of units billed was supported by the submitted document.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in

violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.

4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.
7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the

ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.

12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.
15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts **quarterly** mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	Ongoing process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf

PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (1920SBAPStatewideTraining.pdf Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #4: Improperly Completed Documentation (MR9)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Required provider signature and/or credentials are not present	1	$1,979.86	$12.40
Total	1	$1,979.86	$12.40

State may provide additional Data Analysis here (optional):
This error resulted in an identified total overpayment of $1,979.86 and accounted for 7.7% of the total errors identified during the medical record review and 12.8% of the total sample dollars in error. The error occurred in the Nursing Facility/Intermediate Care Facilities Service Type. The documentation submitted by the provider lacked a signature by the Practitioner.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Required provider signature and/or credentials are not present

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F074	$1,979.86	$12.40

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The provider failed to provide the signed physician's 60 day visit progress note written by the physician for the sampled date of service as required by the regulations. Contact was made with the provider on multiple occasions and the provider was able to submit the other required documentation, but not the physician note for that Date of Service. The provider explained that they had scheduled meetings with their Corporate Compliance Officer, Medical Record Supervisor and Chief of Staff for Physicians to improve the documentation process.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit

procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.

7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and

Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.

15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical Assistance Bulletin 35-17-

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website	Pending	Website will be updated with	April 2022	BPI	Compare the identified

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
updated with RY19 audit findings		startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?			errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	On-going process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud,

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.

3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020 Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - 1920SBAPStatewideTraining.pdf Bulletin 35 17 01 School Base Provide

Return to Top

Data Processing (DP)

FFS Finding Category #5: Provider Information/Enrollment Error (DP10)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Attending provider NPI required, but not submitted on institutional claim	3	$14,121.58	$18.19
Missing provider license information	1	$206.88	$5.05
Missing provider risk-based screening information	5	$17,077.78	$41.69
ORP Type 1 NPI required, but not listed on the claim	1	$65.83	$21.38
Provider not screened using risk based criteria prior to claim payment date	41	$47,288.47	$349.94
Total	51	$78,760.55	$436.26

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Attending provider NPI required, but not submitted on institutional claim

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F006	$4,621.37	$6.33	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1902F025	$3,149.27	$4.31	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required
PAM1903F019	$6,350.95	$7.56	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM190F006, PAM1902F025, PAM19023F019: An Edit was built into the system to validate that an individual was listed not a group.

Qualifier #2: Missing provider license information

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1904F129	$206.88	$5.05	Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1904F129: Unable to locate provisional license during the audit.

Qualifier #3: Missing provider risk-based screening information

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F119	$654.91	$13.83	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1901F160	$1.33	$0.62	Revalidated provider; Limited risk provider; NPPES not present; Billing provider
PAM1902F016	$6,910.34	$9.45	Revalidated provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1904F026	$8,803.13	$11.88	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1904F079	$708.07	$5.91	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1901F119: Revalidation 11/08/17 documented in PEAP contained the required database documentation

PAM1901F160: This provider enrolled prior to the addition of NPPES to the checklist
PAM1902F016: Revalidation 12/11/15 nothing documented.
PAM1904F026: Checklist completed 05/17/2016 Missing System for award Management (SAMS), Medicheck, Provider Enrollment, Chain, and Ownership System (PECOS).
PAM1904F079: All screenings were completed between 8/10-8/29/2017 and are contained in PROMISe.

Qualifier #4: ORP Type 1 NPI required, but not listed on the claim

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1902F168	$65.83	$21.38	No NPI on the claim

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1902F168: Early Intervention did not set Ordering, Referring and Prescribing requirements (ORP) edits. When the claim was processed, system logic was not in place to require an NPI on the claim. DHS has since created system edits requiring an NPI on a claim.

Qualifier #5: Provider not screened using risk based criteria prior to claim payment date

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F015	$6,914.96	$9.47	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F092	$960.21	$4.99	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F093	$875.95	$4.55	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F096	$2,102.38	$10.92	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F107	$575.73	$12.16	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F110	$399.51	$8.44	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F120	$546.12	$11.54	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F130	$659.53	$13.93	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F139	$343.37	$7.25	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F169	$10.95	$5.08	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1902F007	$3,792.29	$5.18	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F025	$3,149.27	$4.31	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F076	$1,626.07	$10.18	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F082	$920.45	$5.76	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F086	$708.07	$4.43	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1902F092	$1,057.38	$6.62	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F119	$200.82	$4.63	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F127	$264.44	$6.10	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F129	$219.72	$5.07	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F133	$525.25	$12.12	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F135	$381.31	$8.80	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1902F141	$202.77	$4.68	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F156	$166.92	$54.21	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F031	$5,278.88	$6.28	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F078	$1,016.76	$6.78	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F084	$657.49	$4.38	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1903F088	$1,273.65	$8.49	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1903F089	$1,106.38	$7.37	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F092	$795.29	$5.30	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F106	$655.42	$4.37	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F109	$428.80	$9.69	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F116	$209.18	$4.73	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F118	$567.82	$12.84	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F131	$473.59	$10.71	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F134	$323.69	$7.32	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F145	$18.99	$5.76	Newly enrolled provider; Moderate risk provider; SAM/EPLS not checked; On-site visit not conducted; Billing provider
PAM1903F159	$3.74	$1.13	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1903F167	$46.92	$14.22	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1904F016	$6,459.52	$8.72	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1904F092	$660.81	$5.52	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1904F102	$708.07	$5.91	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Provider enrollment process failed to accurately track and maintain sufficient provider enrollment documentation.
PAM1901F015, PAM1901F092: Checklist completed in 2015 and does not indicate SAMs, Medicheck, PECOS
PAM1901F093, PAM1901F107, PAM1901F110, PAM1901F120, PAM1901F130, PAM1901F139, PAM1901F169, PAM1902F007, PAM1902F076, PAM1902F082, PAM1902F127, PAM1902F133, PAM1902F141, PAM1902F156, PAM1903F078, PAM1903F088, PAM1903F089, PAM1903F092, PAM1903F106, PAM1903F109, PAM1903F116, PAM1903F118, PAM1903F131 PAM1904F092: These

are the same Provider. These claims are linked to application processed in 2012 by OMAP prior to having a separate document for verification of background checks. ODP PEPs not open, billing for OLTL.
PAM1901F096: This provider was initially enrolled by OMAP in 2014 prior to having a separate document for verification of background checks. ODP processed a revalidation of this site in 2019, the background checks were completed, and the documentation was collected at that time.
PAM1902F025, PAM1902F086: Documentation of screening was not uniform across program offices, poral not in place during enrollment.
PAM1902F092: Revalidation in 2016 on paper no checklist scanned with documents.
PAM1902F119: Checklist not scanned with enrollment in 2013. This claim is related to an application processed thru the Portal with some checks being completed automatically and some completed manually. The system will not allow the application to be processed and enrolled without the completion of all the checks. There is no separate document to be added into the PEAP archives. This could be a document that we could look at creating in the future MMIS system for more easily identifiable documentation.
PAM1902F127: This claim is linked to an application processed in 2012 by OMAP prior to having a separate document for verification of background checks.
PAM1902F129: Does not show a separate document of results in the PEAP archives as the checks are done manually and electronically and indicated automatically in the summary of the application in the Portal as part of the mechanism of processing. They are completed, but without a separate document to verify.
PAM 1902F135, PAM1903F031, PAM1903F084, PAM1903F134, PAM1903F145, PAM1903F159, PAM1903F167, PAM1904F016, PAM1904F102: The provider enrollment documentation process failed as each program office documented different information.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

Qualifier1: Need to make this edit verify type 1 NPI is used not type 2- would require a system change. Edit needs to verify type 1 NPI enrolled and used not Type 2.
Qualifier2: Knowledge reinforcement issue regarding scanning/imaging policy.
Qualifier 3: Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices, and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of paper applications and the applications thru the portal require the background checks as a condition of processing the application. A future document could be created as part of the new MMIS system. The enrollment process was consolidated to make certain all checks are documented every time; the checklist was updated in 2016 after the PERM audit.
Qualifier 4: Since processing of the identified claim on 12/8/17, system edits (ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual) were created to enforce NPI requirements. The edits were implemented on 4/30/18.
Qualifier 5: Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices, and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of

paper applications and the applications thru the portal require the background checks as a condition of processing the application. The checklist was updated in 2016 after the PERM audit. The enrollment process was consolidated on 8/1/2019 to make certain all checks are documented every time. When the provider revalidates in 2020, an updated checklist will be completed by provider enrollment.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
ORP Type 1 NPI required, but not listed on the claim	Implemented	4/30/2018	N/A	MMIS Vendor/DHS	On-going review of edits
Standard Checklists for processing paper applications thru the Portal require the background checks as a condition of processing the application.	Implemented	January 2019	Ongoing	MMIS Vendor/DHS	On-going review of edits

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

DHS reviews edits on an ongoing basis to ensure alignment with NPI requirements.

Return to Top

FFS Finding Category #6: Data Processing Technical Deficiency (DTD)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Provider not screened prior to enrollment determination date but screened prior to claim payment date	14
Total	14

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the deficiency(ies) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the deficiency(ies).*

Qualifier #1: Provider not screened prior to enrollment determination date but screened prior to claim payment date

PERM ID	Sub-qualifier(s)
PAM1901F048	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F058	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F066	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F071	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F137	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1902F058	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F102	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1902F148	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F009	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Sub-qualifier(s)
PAM1903F038	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F048	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F051	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1903F064	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F093	Newly enrolled provider; Limited risk provider; DMF not checked; SAM/EPLS not checked; ORP

- **Enter the root causes of deficiency(ies) identified above. *Simply re-stating the qualifier does not explain what caused the deficiency.***

The applications were processed prior to the ACA requirements being implemented, which led to the implementation of a checklist being a required document of the application package. Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices and the provider applications in question were not among the offices who completed the checklist.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

We now have a standard checklist for processing of paper applications and the applications thru the Portal require the background checks as a condition of processing the application. The checklist was updated in 2016 after the PERM audit. The enrollment process was consolidated to make certain all checks are documented every time. When the provider revalidates in 2020, an updated checklist will be completed by provider enrollment.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Standard Checklists for processing paper applications thru the Portal require the background checks as a condition of processing the application.	Implemented	January 2019	On-going	MMIS Vendor/DHS	On-going review of edits

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, and number of deficiencies. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an on-going monthly random sample review of enrollment packages done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Medicaid FFS Target Rate

Next Cycle Medicaid FFS Target: 5.12%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.

PA will continue to utilize a comprehensive approach to monitor claims for correct payment compliance supported by the medical record documentation. MCO reviews for 2019 have been initiated by BPI. The Medical Record Review error rate increased by 0.25% in the RY19 Cycle, while the number of claims reviewed increased by more than 200%. The Data Processing errors increased as a result of the lack of background checks as well as lack of NPI in the current PERM RY19 Cycle. The implementation of an Online Application Portal, already in effect, and the planned payment edit to deny a claim if the ordering, referring, or prescribing fields are blank is anticipated to decrease the number of Data Processing errors. Also, the MMIS system edits ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual that were created to enforce NPI requirements were implemented on 4/30/2018. Reviewing a small sampling has shown that approximately 40 claims have been denied since these edits were activated. Re-education of providers as to the requirements of the MA Bulletin 99-11-05 will be undertaken. https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx

Medicaid FFS Evaluation of FY 2015 Previous Cycle Corrective Actions

	RY 2019 (Federal)[3]	FY 2015 (Total Computable)
Number of Errors	78	24
Number of Claims in Error	75	24
Number of Claims Sampled	761	332
Dollars in Error	$90,548	$48,938
Projected Dollars in Error	$519,992,086	$694,150,441
Improper Payment Rate	8.74%	7.55%
Target Rate	4.52%	1.67%

Please refer to the state Cycle Summary Report for additional information on cycle comparisons.
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one DP or MR error on the claim. However, for RY 2019, the number of errors row counts all errors found on a claim. For FY 2015, multiple DP or MR errors are not counted, but one DP and one MR error is included per claim, if applicable. Additionally, states are cautioned from making direct comparisons between the cycles, since review requirements and program structure may have changed.

Evaluation of Implemented Corrective Actions

The implementation of the Corrective Actions for the medical record reviews was successful with a decrease in the number of errors identified. This RY19 Cycle identified areas of vulnerability relating to the implementation of the ACA: required enrollment screening of providers based on risk criteria; NPI requirement of all ordering/referring/prescribing providers; and verification that provider licenses are current. DHS has since created system edits requiring an NPI on a claim. System edits ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual were created to enforce NPI requirements. These edits were implemented on 4/30/18.

[3] Dollars in error, projected dollars in error, improper payment rate, and target rate are all based on federal dollars in error for RY 2019 and total computable dollars for FY 2015.

Discussion of Corrective Actions Not Implemented
NA

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
NA

Component: Managed Care (MC)

There were no MC errors sampled in Pennsylvania.

Component: Eligibility

RY 2019 Medicaid Eligibility Federal Improper Payment Rate: 11.36%

As noted in your Cycle Summary report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Eligibility Review (ER)

Eligibility Finding Category #1: Documentation to Support Eligibility Determination Not Maintained (ER1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Blindness/disability determination documentation not on file/incomplete	6	$2,497.53	$142.55
Income verification not on file/incomplete	1	$39.90	$14.16
Level of care determination not on file/incomplete	10	$38,068.19	$307.12
Other required forms not on file/incomplete	1	$6,914.96	$22.42
Record of signature not on file - caseworker	4	$3,162.09	$80.70
Resource verification not on file/incomplete	10	$14,238.47	$158.91
Total	32	$64,921.14	$725.85

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Blindness/disability determination documentation not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M067	$190.49	$36.23

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M003	$732.09	$15.86
PAM1902M018	$721.74	$15.64
PAM1902M059	$176.30	$26.85
PAM1903M045	$427.79	$33.98
PAM1904M043	$249.12	$13.98

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise staff on policy of imaging paperwork to the case record. Failure to train/supervise to correctly apply the ex-parte policy and failed to train/supervise on correct follow up on the reported disability. Failure to supervise correct review and understanding of federal Bendex exchanges. Failure to distribute work effectively to ensure staff can correctly follow up on disability.

Qualifier #2: Income verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M081	$39.90	$14.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The worker did not follow policy that was clearly defined. Training/Supervisory issue.

Qualifier #3: Level of care determination not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F109	$444.73	$21.55
PAM1901F156	$84.82	$110.23
PAM1902F015	$11,094.62	$37.89
PAM1902F028	$6,029.79	$20.59
PAM1902F058	$2,474.87	$17.36
PAM1903F042	$2,772.09	$18.13
PAM1904F026	$8,803.13	$33.84

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904F031	$3,458.01	$13.29
PAM1904F040	$2,664.49	$19.14
PAM1904F127	$241.64	$15.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Confusion over purging/storage during conversion of paper records to electronic files. Procedure regarding who should process waiver renewals not clear. Training/supervisory issue regarding what forms are required at renewal and what should be updated in system. Training/Supervisory issue regarding scanning/imaging policy.

Qualifier #4: Other required forms not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F015	$6,914.96	$22.42

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Confusion over purging/storage during conversion of paper records to electronic files.

Qualifier #5: Record of signature not on file - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F099	$1,699.36	$26.69
PAM1903F093	$725.44	$11.46
PAM1903F119	$495.65	$27.45
PAM1904F127	$241.64	$15.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy

Qualifier #6: Resource verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F005	$4,908.37	$16.76
PAM1902F033	$3,391.14	$11.58
PAM1902F086	$708.07	$11.12
PAM1902F089	$1,562.20	$24.53
PAM1902F116	$252.88	$13.89
PAM1902M074	$138.62	$21.11
PAM1903F103	$819.34	$12.94
PAM1904F070	$1,988.16	$14.28
PAM1904F160	$3.81	$6.54
PAM1904M049	$465.88	$26.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Training/Supervisory issue regarding verification requirements of resources. Training/supervisory issue regarding that resource verification cannot be used from a previous SNAP renewal.
PAM1902F005: Initially enrolled in 2012 by OMAP prior to use of separate verification document being included with the application package. Revalidation of the same site completed 12/23/15 and verification of background checks included in that application package.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: Office policy reviewed to ensure that all verification, including MRT certifications are to be scanned to record upon receipt. Images are to be reviewed prior to shredding of hard copy.
Qualifier #2: Internal memo sent to all staff advising of the error which included the Verification Desk Guide. Discussed error at Supervisor's meeting and reviewed verification of income requirements for SNAP and MA. Supervisors were instructed to review with their areas.
Qualifier #3: Review policy 815.1 and 476.2, scanning and imaging procedures and findings and cause of error with staff and next staff meeting. Sent e-mail to Maximius independent broker for PA 1768, waiting for a response.
Qualifier #4: Assuring that all renewals are being stamp dated upon receipt. Checking all cases before renewals are sent to verify that all required documents are scanned to the case, if documents are missing, they will be requested with the renewal packet.
Qualifier #5: Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form

where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
Qualifier #6: Managers have added to the agenda of the next scheduled unit meetings to review resource verification Medicaid policy requirements.
Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within the Department varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of paper applications and the applications thru the Portal require the background checks as a condition of processing the application. A future document could be created as part of the new MMIS system.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Random Sample of Quality Control Reviews
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Random Sample of Quality Control Reviews

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #2: Verification/Documentation Not Done/Collected at the Time of Determination (ER2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income not verified - caseworker	1	$197.17	$30.37
Income not verified - system	1	$43.06	$14.00
Other element not verified - caseworker	2	$1,263.97	$45.27
Other eligibility process(es) not followed - caseworker	2	$853.14	$37.22
Resources not verified - caseworker	6	$5,950.51	$207.47
Signature not recorded at initial application - caseworker	3	$4,543.79	$50.75
State did not do required disability/blindness determination - caseworker	1	$72.85	$35.33
When appropriate, signature not recorded at renewal - caseworker	12	$7,611.62	$453.29
Total	28	$20,536.11	$873.71

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M070	$197.17	$30.37

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR

Qualifier #2: Income not verified - system

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904M082	$43.06	$14.00

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR

Qualifier #3: Other element not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M021	$541.38	$29.62
PAM1902M004	$722.59	$15.66

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision of DAP referral requirements. Lack of training and supervision regarding requesting medical documents for a child and processing renewal without said documents.

Qualifier #4: Other eligibility process(es) not followed - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M092	$51.04	$21.29
PAM1904F090	$802.10	$15.93

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR.

Qualifier #5: Resources not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F044	$2,555.20	$16.13
PAM1901F112	$317.14	$15.36
PAM1901F156	$84.82	$110.23

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F058	$2,474.87	$17.36
PAM1903M079	$53.42	$22.29
PAM1904M047	$465.06	$26.10

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding resource policy and requirements. Lack of training and supervision regarding "ex parte" rules. Lack of policy/guidelines explaining required scanning and imaging procedure for LTC/waiver cases

Qualifier #6: Signature not recorded at initial application - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903F008	$4,287.85	$14.92
PAM1903M073	$157.15	$24.20
PAM1904M075	$98.79	$11.62

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy

Qualifier #7: State did not do required disability/blindness determination - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M086	$72.85	$35.33

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision on procedure to follow when "J" SSI budget closes

Qualifier #8: When appropriate, signature not recorded at renewal - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F069	$2,454.30	$15.49
PAM1901F109	$444.73	$21.55
PAM1901F156	$84.82	$110.23
PAM1901F178	$3.23	$4.68
PAM1902F053	$2,841.67	$19.94
PAM1902M077	$75.30	$26.72
PAM1902M081	$39.90	$14.16
PAM1902M082	$35.23	$12.50
PAM1903M039	$762.74	$60.59
PAM1903M051	$780.65	$62.01
PAM1904F157	$54.94	$94.35
PAM1904M084	$34.11	$11.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of policy/guidelines explaining required scanning and imaging procedure for LTC/waiver cases. Lack of training/supervision regarding policy requirements on verification requirements. Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days from the initial 6-month review.
Qualifier #2: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days from the initial 6-month review.
Qualifier #3: A DAP Tip Sheet was developed as a quick reference for workers when reviewing for disability Medicaid categories and DAP referrals. This sheet was distributed via email. The DAP TIP sheet along with program eligibility for disability related Medicaid categories and DAP referral process is on the agenda to be reviewed at the next scheduled staff meetings. Office wide training was completed by all workers and supervisors on DAP procedures including presumptive eligibility requirements.
Qualifier #4: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days for the initial 6-month review.
Qualifier #5: Multiple reviews done in the Rushmore database on a local level to ensure policy is being applied correctly. Conduct office wide training regarding resources on LTC cases.

Qualifier #6: Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
Qualifier #7: Supervisors will review training/materials with each worker at their next unit meeting. Training with supervisors on Extended NMP categories.
Qualifier #8: Sent e-mail to Maximus independent broker for PA 1768, waiting for a response. review policy, scanning and imaging procedures and findings and cause of error with staff and next staff meeting. Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly sample of Quality Control Reviews
Statewide mentoring Calls	Implemented	Jan 2019	On-going	Division of Corrective Action	Monthly sample of Quality Control Reviews

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #3: Determination Not Conducted as Required (ER3)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Initial determination not conducted	13	$1,041.97	$252.50
Redetermination was not conducted within 12 months before date of payment for services - caseworker	5	$7,265.29	$107.37
Total	18	$8,307.26	$359.87

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Initial determination not conducted

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F170	$3.01	$3.91
PAM1901M075	$99.96	$19.01
PAM1901M081	$44.91	$21.78
PAM1901M085	$91.77	$44.51
PAM1901M088	$44.91	$21.78
PAM1901M093	$43.46	$21.08
PAM1902M063	$91.32	$13.91
PAM1903M062	$98.79	$15.22
PAM1903M063	$91.18	$14.04
PAM1903M076	$90.07	$13.87

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M089	$86.84	$36.23
PAM1904M046	$208.15	$11.68
PAM1904M086	$47.60	$15.48

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

While the calculation is not shown for the MA eligibility when TANF is opened, households eligible for TANF are eligible for MA.

Qualifier #2: Redetermination was not conducted within 12 months before date of payment for services - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F030	$3,782.77	$12.26
PAM1901F127	$228.47	$11.07
PAM1903F060	$2,330.93	$15.25
PAM1903F080	$849.68	$13.42
PAM1903F155	$73.44	$55.36

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of supervision/training on policy of when to close a case if client does not provide verification timely and to not update renewal dates when doing maintenance on a case.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: System changes are being made so that the MA calculation and category will show separately from the TANF eligibility.

Qualifier #2: The error, case details, root cause, and ways to possibly prevent errors like this will be discussed during the June 2019 Corrective Action Committee Meeting. Individual staff conferences and trainings. Renewal supervisors have been instructed that all renewals need to be completed in the month they are due, no longer holding renewal up to day -45 for closure. LTIS is receiving additional workers and monitoring renewals for timeliness.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic*

approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Corrective Action Committee Meetings	Implemented at County Level	June 2019	On-going	County Offices	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Individual Staff Conferences and Trainings	Implemented at County Level	Continuous	On-going	County Offices	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Statewide Mentoring Calls	Implemented	January 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #4: Not Eligible for Enrolled Program - Financial Issue (ER4)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Resources incorrectly calculated - caseworker*	2	$3,746.45	$40.23
Resources incorrectly included/excluded - caseworker*	1	$2,068.81	$32.68
Total	3	$5,815.26	$72.91

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Resources incorrectly calculated - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F089	$1,562.20	$24.53
PAM1904F057	$2,184.25	$15.69

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding verification requirements of exempt resources. Lack of training/supervision regarding if eligibility could be granted, and then overpayment filed if resources exceed the limit.

Qualifier #2: Resources incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903F085	$2,068.81	$32.68

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Many staff out of the office resulting in higher workload and fewer hours to process work items timely and accurately resulting in data entry errors.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: The CAO attempted to obtain verification of irrevocable burial reserve by issuing a PA253 (Request for Verification) notice in order to have documentation in the case record. The next CAO staff meeting will include reviewing verification of resources and case comments requirements. IMCW supervisors discussed error with IMCWs who processed the application to review one-on-one the policy and procedures for resource verification including when resources should be excluded and narrating how resources were calculated. Discussion of errors was also included as part of the Area Corrective Action unit meeting agenda. The Unit discussion reminded staff that policy states authorization of benefits is not allowed if eligibility verification is still needed; client needs to be eligible before the renewal is processed. Staff, worker and unit discussions included reviewing LTC HB 440.721 when a recipient can pre-pay for expenses when over the resource limit. LTC HB 440.73 for completing overpayments when client does not report resources by sending a request to the Office of State Inspector General to recoup the amount the client was over the resource limit. The workers did not follow federal guidelines for determining eligibility of benefits.
Qualifier #2: County Caseworker Supervisor will complete 2-4 targeted Rushmore Reviews per month. The sample cases will be LTC/Waiver. The review will solely target "Resources." Supervisor will review policy and procedure with all IMCW staff. Policy/References: (1) Using CIS - Chapter 5, CAPERS:

Availability (AV) - Y or N. (2) eCIStance, "How do I add a resource in Maintenance?" Specific attention on "Shared Resources" and "Available." (3) Chapter 440.3, Personal Property.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #5: Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Countable income incorrectly excluded - system*	1	$39.90	$16.65
Income incorrectly calculated; other - caseworker*	1	$35.56	$14.84
Total	2	$75.46	$31.48

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M094	$39.90	$16.65

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of supervision/training on procedure to review income being counted before authorizing medical benefits

Qualifier #2: Income incorrectly calculated; other - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M088	$35.56	$14.84

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

IMCW failed to update income at SAR.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: 1) Meet with the supervisor of this worker to go over this finding and talk about the root cause, which is, to make sure each case is reviewed in full (income, resources, etc.) before submitting the case. I will explain the importance of checking for input errors so that the correct determination and program category is authorized. 2) I will instruct the supervisor to meet with the individual privately to go over this information also. The supervisor will then have a unit meeting reminding staff the importance of checking to make sure the information is correct before submitted a case. 3) I will follow up with the supervisor to make sure the worker is still consistently checking work before submitting.
Qualifier #2: MA 312.1 HB updated to provide clarification on properly processing a MG19. The system is correctly working to follow policy.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
and Trainings					Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Meeting with policy and DAPS regarding handbook and system changes	Implemented	June 2019	Ongoing	Policy, DAPS	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #6: Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Household composition/tax filer unit or tax filer status incorrect - caseworker*	1	$159.74	$18.79
Other non-financial error - caseworker*	1	$463.43	$19.77
Total	2	$623.17	$38.56

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Household composition/tax filer unit or tax filer status incorrect - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904M069	$159.74	$18.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Caseworker failure to follow policy and procedures for establishing proper household composition and tax filing status.

Qualifier #2: Other non-financial error - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M033	$463.43	$19.77

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Caseworker failure to follow policy and procedures regarding the transition of a disabled child to a disabled adult.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: A corrective conference was held with worker. It will be discussed at the next staff meeting and E-Blast has been developed and emailed to all staff to remind them of about household composition rules/ wages matches how to use them for MA.
Qualifier #2: Error and its cause will be reviewed at a supervisor's meeting. Policy at 319.32 will be reviewed. The supervisor will be reminded of the in-house CAP for these budgets. The CAP will be reviewed. The supervisors will take this information and review at their next unit meeting. A conference was held with the worker who caused the error. Policy at 319.32 was reviewed with the worker to ensure disability determinations for PH categories was understood. The exchange was also reviewed as the worker mis-read the information. The worker was reminded to update all resource and income information in the system that is provided as it may affect future eligibility. The worker was also reminded to review all case information at each renewal even though she may be familiar with the case. The in-house procedure for the authorization and renewal of PH and PW budgets was reviewed as well.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
and Trainings					reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such can continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #7: Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Countable income incorrectly excluded - caseworker*	1	$365.60	$28.79
Total	1	$365.60	$28.79

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M044	$365.60	$28.79

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding caseworkers following of policy.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Six Rushmore reviews conducted by local supervisors. Local manager will conduct Management Rushmore Re-Reviews in April and/or May on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual report a change in situation including income variances and job starts. Staff meetings conducted.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #8: Other Errors (ER10)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker*	2	$165.86	$1.37
Other error	2	$282.68	$1.78
Total	4	$448.54	$3.16

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F089	$50.19	$0.62
PAM1903F067	$115.67	$0.76

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding scanning and imaging and narration.

Qualifier #2: Other error

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F049	$259.56	$1.64
PAM1901F059	$23.12	$0.15

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding LTC policy and procedure for processing renewals

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: The PERM finding was discussed in detail during this morning's CAC Meeting. Both the root cause and ways to prevent future errors of this type were discussed. A worker conference was held with the IMCW that processed the last renewal. The finding and root cause were discussed in detail.
Qualifier #2: Supervisors meeting to be held to review QC findings and policies cited.
Unit meeting to be held to review 468.34 and the need to review client responsibility to report changes. 5 targeted Rushmore reviews to be completed by worker and immediate Supervisor. Staff meeting to be held to review findings, 468.34, the need to review client responsibility to report changes, determine income, resources and needs for Client Spouse at renewal and narrating. The error, root cause, and ways to prevent future errors of this type will be discussed in detail during the June 2019 CAC meeting on 6/20/2019 at 9:30 am. A worker conference was held by the IMCW Supervisor with the IMCW that took the case action. LTC HB chapter 476 & 468.34 were reviewed.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such can continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level

Return to Top

Eligibility Finding Category #9: Incorrect Case Determination, But There was No Payment on Claim (ERTD1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	2
Not eligible for enrolled program; financial issue	1
Total	3

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility

PERM ID
PAM1901F151
PAM1901F162

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding required verification

Qualifier #2: Not eligible for enrolled program; financial issue

PERM ID
PAM1903F171

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/Supervision regarding income limits

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Local offices to conduct trainings to ensure staff is current on policy/procedure. Rushmore reviews to be conducted to verify staff is aware of policy.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #10: Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Countable income incorrectly excluded; eligible for enrolled category - caseworker	9
Countable income incorrectly excluded; eligible for enrolled category - system	5
Exempt income incorrectly included; eligible for enrolled category - system	1
Exempt income incorrectly included; not eligible for enrolled category - caseworker	1
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	15
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	12
Income deduction incorrectly included/excluded; eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; eligible for enrolled category - caseworker	36
Income incorrectly calculated; other; eligible for enrolled category - system	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	4
Other financial deficiency - caseworker	1
Other non-financial deficiency - caseworker	7
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	5

Qualifiers	Number of Deficiencies
Resources incorrectly calculated; eligible for enrolled category - caseworker	43
Resources incorrectly included/excluded; eligible for enrolled category - caseworker	8
Total	151

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901M007
PAM1901M014
PAM1901M060
PAM1902M054
PAM1902M088
PAM1903M040
PAM1903M065
PAM1904F187
PAM1904M069

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding taking proper action (sending a 253), doing a narrative upon clearing an Exchange 1 New Hire Hit and reviewing Exchanges (specifically Exchange 1) prior to processing an ex-parte renewal. Lack of training and supervision regarding comprehensive review of the renewal form and all supporting documents prior to case processing.

Qualifier #2: Countable income incorrectly excluded; eligible for enrolled category - system

PERM ID
PAM1901M073
PAM1903M040
PAM1903M044
PAM1903M054
PAM1903M056

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding reviewing case comments prior to running the SAR, and data entering income correctly.

Qualifier #3: Exempt income incorrectly included; eligible for enrolled category - system

PERM ID
PAM1902M044

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding following correct policy and procedures

Qualifier #4: Exempt income incorrectly included; not eligible for enrolled category - caseworker

PERM ID
PAM1901M084

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding income being counted that should have been excluded.

Qualifier #5: Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker

PERM ID
PAM1901M051
PAM1901M076
PAM1902M049
PAM1902M087
PAM1903F021
PAM1903M046
PAM1903M058
PAM1903M060
PAM1904M014
PAM1904M042
PAM1904M056
PAM1904M058
PAM1904M088
PAM1904M091
PAM1904M095

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding reviewing the application in detail to notice any discrepancies between what was noted on the application and what verification was provided, verification that the tax relationships were entered correctly, and image notifications not being addressed timely.

Qualifier #6: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system

PERM ID
PAM1903M042

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding scanning and imaging policy.

Qualifier #7: Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901M054
PAM1902M051
PAM1902M064
PAM1902M070
PAM1902M093
PAM1903M032
PAM1903M054
PAM1903M058
PAM1904M042
PAM1904M045
PAM1904M077
PAM1904M078

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise regarding applying the deductions allowed for self-employment, understanding and evaluation of the 1040 and Schedule C Forms, understanding of terminology of various items on these tax documents, and entering pre-tax deductions.

Qualifier #8: Income deduction incorrectly included/excluded; eligible for enrolled category - system

PERM ID
PAM1902M046

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise policy regarding self-employment tax deductions.

Qualifier #9: Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker

PERM ID
PAM1903M090

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise policy regarding counting income derived from Self-Employment and calculating gross sales and allowable income deductions for MAGI MA.

Qualifier #10: Income incorrectly calculated; other; eligible for enrolled category - caseworker

PERM ID
PAM1901F022
PAM1901F025
PAM1901F054
PAM1901F079
PAM1901F104
PAM1901F156
PAM1901M031
PAM1901M041
PAM1901M046
PAM1901M055
PAM1901M058
PAM1901M064
PAM1901M070
PAM1901M080
PAM1901M082
PAM1902F101
PAM1902F192
PAM1902M051

PERM ID
PAM1902M060
PAM1902M068
PAM1902M077
PAM1903F075
PAM1903F093
PAM1903M035
PAM1903M053
PAM1903M058
PAM1903M069
PAM1903M081
PAM1904F031
PAM1904F033
PAM1904F085
PAM1904F090
PAM1904M040
PAM1904M045
PAM1904M061
PAM1904M092

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise scanning and imaging procedure, proper ex-parte procedure and verifications required, and proper resource verification at renewal.

Qualifier #11: Income incorrectly calculated; other; eligible for enrolled category - system

PERM ID
PAM1901F107

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding what income is exempt and why at application, and at renewal.

Qualifier #12: Income incorrectly calculated; other; not eligible for enrolled category - caseworker

PERM ID
PAM1902M025
PAM1902M049
PAM1903M075
PAM1903M090

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding timely action on imaging alerts, and actually taking action when alert is cleared. Lack of training and supervision on taking proper action when verification is required.

Qualifier #13: Other financial deficiency - caseworker

PERM ID
PAM1903M002

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding timely updating of income information to cases when received by worker.

Qualifier #14: Other non-financial deficiency - caseworker

PERM ID
PAM1901M047
PAM1901M065
PAM1902M001
PAM1902M023
PAM1903F075
PAM1903M090
PAM1904M039

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy issue as verbiage in MAHB 339.2 is distinct from verbiage in pre-ACA handbooks. Pre-ACA handbooks specifically noted that the month of closing for NMP-F does not count as one of the three months out of six. This language is absent from the current handbook. Lack of training and supervision regarding correctly counting income derived from Self-Employment. Errors occurred in calculating gross sales and allowable income deductions for MAGI MA.

Qualifier #15: Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker

PERM ID
PAM1901F072
PAM1901M067
PAM1902F086
PAM1903F103
PAM1904F065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

No plan in place on how to effectively handle renewals timely when received on the last day of the month. Failure to have an effective scanning and imaging procedure in place. Some offices were under the impression they had 45 days to complete a renewal.

Qualifier #16: Resources incorrectly calculated; eligible for enrolled category - caseworker

PERM ID
PAM1901F005
PAM1901F025
PAM1901F056
PAM1901F074
PAM1901F089
PAM1901F097
PAM1901F099
PAM1901F124
PAM1901F156

PERM ID
PAM1901F162
PAM1901M023
PAM1902F015
PAM1902F055
PAM1902F068
PAM1902F096
PAM1902F111
PAM1902F111
PAM1902F166
PAM1902F174
PAM1903F010
PAM1903F067
PAM1903F075
PAM1903F090
PAM1903F124
PAM1903F144
PAM1903F173
PAM1904F008
PAM1904F033
PAM1904F062
PAM1904F070
PAM1904F085
PAM1904F111
PAM1904F111
PAM1904F116
PAM1904F121
PAM1904F129
PAM1904F171

PERM ID
PAM1904F192
PAM1904M003
PAM1904M004
PAM1904M012
PAM1904M013
PAM1904M015

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Local office did not have an effective plan in place to handle the volume of documents received and get them scanned to the cases timely for worker to review. Lack of training and supervision on timely scanning of documents to a case.

Qualifier #17: Resources incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901F061
PAM1901F064
PAM1902F023
PAM1902F111
PAM1902F187
PAM1903F057
PAM1904F033
PAM1904F065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding policy pertaining to shared resources. Lack of training and supervision regarding accurate data entry of bank accounts and real estate.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

Qualifier #1: Ongoing IMCW Supervisors will do 5 targeted Rushmore Reviews for the months of March, April, and May to review that Exchange 1 New Hire hits are processed correctly. Review policy 312.71 Verification and 310.1 General with MA staff. QC error specifics to be reviewed and discussed at Supervisors meeting.
Qualifier #2: Review of similar cases found this error appears to be worker specific. As worker has retired, no further action is required.
Qualifier #3: Manager will conduct Management Rushmore Re-Reviews on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual report a change in situation including income variances and job starts. CAO SNAP/MA Supervisors will conduct 1 Rushmore Review each on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual reports a change in situation including income variances and job starts for a total of 6 reviews. Supervisors will discuss these findings and the information reviewed at their Unit Meetings.
Qualifier #4: Internal memo sent to all staff advising of the error which included the Verification Desk Guide. Discussed error at Supervisor's meeting and reviewed verification of income requirements for SNAP and MA. Supervisors were instructed to review with their areas.
Qualifier #5: Review with staff MA policy a.312.16: Adults Ages 19-64b.312.22: MAGI Filer/Non-Filer Rules for Household Composition. Discuss with staff how to correctly determine what the MAGI household composition should be using the tax filing status that is reported on application & renewal forms. CAO will follow DCA recommendations and review the finding with all MA staff and the MA Policy @ MAEH 312.22 MAGI Filer/Non-Filer Rules for HH composition. The review will take place during one of our upcoming March 2020 Manager/Supervisors meetings. Supervisors will then conduct group meetings with MA caseworkers to review the same.
Qualifier #6: The PERM finding was discussed in detail during CAC Meeting. Both the root cause and ways to prevent future errors of this type were discussed. A worker conference was held with the IMCW that processed the last renewal. The finding and root cause were discussed in detail.
Qualifier #7: Staff meeting held 12/17/18 to review the need to enter the self-employment deductions on the SE Screen whether they are needed for household to be eligible or not. Supervisory conference held 12/12/18.
Qualifier #8: Advise staff of the system issue regarding expenses not calculating properly for self-employment. Ensure staff know that they need to manually compute the net income in order to determine eligibility for self-employment calculations that are not computed correctly by the system. This issue was the self-employment tax deduction did not compute properly. If the system is incorrectly calculating the self-employment income, a manual notice may be necessary to inform the client of eligibility or ineligibility.
Qualifier #9: Staff meeting held to review the need to enter the self-employment income and deductions on the SE Screen needed for household to be eligible or not. Supervisory conference also held.
Qualifier #10: Requested and received information from the Facility Reimbursement Officer in Harrisburg who gave us information for May 2017 which was not used for the 06/2017 Renewal. The Facility Reimbursement Officer used 04/2017 information for this renewal. I would like to point out that the CAO does not receive income/resource verifications for individuals in ICF facilities. All information is sent from the Guardian's Office at the Center (or client representative) to the Facility Reimbursement Office in Harrisburg. The Facility Reimbursement Officer completes the Compass Renewal/Application for these individuals and submits the Compass Renewal/Application to the CAO for processing. Since the Facility Officer has verified the resources/income the IMCW inputs what is on the Compass Renewal/Application. The CAO only contacts the facility, the individual's representative, or family members if the information presented is unclear or inconsistent or not verified. The error and its cause

will be reviewed at the next supervisor's meeting. Renewal policy at LTC 440 &476 and MA 340 & 376 will be reviewed. The ex-parte policy and desk guide will be reviewed. It will be stressed that an ex-parte review is not a re-hash of the last renewal completed. The workers must review the case, exchanges, imaging, and narratives. Of discussion will be the policy that MA budgets with resources cannot be renewed by ex-parte when current resource verification is not in the record because the resources must be verified at each renewal. The office renewal procedure will be reviewed. The requirement to review IEVS at each renewal will also be discussed. All updates to income must be made. The supervisors will discuss this material at their next unit meeting.

Qualifier #11: The error and its cause was reviewed in a supervisor's meeting. Policy including LTC 450.2, 450.24, 476.2, 476.21, and MAH 350.3, 305.27, and 376.24. Requirements to thoroughly review case and outcomes at both renewal and application were reviewed. Workers are to ensure their data-entry is correct and the correct outcome is received. This will require a review of the eligibility outcomes after eligibility is ran in the system. A review of DAC and proper data-entry to build the category was also discussed. The supervisors will review this information in their next unit meeting.

Qualifier #12: The case/error was reviewed with the worker for understanding, reviewing MHB 312.2 (MAGI household) and 312.5 (income); a unit and staff meeting was also held. Review policy 312.5 Income. Review policy 312.72 Reasonable Compatibility. Review proper procedures to follow up on income requests when a client reports new or changed income.

Qualifier #13: Individual and staff meetings and trainings held.

Qualifier #14: Deficiency will be discussed at Area Manager meeting. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed with the Executive Director that the "error" should be challenged. The worker data entered information as presented on the PA600R with respect to the recipient's marital status. Per policy, the spouse's earned income was considered in the eligibility determination and TMA was authorized. Office-wide staff meetings conducted on March 19th & 21st during which the deficiency was used as an example of (1) better defining errors that fall under the "Failure to Act" umbrella, and (2) current expectations for case management.

Qualifier #15: CAO is in the Process of restructuring the Unit. New CW in the unit just finished LTC training. CAO also just promoted a new LTC Supervisor in November of 2018. LTC unit should be restructured and trained by the end of May. Staff training held during staff meeting to review proper procedures for timely completion of renewals. Philadelphia LTIS is working towards processing all renewals within the month the are due. Previously instructions were given to hold renewals until day -45 before closure. Working on a cleanup project projected completion date 9/30/2019. Review the findings and the cause of error with MA staff members. All units have reviewed 476.1 and 476.2, confirmation received.

Qualifier #16: LTC/Waiver Supervisor will conduct staff training with all LTC/Waiver workers to focus on policy from LTC 440.31 Verification of Personal Property, 440.33 Verification of Life Insurance, 476.21 CAO responsibilities at renewal and proper procedure regarding Scanning and Imaging of documents to case records. Requested and received information from the Facility Reimbursement Officer in Harrisburg who gave us information for May 2017 which was not used for the 06/2017 Renewal. The Facility Reimbursement Officer used 04/2017 information for this renewal. I would like to point out that the CAO does not receive income/resource verifications for individuals in ICF facilities. All information is sent from the Guardian's Office at the Center (or client representative) to the Facility Reimbursement Office in Harrisburg. The Facility Reimbursement Officer completes the Compass Renewal/Application for these individuals and submits the Compass Renewal/Application to the CAO for processing. Since the Facility Officer has verified the resources/income the IMCW inputs what is on the Compass Renewal/Application. The CAO only contacts the facility, the individual's representative, or family members if the information presented is unclear or inconsistent or not verified. Luzerne is scheduled to participate in a LTC Process Review office visit during which DCA staff will present and discuss additional corrective actions to improve case and payment accuracy. Director met with LTC Supervisors to review the deficiency and the expectation that all resources must be verified, and data entered at the point of application and again at

renewal. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed that the worker failed to verify resource information at the time of transition from Healthy Horizons to PAN. The Committee discussed worker actions considering MAHB 440.31 Verification of Personal Property and MAHB 440.33 Life Insurance. Several Departmental and County actions have been taken to address an unacceptable LTC error rate. An Information Memorandum released September 1, 2017 instituted a statewide MA LTC Process Review. LTC Process Review I sampled 4 cases from Luzerne, none of which had an error related to resources (100%). LTC Process Review II sampled 14 cases from Luzerne, 3 of which had errors related to resources (79%). Luzerne and Lackawanna LTC management met with Philadelphia LTC management to discuss best practices in a meeting facilitated by the area managers of Areas 1, 2 & 6. LTC/HCBS budgets were sampled for the March Rushmore Review. Of 27 cases reviewed, six cases had resource-related deficiencies (78%). Staff meetings conducted in September 2017 and March 2019 specifically highlighted LTC process review concerns. CAO staff participated in mentoring calls in August and November 2017, March and May 2018 and January 2019 that dealt with LTC/HCBS issues and concerns.

Qualifier #17: Supervisors meeting to be held to review and discuss accurate data entry of resources. Unit meeting to be held to review and discuss accurate data entry of resources. 5 Rushmore reviews for resources on LTC cases. Staff meeting to be held to review QC finding and discuss accurate data entry of resources. Director met with LTC Supervisors to review the deficiency and the expectation that all resources must be verified, and data entered at the point of application and again at renewal. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed that the worker failed to data enter information known to the CAO in the form of a resident bank account during the March 2018 renewal. The Committee discussed worker actions in not closing the budget until after the due date has passed under LTC HB 476.23, and of reconsidering the late submitted renewal per LTC HB 479.3 and found no inconsistency with policy. 14 LTC cases were reviewed in November 2018 as part of the LTC Process Review. 2 cases were found to be in error due to failure to verify resources. Office-wide staff meetings conducted on March 19th & 21st during which the deficiency was used as an example of (1) the result of failing to reconcile information known to the CAO with what is reported on the renewal/SAR/or application document, and (2) current expectations for case management. Individual worker conference was conducted to reinforce the need to accurately and thoroughly data enter resources. LTC HB 440.31 "Verification of Personal Property" was reviewed as was the E-Mail Blast distributed in November 2018 "Money, Money Everywhere."

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff	Implemented	Continuous	On-going	County Management	Monthly Sample of

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Conferences and Trainings					Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented		On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Medicaid Eligibility Target Rate

Next Cycle Medicaid Eligibility Target: 3.00%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.

Most of the eligibility errors fall under the category of "failure to act". If a worker "fails to act" or fails to do their job, usually the cause is either a lack of proper training or supervision. We feel that an approach ensuring that workers in the office get the training they need, AND the supervision they need will help us meet the target rate. First, County Supervisors will identify if the workers in question have work performance issues. If so, that will be handled accordingly. If not, then the real issue is an underlying root cause to a system or process that is causing a quality worker to 'fail to act". We feel that if County Management in these cases does a thorough and proper root cause analysis to address these issues, these workers will be able to effectively do their jobs, and we will meet the target rate.

	RY 2019
Number of Errors	244
Number of Claims in Error	201
Number of Claims Sampled	677
Sampled Federal Dollars in Error	$96,160
Projected Federal Dollars in Error	$1,821,156,133
Improper Payment Rate	11.36%
Target Rate	3.00%
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one ER error on the claim.	

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).

With regard to the failure to act errors in the eligibility category, an Information memo was released to the county offices 4/24/19 stating the following: Root Cause Analysis is an expectation of the Commonwealth when submitting a statewide Corrective Action Plan (CAP) to Food and Nutrition Services (FNS) for the SNAP program, and Center for Medicare and Medicaid Services (CMS) for Medicaid. BPE relies upon each County Assistance Office (CAO) to do a thorough Root Cause Analysis when they receive an error finding from Quality Control (QC) or any other BPE review. Failure to provide a root cause to BPE prevents the Bureau from meeting the federal requirements of our statewide CAP.

Moving forward, BPE can no longer accept "worker error", "worker oversight", "worker failed to act", or "worker failed to follow policy" as a root cause. Types of statements like these are not the actual root cause of why an error occurred. If BPE receives a response such as this from a CAO, a request will be made to further analyze the error and resubmit the response. A proper root cause analysis involves identifying the factors that resulted in the worker error, or worker oversight.

Appendix A: Acronym Glossary

CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
DMF	Social Security Death Master File
DOS	Date Of Service
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Estimate
POC	Plan Of Care
SAM/EPLS	System for Award Management/Excluded Parties List System
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TD	Technical Deficiency
TPL	Third Party Liability

Payment Error Rate Measurement (PERM)
RY 2019 CHIP Corrective Action Plan
Pennsylvania

Table of Contents

CHIP Corrective Action Cover Page

This document serves as a template for the state to enter its plan for corrective actions. The template will guide Pennsylvania in reporting the root cause for each error and deficiency found in the RY 2019 measurement and the appropriate corrective actions to resolve them. Please refer to the state's Cycle Summary report for a full analysis and breakdown of the findings that contribute to Pennsylvania's improper payment rate through the PERM program. Please note that the definition of an improper payment is derived from the Improper Payments Information Act (IPIA) of 2002, as amended, and 42 CFR 431.958. Please keep in mind that corrective actions should focus on how to prevent the same improper payment (or deficiency) from occurring again. Please also keep in mind that the Corrective Action Plan (CAP) is not a venue to dispute errors or deficiencies cited. For more information on completing this template, please refer to the CAP template instructions.

A. (State): Pennsylvania **Fiscal Year:** 2019

B. (Date): 2/24/2020

C. State Contact: Virginia Perry
Phone number: 717-772-1110
Email address: virperry@pa.gov

D. CHIP Federal Improper Payment Rate: 20.67%
Fee-For-Service Rate: 0.00%
Managed Care Rate: 11.31%
Eligibility Rate: 10.55%

Next Cycle Fee-For-Service Target: 0.00%
Next Cycle Managed Care Target: 6.15%
Next Cycle Eligibility Target: 3.00%

E. Summary of CHIP Error Causes[1]

Fee-For-Service:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
There is no Fee-For-Service program	N/A	N/A	N/A

Managed Care:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Administrative/Other Error (DP12)	5	$965.37	$68.83

Eligibility:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	7	$1,432.34	$13.20
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	8	$1,397.79	$16.66
Determination Not Conducted as Required (ER3)	2	$205.68	$4.84
Not Eligible for Enrolled Program - Financial Issue (ER4)	1	$175.74	$1.02
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	3	$347.72	$6.33
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	17	$2,142.20	$33.65
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	123	$0.00	$0.00

F. Optional State CHIP Corrective Action Discussion

Click here to enter text.

[1] Multiple errors on a claim are counted separately, which may result in a discrepancy when compared to the Cycle Summary Report results by type of error.

Component: Fee-For-Service (FFS)

There is no FFS program in Pennsylvania.

Component: Managed Care (MC)

RY 2019 CHIP MC Federal Improper Payment Rate: 11.31%

As noted in your Cycle Summary Report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

MC Finding Category #1: Administrative/Other Error (DP12)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Other	5	$965.37	$68.83
Total	5	$965.37	$68.83

State may provide additional Data Analysis here (optional):

The five errors listed in this section were overturned on 9/12/2019. The Office of CHIP received a PERM Alert email on August 03, 2019, notifying us of the PERM error. The Office of CHIP provided requested documentation on August 6, 2019 to AdvanceMed. The Sampling Unit Disposition (SUD) report on September 6 indicated that the information provided was incorrect. CHIP immediately contacted AdvanceMed to clarify information required. The Office of CHIP requested a Difference Resolution for all five cases and provided new information as requested by AdvanceMed. The errors were overturned on 9/12/19 by CMS within the State Medicaid Error Rate Finding (SMERF) system. Therefore, the Office of CHIP has no further corrections regarding the five errors listed in this report because the errors have been overturned.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Other

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M015	$252.46	$13.26
PAC1904M019	$239.70	$15.54
PAC1904M027	$188.96	$12.25
PAC1904M053	$141.72	$13.85
PAC1904M061	$142.54	$13.93

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

When alerted to the error, AdvanceMed advised CHIP to provide the capitation rates for the month of service. Upon further review, AdvanceMed actually needed the capitation rates within the Managed Care Contracts, the capitation rates paid in the prior month of service, and rates paid in the month after the service, as well as the full contracts for three of the MCOs. Had this information been initially requested by AdvanceMed, the error would not have occurred. After the Difference Resolution review, CMS found in CHIP's favor and these errors were overturned within the SMERF system as of 9/12/19.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

There is no corrective action plan for these categories because there are no errors.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected*

implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
none					

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

  There are no proposed corrective action plans so there is no need for evaluation.

Return to Top

CHIP MC Target Rate

Next Cycle CHIP MC Target: 6.15%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.
There are no proposed corrective action plans because there were no errors.

CHIP MC Evaluation of FY 2015 Previous Cycle Corrective Actions

	RY 2019 (Federal)[2]	FY 2015 (Total Computable)
Number of Errors	5	1
Number of Claims in Error	5	1
Number of Claims Sampled	41	241
Dollars in Error	$965	$224
Projected Dollars in Error	$68,828,125	$1,275,579
Improper Payment Rate	11.31%	0.33%
Target Rate	0.33%	1.04%

Please refer to the state Cycle Summary Report for additional information on cycle comparisons.
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one DP or MR error on the claim. However, for RY 2019, the number of errors row counts all errors found on a claim. For FY 2015, multiple DP or MR errors are not counted, but one DP and one MR error is included per claim, if applicable. Additionally, states are cautioned from making direct comparisons between the cycles, since review requirements and program structure may have changed.

Evaluation of Implemented Corrective Actions
None

Discussion of Corrective Actions Not Implemented
None

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
None

[2] Dollars in error, projected dollars in error, improper payment rate, and target rate are all based on federal dollars in RY 2019 and total computable dollars in FY 2015.

Component: Eligibility

RY 2019 CHIP Eligibility Federal Improper Payment Rate: 10.55%

As noted in your Cycle Summary report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Eligibility Review (ER)

Eligibility Finding Category #1: Documentation to Support Eligibility Determination Not Maintained (ER1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income verification not on file/incomplete	3	$675.95	$6.05
Other required forms not on file/incomplete	2	$436.62	$3.15
Record of signature not on file - caseworker	2	$319.77	$4.00
Total	7	$1,432.34	$13.20

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M024	$254.13	$1.15
PAC1902M001	$266.70	$3.02
PAC1904M059	$155.12	$1.88

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M024: The root cause was human error in not retaining required records. The MCO did not follow the policy and procedure regarding record retention as required by its agreement with the Department. The MCO failed to keep or provide copies of paystubs used to determine eligibility.
PAC1902M001: Caseworker did not correctly obtain the most recent tax return to determine the household's self-employment income. A copy of a 2015 tax return was used instead of a 2016 tax return. Caseworker misunderstood policy and incorrectly concluded that it was appropriate to utilize the 2-year-old tax return as income verification.
PAC1904M059: Caseworker completed an ex-parte review for MA benefits for child and used mother's income already on file in the Client Eligibility System (eCIS) due to no-response from client regarding renewal of Medical Assistance (MA) benefits. Caseworker lacked training failed to follow the outlined policy and procedures on how to complete an ex-parte review.

Qualifier #2: Other required forms not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M004	$262.50	$1.11
PAC1903M044	$174.12	$2.04

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M004: The root cause was human error in not retaining required records. The MCO worker did not follow the policy and procedure regarding record retention required by its agreement with the Department. The MCO failed to keep or provide copies of the renewal packet used to

determine eligibility
PAC1903M044: Case was an inter-county transfer to Berks County Assistance Office (CAO). CAO used household information obtained during client walk-in to new county to re-open benefits. Caseworker lacked knowledge of and failed to follow inter-county transfer policy and procedures to complete a new application in the new county of residence.

Qualifier #3: Record of signature not on file - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M024	$254.13	$1.15
PAC1902M076	$65.64	$2.85

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M024: The root cause was human error in not retaining required records. The MCO worker follow the policy and procedure regarding record retention required by its agreement with the Department. The MCO failed to keep or provide copies of paystubs used to determine eligibility.
PAC1902M076: COMPASS application received from telephone application services contractor Inspiritec. Once COMPASS application was received, caseworker failed to send a signature page to client for completion prior to authorizing benefits due to worker confusion regarding signature page requirements when application submitted by a contractor.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce the areas of the MCO agreement regarding retention of documentation relating to eligibility determination. The Policy Clarification will also reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of

CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.

3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.

10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above
13. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
14. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
15. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews and provide Policy Clarification

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Implement SMART tool for case review monitoring	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews
SMART tool update to focus on PERM QC errors	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification.
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1. Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to the MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.
2. Case review for SMART: The Office of CHIP will pull sample cases and review the MCOs' ability to determine eligibility. We will measure the MCOs' incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of an MCO as well as the measurement of compliance, with lack of compliance being one of the steps to a sanction.
3. Trainings: The Office of CHIP will track MCO training and follow-up with any MCOs that have failed to complete the requirement.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
4. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
5. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
6. Open communication with CAOs to determine if developed tools and training have been helpful

Return to Top

Eligibility Finding Category #2: Verification/Documentation Not Done/Collected at the Time of Determination (ER2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Citizenship not verified - caseworker	1	$254.13	$1.15
Household composition/tax filer status not verified - caseworker	2	$349.90	$4.56
Other element not verified - caseworker	1	$138.25	$2.95
Signature not recorded at initial application - caseworker	1	$52.38	$1.14
When appropriate, signature not recorded at renewal - caseworker	3	$603.13	$6.86
Total	8	$1,397.79	$16.66

State may provide additional Data Analysis here (optional):

PAC1902M025: In this case, the mother died during the eligibility period. The PA CHIP State Plan Amendment, section 4.1.8 provides that enrollees will maintain their eligibility for a period not to exceed 12 months. This SPA section is interpreted by both CMS and PA CHIP to mean that enrollees found eligible will maintain their eligibility for a period of 12 consecutive months with few exceptions. If an enrollee does not meet the stated exceptions, the Office of CHIP does not re-evaluate the eligibility without a request from the Enrollee or until the renewal period.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Citizenship not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M020	$254.13	$1.15

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

CHIP:PAC1901M020: The Office of CHIP does not agree that this is an error. Citizenship was verified through an automatic system connection with the Social Security Administration. The CAPS system allowed the case to continue with the citizenship verified but there was not action recorded or needed by a caseworker for the verification process. This is the reason that the system did not keep a decent record of the verification.

Qualifier #2: Household composition/tax filer status not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M025	$175.78	$2.78
PAC1904M044	$174.12	$1.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M025: The Office of CHIP does not agree that this is an error. Based on the Office of CHIP's CMS-approved annual eligibility determination policy, the child's case was run, and the child became eligible for a year of coverage. The child's parent died, and this information was put into the system, however the household did not ask for a reassessment of the eligibility. The enrollees have the right to keep their annual eligibility at the same level as determined at the beginning unless certain changes/issues occur.
PAC1904M044: The Client reported the daughter moved to North Carolina to seek employment but did not stay there and returned home. Caseworker failed to determine how long the daughter was out of the household when temporarily moved to North Carolina.

Qualifier #3: Other element not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M061	$138.25	$2.95

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M061: COMPASS FFM Transfer application received. Caseworker failed to determine eligibility for MA for potentially eligible household members due to failure to follow policy and procedures on handling FFM transferred applications.

Qualifier #4: Signature not recorded at initial application - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M070	$52.38	$1.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M070: Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy.

Qualifier #5: When appropriate, signature not recorded at renewal - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M044	$156.38	$2.84
PAC1903M001	$276.56	$2.03
PAC1903M040	$170.19	$1.99

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M044, PAC1903M001, and PAC1903M040: Policy does not specifically direct caseworkers in the field to obtain client signatures on the application to renew benefits where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy .

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category**

CHIP:

There is no corrective action for PAC1902M025. The Office of CHIP received approval from CMS to perform eligibility in this way through the State Plan Amendment

OIM:

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household) and May 2017 (MA SAVE). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate

data entry and properly applying policy to eligibility determinations.

10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above.
13. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
14. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
15. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
16. Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
17. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
18. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected*

implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
CAO staff are to follow					

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
4. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
5. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
6. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #3: Determination Not Conducted as Required (ER3)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Redetermination was not conducted within 12 months before date of payment for services - caseworker	2	$205.68	$4.84
Total	2	$205.68	$4.84

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Redetermination was not conducted within 12 months before date of payment for services – caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M063	$128.25	$2.74
PAC1903M066	$77.43	$2.10

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M063: Caseworker failed to process renewal timely due to worker oversight and not failure to keep case processing work up to date.
PAC1903M066: Client failed to provide renewal packet and information timely which caused the caseworker to process renewal untimely. Lack of caseworker training on policy to close a case if client does not provide verification timely.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and

tip sheets.

2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the month of December 2017 (MA Closings). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above.
13. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
14. Daily Status D-17072001 issued July 20, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
15. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to

increase accuracy.

16. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
17. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.

7. Open communication with CAOs to determine if developed tools and training have been helpful

Return to Top

Eligibility Finding Category #4: Not Eligible for Enrolled Program - Financial Issue (ER4)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income deduction incorrectly included/excluded - caseworker*	1	$175.74	$1.02
Total	1	$175.74	$1.02

State may provide additional Data Analysis here (optional):

This case involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the requirements of 42 U.S.C. § 1397bb(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income deduction incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M048	$175.74	$1.02

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M048: Caseworker failed to use pre-tax deduction as an income deduction and incorrectly determined household ineligible for MA benefits due to lack of knowledge of this deduction and not following policy and procedures.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring
3. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
4. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
5. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
6. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
7. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
8. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
9. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
10. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors

regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample issued by DCA.

11. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
12. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
13. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
14. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
15. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers

continue to be problematic.

3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits
7. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #5: Not Eligible for Enrolled Program - Non-Financial Issue (ER5)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Beneficiary had Third Party Insurance (CHIP only) - caseworker*	3	$347.72	$6.33
Total	3	$347.72	$6.33

State may provide additional Data Analysis here (optional):

This case involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the requirements of 42U.S.C. § 139766(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Beneficiary had Third Party Insurance (CHIP only) - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1903M054	$155.12	$2.14
PAC1904M065	$122.92	$2.68
PAC1904M068	$69.68	$1.52

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M054, PAC1904M065 and PAC1904M068: Caseworkers failed to identify client's ineligibility for CHIP coverage due to having insurance through a parent's employer and incorrectly referred case to CHIP. Caseworkers failure to follow policy and procedures and correctly identify and data enter this information in eCIS

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
4. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
5. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
6. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
7. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate

data entry and properly applying policy to eligibility determinations.

8. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
9. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
10. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
needed updates					
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM

agencies for resolution

5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
7. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #6: Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Beneficiary had Third Party Insurance (CHIP only) - caseworker*	1	$123.01	$2.63
Exempt income incorrectly included - system*	2	$140.57	$3.06
Household composition/tax filer unit or tax filer status incorrect - caseworker*	4	$454.11	$6.77
Income correctly calculated; below/above income limit - system*	3	$588.05	$5.76
Income deduction incorrectly included/excluded - caseworker*	4	$545.41	$10.36
Income incorrectly calculated; other - caseworker*	1	$49.71	$2.16
Other non-financial error - caseworker*	2	$241.34	$2.91
Total	17	$2,142.20	$33.65

State may provide additional Data Analysis here (optional):

This category, except for PAC1901M042, involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshakes allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the regulations of 42U.S.C. § 139766(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Beneficiary had Third Party Insurance (CHIP only) - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M056	$123.01	$2.63

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M056: Caseworkers failed to identify client's ineligibility for CHIP coverage due to having insurance through a parent's employer and incorrectly referred case to CHIP. Caseworker failure to follow policy and procedures and correctly identify and data enter this information in eCIS

Qualifier #2: Exempt income incorrectly included - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M067	$74.93	$1.63
PAC1904M069	$65.64	$1.43

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M067: Caseworker incorrectly included monthly sponsor income and incorrectly determined household ineligible for MA.
PAC1904M069: Caseworker incorrectly included non-taxable monthly adoption assistance, but a system glitch incorrectly counted exempt income and incorrectly determined the household ineligible for MA.

Qualifier #3: Household composition/tax filer unit or tax filer status incorrect - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M043	$175.74	$1.02
PAC1902M043	$160.93	$2.92
PAC1903M069	$51.80	$1.40
PAC1904M069	$65.64	$1.43

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M043: A PID referral was received for one child in the household as the sibling was already authorized for medical assistance. Caseworker failed to include both children in the PID referred MA determination and incorrectly rejected household for MA and referred household to CHIP. This error occurred due to lack of training on correct policy and procedure to follow for PID referrals.
PAC1902M043: Newborn notification was received and the caseworker authorized benefits for the newborn. An eligibility determination was processed with the additional member to increase the household size and a CHIP referral was incorrectly made. Caseworker failed to follow procedure outlined in policy for adding additional household member.
PAC1903M069: Caseworker incorrectly excluded one of the three children in the household when determining eligibility for MA because caseworker was rushing to process case and data entered an incorrect eligibility code for the child which caused an incorrect referral to CHIP.
PAC1904M069: Caseworker incorrectly included an absent father who recently moved out of household in the budget which caused the household o be incorrectly determined ineligible for MA. Caseworker failed to correctly process in case maintenance mode to remove household member

Qualifier #4: Income correctly calculated; below/above income limit - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M042	$175.74	$1.02
PAC1902M061	$138.25	$2.95
PAC1904M009	$274.06	$1.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M042: Caseworker appears to have calculated the parent's income correctly and was waiting for wage information of 18-year-old which was not received. System glitch incorrectly sent application for a CHIP referral when rejected for failure to provide verification.
PAC1902M061: COMPASS FFM Transfer application received. Caseworker appears to have correctly calculated income, but caseworker needed income verification from household which was not received. System glitch incorrect sent application for a CHIP referral.
PAC1904M009: Medical assistance cascade incorrectly placed child in incorrect MA category. System glitch caused an incorrect MA category assigned to child.

Qualifier #5: Income deduction incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M015	$236.91	$2.68
PAC1902M053	$135.78	$2.90
PAC1902M056	$123.01	$2.63
PAC1902M079	$49.71	$2.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M015: Client received self-employment income from rental property and trucking business. Caseworker incorrectly excluded the deductible portion of the self-employment tax because failure to follow policy and procedures outlined in handbook to determine self-employment deductions.

PAC1902M053, PAC1902M056 and PAC1902M079: Caseworkers failed to use failed to use pre-tax deductions for medical insurance premiums and/or retirement contributions as income deductions and incorrectly determined household ineligible for MA benefits. Caseworkers lacked knowledge and training of policy to identify income deductions.

Qualifier #6: Income incorrectly calculated; other - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M079	$49.71	$2.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M079: Caseworker failed to use pre-tax deductions for medical insurance premiums as income deductions and incorrectly determined household ineligible for MA benefits. Caseworker lacked knowledge and training of policy to identify income deductions.

Qualifier #7: Other non-financial error - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1903M026	$188.96	$1.77
PAC1904M070	$52.38	$1.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M026: Caseworker failed to correctly calculate household income and incorrectly determined household over income limits due to failure to properly compute income that resulted from a mathematical error.
PAC1904M070: Caseworker failed to identify household was incorrectly authorized and open for both MA and CHIP benefits at the same time. Caseworker lacked training on how to process a case that is already receiving CHIP benefits.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce the areas of the MCO agreement regarding retention of documentation relating to eligibility determination. The Policy Clarification will also reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.
3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Any system caused errors are reported to the Division of Automation Planning and Support for research to fix the issue and develop future system enhancements to avoid repetition of errors.
2. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
3. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs' aware of errors, in an attempt to prevent these errors from occurring.
4. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
5. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #4 above for

the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.

6. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff'
7. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
8. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
9. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
10. Supervisory staff in CAO's where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
11. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
12. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
13. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #4 above.
14. Daily Status D-17072001 issued September1, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
15. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
16. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
17. Daily Status D-18020201 issued February 2, 2018 identified a system glitch where 2018 COLA income limit updates were not properly calculated on MA cases that were processed January 13, 2018 through January 31, 2018. Cases that were close to the 2017 income limit for their current medical benefits may have had their current MA benefit levels incorrectly decreased or closed after January 13 due to this issue. Cases were identified and fixed that had this issue.
18. Daily Status D-18032601 issued March 26, 2018 identified instances where self-employment expenses are entered along with

tax deductions for the individual in the case, the system is ignoring self-employment expenses. MAGI income calculations were incorrect causing incorrect budgets to pass or fail. The daily status outlined the manual procedural steps caseworkers had to use to correctly determine self-employment income.

19. Daily Status D-18032705 issued March 27, 2018 identified a system glitch where the system is not calculating allowable self-employment income offsets when a net loss is reported correctly which results in incorrect income calculations for MA budgets. The daily status provided a temporary work around for caseworkers to use to correctly data enter self-employment income.
20. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
21. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Implement SMART tool for case	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
review monitoring					
SMART tool update to focus on PERM QC errors	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1. Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.
2. Case review for SMART: The Office of CHIP will pull sample cases and review the MCO's ability to determine eligibility. We will measure the MCO's incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of the MCO as well as be the measurement of compliance with lack of compliance being one of the steps to a sanction.
3. Trainings: The Office of CHIP will track MCO training and follow-up with any MCOs that have failed to complete the requirement.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Assisting DAPS in ascertaining if any system enhancements implemented have negatively or positively impacted the number of MA errors.
5. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
6. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
7. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
8. Participating in various workgroups for system initiatives and possible resolution techniques for future system releases.
9. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #7: Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Countable income incorrectly excluded; eligible for enrolled category - caseworker	2
Countable income incorrectly excluded; not eligible for enrolled category - caseworker	5
Countable income incorrectly excluded; not eligible for enrolled category - system	1
Exempt income incorrectly included; eligible for enrolled category - caseworker	3
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	9
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - caseworker	2
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
Income correctly calculated; below/above income limit; eligible for enrolled category - system	1
Income correctly calculated; below/above income limit; not eligible for enrolled category - caseworker	2
Income correctly calculated; below/above income limit; not eligible for enrolled category - system	3

Qualifiers	Number of Deficiencies
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	37
Income deduction incorrectly included/excluded; eligible for enrolled category - system	2
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	4
Income incorrectly calculated; other; eligible for enrolled category - caseworker	35
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	13
Other financial deficiency - system	2
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - system	1
Total	123

State may provide additional Data Analysis here (optional):

These cases involve an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the regulations of 42 U.S.C § 1397bb(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and42 CFR 457.340(d)(3).

This category involves the PA CHIP State Plan Amendment, section 4.1.8 provides that enrollees will maintain their eligibility for a period not to exceed 12 months. This SPA section is interpreted by both CMS and PA CHIP to mean that enrollees found eligible will maintain their eligibility

for a period of 12 consecutive months with few exceptions. If an enrollee does not meet the stated exceptions, the Office of CHIP does not re-evaluate the eligibility without a request from the Enrollee or until the renewal period.

This category involves different income determination paths between CHIP and AdvancedMed. The Office of CHIP to use paystubs and electronic verification through the Equifax system, as long as it is representative of the income received by the household. AdvancedMed relied on averaging the Interstate Exchange Verification System (IEVS) quarterly income of the enrollee to determine eligibility only. Both calculations were within tolerance, meaning no change to the category of CHIP the child is to receive (free, subsidized level, or Full Cost).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded; eligible for enrolled category - caseworker

PERM ID
PAC1903M037
PAC1904M001

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M037: The root cause was human error. The MCO worker did not follow the proper policy and procedure. The MCO worker did not include the overtime from the paystubs or overtime YTD from the paystub to determine eligibility

PAC1904M001: The root cause was human error. The MCO worker did not follow proper policy and procedure by not including the second job in the income calculation.

Qualifier #2: Countable income incorrectly excluded; not eligible for enrolled category - caseworker

PERM ID
PAC1901M012

PERM ID
PAC1902M075
PAC1903M007
PAC1903M053
PAC1903M065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M012: The root cause of the error was because of the decision made by the CAO caseworker. However, when the income was updated in the system, it did not change eligibly because of the Healthcare Handshake process and the12-month duration of eligibility as stated under the "Data Analysis Results" for this category.
PAC1902M075: Caseworker incorrectly excluded non-deductible rental property expenses and incorrectly determined household eligible for incorrect MA category. Caseworker lacked training on allowable self-employment deductions.
PAC1903M007 and PAC1903M065: Caseworker incorrectly excluded self-employment income that should have been calculated in eligibility determination. Caseworker lacked training on allowable self-employment deductions.
PAC1903M053: Caseworker failed to timely include new employment income in MA determination. Income was not included in budge calculation for 2 months after client reported change. Caseworker failed to follow established policy and procedure to add income to case in a certain amount of time from being reported due to worker oversight.

Qualifier #3: Countable income incorrectly excluded; not eligible for enrolled category - system

PERM ID
PAC1902M001

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M001. System logic programming incorrectly excluded this countable income when the State received the data exchange hit from Social Security Administration (SSA) with Retirement, Survivors, Disability Insurance (RSDI) income. The caseworker failed to recognize the system glitch in the MA cascade which caused the incorrect CHIP eligibility category.

Qualifier #4: Exempt income incorrectly included; eligible for enrolled category - caseworker

PERM ID
PAC1904M019
PAC1904M021
PAC1904M025

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The root cause for these errors was the result of the Office of CHIP not providing updated requirements regarding pre-tax deductions. The pretax deduction information has not been provided in the procedure handbook, any transmittals, or training given to the MCO.

Qualifier #5: Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker

PERM ID
PAC1901M071
PAC1902M041
PAC1903M004
PAC1903M040
PAC1903M049
PAC1903M050
PAC1903M053
PAC1904M021

PERM ID
PAC1904M066

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M004: The Office of CHIP does not believe this is an error. The stated PERM error was an adult sibling in the household that PERM claimed self-attested as not being a tax dependent. However, that is incorrect. The adult sibling was listed as a tax dependent of the household in our system until 9/12/18, after the reviewed claim's date of service of January 2018. The adult sibling was stated as filing taxes because of her employment but that does not mean that the adult sibling was not a tax dependent.
PAC1903M050: The root cause was because of human error. The MCO worker indicated that a sibling had care-and-control of the applicant instead of the applicant's father.
PAC1904M021: The root cause was because of human error. The MCO worker did include the absent child on the application and care/control but appears to have indicated they were not a tax dependent.
PAC1901M071 and PAC1903M040: Caseworker failed to include unborn child in budget group when the household indicated a pregnancy due to worker oversight not looking at information indicated on the application..
PAC1902M041: Caseworker failed to remove a sibling from eCIS when the application did not list the older sibling as being in the household and caseworker case comments state the sibling moved out. Caseworker failed to review information refreshed on household screen in eCIS due to rushing to process case.
PAC1903M049: Caseworker incorrectly removed mother and her 2 children from budget group when mother should have been a non-eligible household member due to 5-year bar limit. Caseworker lacked training on how to data enter and process a payment name that is not receiving benefits for self and only receiving on behalf of children.
PAC1903M053: System processing error occurred, and caseworker cancelled eligibility determination and started processing case over again. When caseworker processed case with a household of five, the system only included 4 household members due to the system glitch. Caseworker failed to recognize system glitch and did not follow procedure to ensure correct household established.
PAC1904M066: Caseworker incorrectly included a sibling in the budget group when the sibling was being claimed by her grandmother that was not a part of the same household. Caseworker lacked training on how to determine household composition based on tax filer status.

Qualifier #6: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - caseworker

PERM ID
PAC1902M032

PERM ID
PAC1903M047

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M032: Caseworker incorrectly included 2 siblings that were not claimed as dependents by parents in household determination. Caseworker lacked training on how to determine household composition based on tax filer status.
PAC1903M047: Caseworker correctly added newborn to household however, when running eligibility, it appears a system glitch caused the newborn not to be included in budget group. Caseworker failed to recognize system glitch and did not follow procedure to ensure correct household established.

Qualifier #7: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system

PERM ID
PAC1901M334

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M334: Caseworker failed to ensure a sibling that was previously removed from budget due to moving to Alaska, remained excluded from the budget group. System glitch incorrectly added the sibling that was previously removed.

Qualifier #8: Income correctly calculated; below/above income limit; eligible for enrolled category - system

PERM ID
PAC1904M007

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M007: Medical assistance cascade incorrectly placed child in incorrect MA category. System glitch incorrectly placed child in wrong category.

Qualifier #9: Income correctly calculated; below/above income limit; not eligible for enrolled category - caseworker

PERM ID
PAC1904M014
PAC1904M052

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M014: Case comments indicate caseworker correctly calculated wage income; however, income was not correctly data entered in eCIS due to worker failure to review information prior to transmitting off income screen.
PAC1904M052: Caseworker incorrectly averaged wages and data entered $7 above the income verification that was received. Caseworker failed to correctly compute wages due to misreading dollar amounts listed on paystubs.

Qualifier #10: Income correctly calculated; below/above income limit; not eligible for enrolled category - system

PERM ID
PAC1901M020
PAC1903M015
PAC1903M020

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M020: Caseworker case comments indicate household income did not include unemployment due to non-receipt as verified by Exchange information. The caseworker failed to ensure the system did not include unemployment compensation in category determination by worker oversights and failing to review the information refreshed on the unearned screen prior to transmitting off screen.
PAC1903M015: Caseworker failed to use the 4 paystubs provided to determine household income and incorrectly used 1 of the 4 paystubs to represent future income. Caseworker failed to follow established policy and procedures on estimating income outlined in the handbook.
PAC1903M020: Caseworker used 4 paystubs to determine household income which was over the medical assistance limit. It appears information in CAPS and Equifax verification are different. The two systems available to caseworker contained different information due to system logics established to capture wage information

Qualifier #11: Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAC1901M002
PAC1901M038
PAC1901M046
PAC1901M066
PAC1901M073
PAC1901M076
PAC1901M335
PAC1901M337
PAC1901M352
PAC1902M010
PAC1902M013
PAC1902M015
PAC1902M030
PAC1902M032
PAC1902M046
PAC1902M058

PERM ID
PAC1902M060
PAC1902M064
PAC1902M075
PAC1903M001
PAC1903M018
PAC1903M057
PAC1903M058
PAC1903M069
PAC1903M077
PAC1904M001
PAC1904M006
PAC1904M020
PAC1904M029
PAC1904M032
PAC1904M036
PAC1904M048
PAC1904M053
PAC1904M065

PERM ID
PAC1904M068
PAC1904M073
PAC1904M075

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M002: The root cause of the error was that the MCO worker did not follow policy and procedure and used an old tax return to verify current income deductions.
PAC1901M038 PAC1901M046, PAC1901M066, PAC1901M076, PAC1902M013, PAC1902M030, PAC1904M001, PAC1904M020, PAC1904M029, PAC1904M048, and PAC1904M053: The root cause of these errors was because the Office of CHIP did not provide updated requirements regarding pre-tax deductions. The pretax deduction had not been provided in the procedure handbook, in any transmittals, or any training given to the MCOs.
PAC1904M036: The root cause was human error. The MCO worker did not follow policy and procedure and included the student loan deduction.
PAC1901M073, PAC1901M335, PAC1901M337, PAC1901M352, PAC1902M010, PAC1902M013, PAC1902M015, PAC1902M032, PAC1902M046, PAC1902M058, PAC1902M060, PAC1902M064, PAC1902M075, PAC1903M001, PAC1903M018, PAC1903M057, PAC1903M058, PAC1903M069, PAC1903M077, PAC1904M006, PAC1904M029, PAC1904M032, PAC1904M036, PAC1904M048, PAC1904M053, PAC1904M065, PAC1904M068, PAC1904M073, and PAC1904M075: In all instances, the caseworker failed to allow medical vision and dental insurance premiums, retirement deductions, allowable self-employment income tax deductions, and/or rental property self-employment income deduction. Caseworkers failed to follow established policy and procedures outlined in the handbook and properly review paystubs, wage or income verification to determine allowable income deductions.

Qualifier #12: Income deduction incorrectly included/excluded; eligible for enrolled category - system

PERM ID
PAC1902M059
PAC1904M054

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M054: The root cause was human error. The MCO worker did not follow policy and procedure and used an older student loan deduction verification for a newer student loan year.
PAC1902M059. Caseworker failed to allow vision insurance premium and retirement deductions when calculating household income. The caseworker lacked training on how to calculate income by including these allowable deductions.

Qualifier #13: Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker

PERM ID
PAC1903M007
PAC1903M012
PAC1903M060
PAC1904M078

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M012: The root cause of the error was that the MCO did not follow policy and procedure and used student loan income deduction without verification.
PAC1903M007, PAC1903M060 and PAC1904M078: In all instances, a caseworker incorrectly excluded income that should have been calculated in eligibility determination. Caseworkers incorrectly data entered an income exclusion code instead of the frequency code to indicate how often the client is paid. Caseworkers rushing to process cases and failure to review information data entered on the income screen before transmitting caused errors

Qualifier #14: Income incorrectly calculated; other; eligible for enrolled category - caseworker

PERM ID
PAC1901M037
PAC1901M046

PERM ID
PAC1901M047
PAC1901M053
PAC1901M068
PAC1901M070
PAC1901M071
PAC1901M075
PAC1901M321
PAC1901M365
PAC1901M367
PAC1901M368
PAC1902M012
PAC1902M041
PAC1902M047
PAC1902M048
PAC1903M006
PAC1903M018
PAC1903M022
PAC1903M035

PERM ID
PAC1903M055
PAC1903M065
PAC1903M067
PAC1903M070
PAC1903M073
PAC1904M007
PAC1904M008
PAC1904M027
PAC1904M034
PAC1904M034
PAC1904M035
PAC1904M057
PAC1904M062
PAC1904M065
PAC1904M068

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M037: The root cause was because of human error. The Central Eligibility Unit worker miscalculated the income.
PAC1901M046: The root cause was because of human error. The MCO worker used the incorrect YTD on the available paystub; however, the difference was around ten dollars annually, or twenty cents per weekly pay.
PAC1901M047: The root cause was because of human error. The MCO worker did not follow policy and procedure regarding income and did not allow the appropriate pre-tax deductions and did not use the correct YTD income calculation.

PAC1901M068: The Office of CHIP does not agree that there is an error in this case. The Central Eligibility Unit verified income using Equifax, the electronic income verification program. The MCO worker verified the eight most recent paystubs. PERM used the State DOL quarterly wage YTD. The electronic verification and paystub calculations are acceptable processes. The calculated income difference between the methods came to an approximately sixty-two-dollar difference annually or two-and-a-half-dollar difference between paystubs.
PAC1901M075: The Office of CHIP does not agree that there is an error in this case. The MCO worker verified the income using current paystubs while PERM used the YTD on the paystubs. The paystub calculations are acceptable processes. The calculated income difference between the methods came to about an eighty-two-cent difference per month.
PAC1902M012: The Office of CHIP does not agree that there is an error in this case. The Central Eligibility Unit worker verified the income through the State DOL(IEVS) system as stated in our "comment" of the CAPS system. The worker used the same methods that the PERM used in other cases such as PAC1901M068.
PAC1903M022: The root cause was because of human error and confusion. The MCO worker excluded expense reimbursement because of the confusion of the expense being paid on business costs.
PAC1904M008: The Office of CHIP does not agree that there is an error in this case. The case's income was verified using Equifax, an electronic income verification program that verified the income while PERM used the DOL quarterly wage YTD. The electronic verification and paystub calculation are acceptable processes.
PAC1904M027: The root cause was because of human error. The MCO worker typed a "9" rather than an "8".
PAC1904M057: The root cause of the error was that the MCO did not follow policy and procedure regarding income. The enrollee stated that he had applied for Unemployment Compensation (UC) but had not received any monies or statements. The MCO worker put the UC in as one dollar and required verification, but the case should have been run without the UC since it was not currently being received.

PAC1901M053, PAC1901M070, PAC1901M071, PAC1901M321, PAC1901M365, PAC1901M367, PAC1901M368, PAC1902M012, PAC1902M041, PAC1902M047, PAC1902M048, PAC1903M006, PAC1903M018, PAC1903M035, PAC1903M055, PAC1903M065, PAC1903M067, PAC1903M070, PAC1903M073, PAC1904M007, PAC1904M034, PAC1904M035, PAC1904M057, PAC1904M062, PAC1904M065, and PAC1904M068. In all instances, the caseworker's failure to calculate income correctly included: incorrectly data entering paystub amounts; incorrectly using Exchange quarterly information to calculate an annual income amount and dividing by 12; averaging multiple paystubs to derive a monthly income amount when 30 days of income were provided so no averaging was needed and failure to double check data entry amounts and entries on each case processing screen prior to finalizing eligibility determination. Caseworkers failure to follow established policy and procedure outlined in handbook caused errors.

Qualifier #15: Income incorrectly calculated; other; not eligible for enrolled category - caseworker

PERM ID
PAC1901M061

PERM ID
PAC1901M323
PAC1902M004
PAC1903M004
PAC1903M048
PAC1904M011
PAC1904M025
PAC1904M046
PAC1904M052
PAC1904M052
PAC1904M060
PAC1904M071
PAC1904M071

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M061: The Office of CHIP does not agree that there is an error in this case. The case's income was verified using Equifax, an electronic income verification program, that verified the income while PERM used the DOL quarterly wage YTD. The electronic verification and paystub calculation are acceptable processes.
PAC1902M004: The root cause of the error was related to the CHIP system, CAPS and how it works. The CAPS system tries to perform an Ex Parte review with electronic sources if available. In this case, an Ex Parte review was tried but failed because of the household variance of income. The MCO worker sent the appropriate renewal and request for updated documentation. The MCO worker received the information and ran the case without the Department of Labor and Industry (DLI) income because it would have been double income. The calculated income by CHIP and by the PERM team both noted that the enrollee would not be eligible for standard CHIP and should be eligible for Medicaid expansion through the CAO. The reason the household is not eligible for medical assistance is the way the system pulls and updates information such as

income. The income is from seasonal employment and unemployment, the CAO must determine eligibility per month, this causes the income to be higher than the medical assistance limits. If the income is calculated annually, the family is ineligible for CHIP benefits. When the case is run and found ineligible for CHIP, it is forwarded to medical assistance eligibility and found ineligible as well, so the case stays within the CHIP system as eligible.

PAC1903M004: The Office of CHIP does not believe this is an error. The previously stated PERM error was an adult sibling in the household that PERM claimed self-attested as not being a tax dependent should have been a tax dependent. This error is stated as being that the income from that tax dependent should not be counted in the review. However, that is incorrect if the tax dependent should have been counted in the household. The adult sibling was listed as a tax dependent of the household in our system until 9/12/18, after the reviewed claim's date of service of January 2018. The adult sibling's income was in our system. The adult sibling was stated as filing taxes because of her employment but that does not mean that the adult sibling was not a tax dependent.

PAC1904M025: The root cause was because of human error. The MCO worker counted the negative self-employment as positive income.

PAC1901M323: Caseworker incorrectly used Equifax wage information instead of the paystubs submitted with renewal. Caseworker did not use the most recent wage information and did not verify the two sources of income verification matched. Caseworker lacked training on how to correctly process wage information using available information.

PAC1903M004: Caseworker failed to follow operational mandate to image verification (including application) and create case comments to explain eligibility determination. Paperwork was misplaced and was not incorporated into electronic case record.

PAC1903M048 and PAC1904M046: Caseworker data entered incorrect frequency code and incorrectly entered weekly wages and not bi-weekly. Caseworker failure to review information data entered due to rushing to process case caused error.

PAC1904M011: Caseworker incorrectly tried to average quarterly income using Exchange 1 wage information by adding quarters together and incorrectly divided by 24 instead of 12. Mathematical mistake made using an incorrect divisor and caseworker failure to double check calculation results caused error

PAC1904M052: Caseworker incorrectly used a paystub twice when calculating household income. Caseworker failed to ensure accurate amount of household wages was data entered into eCIS. A second error cited for incorrect monthly calculation caused an incorrect annual amount for household which made household still ineligible for CHIP. Both errors caused by caseworker failure to accurately data enter wage information into eCIS and review income prior to transmitting off screen.

PAC1904M060: Caseworker incorrectly tried to average monthly income using Exchange 1 wage information by adding quarters together and made a mathematical mistake in addition. Mathematical mistake and caseworker failure to double check calculations caused error.

PAC1904M071: Caseworker incorrectly allowed expenses listed on an ownership statement for rental income received from a property management company. Caseworker failed to accurately determine allowable expenses deducted from rental income received should not have included the security deposit amounts held listed on the ownership statement. Caseworker lack of training on allowable expense deduction caused error.

Qualifier #16: Other financial deficiency - system

PERM ID
PAC1902M073
PAC1903M063

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M073: Caseworker incorrectly added both 2016 and 2017 allowable self-employment income deductions and data entered into eCIS for eligibility determination. Caseworker failed to use just 1 tax return as verification of allowed deductions due to lack of knowledge on using tax returns for self-employment income verification contributed to error. System glitch also incorrectly did not allow self-employment income deductions data entered by caseworker.
PAC1903M063: Caseworker failed to data enter the correct tax return line item for the household adjusted gross income to determine the net monthly income and allowable deductions. Caseworker lacked training on tax return line items contributed to error. System glitch also incorrectly did not allow self-employment income deductions data entered by caseworker.

Qualifier #17: Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - system

PERM ID
PAC1901M334

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M334: Caseworker was waiting for client to provide renewal information before processing renewal. Ex-parte review completed due to non-receipt of renewal packet. Ex-parte review completed untimely due to giving client time to provide renewal information. Caseworker was unable to follow established policy and procedure for renewals when client failed to provide information timely due to receiving system error. System glitch caused error.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.
3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Any system caused errors are reported to the Division of Automation Planning and Support for research to fix the issue and develop future system enhancements to avoid repetition of errors.
2. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
3. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
4. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAO's in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
5. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #4 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
6. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client

Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.

7. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
8. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
9. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
10. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
11. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
12. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
13. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #4 above.
14. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
15. Operations Memorandum #17-08-03 issued on August 15, 2017 outlined the system enhancements made in response to the Affordable Care Act mandate. System changes included automated case actions, real time eligibility determinations and enhanced medical assistance renewals.
16. Daily Status D-17072001 issued July 20, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
17. Daily Status D-17081001 issued August 9, 2017 outlined the August 2017 system enhancement release that converted and migrated various data exchange interfaces from mainframe system to an open system for our Client Information System (eCIS). This system enhancement created new eligibility screens and messages that would require adjustment in becoming familiar with the changes when processing cases by CAO staff.
18. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
19. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
20. Daily Status D-18032601 issued March 26, 2018 identified instances where self-employment expenses are entered along with tax deductions for the individual in the case, the system is ignoring self-employment expenses. MAGI income calculations were incorrect

causing incorrect budgets to pass or fail. The daily status outlined the manual procedural steps caseworkers had to use to correctly determine self-employment income.

21. Daily Status D-18032705 issued March 27, 2018 identified a system glitch where the system is not calculating allowable self-employment income offsets when a net loss is reported correctly which results in incorrect income calculations for MA budgets. The daily status provided a temporary work around for caseworkers to use to correctly data enter self-employment income.
22. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
23. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews; issue Policy Clarification
Implement SMART tool for case review monitoring	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1 Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.

2 Case review for SMART: The Office of CHIP will pull sample cases and review the MCO's ability to determine eligibility. We will measure the MCO's incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of the MCO as well as be the measurement of compliance with lack of compliance being one of the steps to a sanction.

3 Trainings: The Office of CHIP will track MCOs who have performed the training and follow-up with those who haven't to ensure completion of the training.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Assisting DAPS in ascertaining if any system enhancements implemented have negatively or positively impacted the number of MA errors.
5. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
6. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
7. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
8. Participating in various workgroups for system initiatives and possible resolution techniques for future system releases.
9. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top(CMS)

CHIP Eligibility Target Rate

Next Cycle CHIP Eligibility Target: 3.00%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.
The Office of CHIP believes that with the addition of pre-tax deductions into our handbooks and MCO training, the MCOs will no longer make the same error. The number of errors for pretax deductions should drop by sixteen.
The Office of CHIP disagreed with eight eligibility errors stated by the PERM review. These errors included calculating income and the duration of eligibility that was approved by the SPA. Only four of the cases that had federal dollars in error were completed by CHIP, totaling $692.41 out of the $5,018.00. CHIP disagrees with one of these errors is one that because of the approved method in the SPA.

	RY 2019
Number of Errors	161
Number of Claims in Error	126
Number of Claims Sampled	317
Sampled Federal Dollars in Error	$5,018
Projected Federal Dollars in Error	$64,242,267
Improper Payment Rate	10.55%
Target Rate	3.00%
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one ER error on the claim.	

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
Click here to enter text.

Appendix A: Acronym Glossary

CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
DMF	Social Security Death Master File
DOS	Date Of Service
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Estimate
POC	Plan Of Care

SAM/EPLS	System for Award Management/Excluded Parties List System
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TD	Technical Deficiency
TPL	Third Party Liability

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

RY 2019 Pennsylvania Medicaid

Payment Error Rate Measurement (PERM) Cycle 1 Summary Report

November 26, 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

A. Program and Report Overview

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

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

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

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

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

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

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

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

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

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

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

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

B. PERM 17-State Cycle 1 Medicaid Findings

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

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

C. Pennsylvania's Medicaid Findings

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

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

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

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

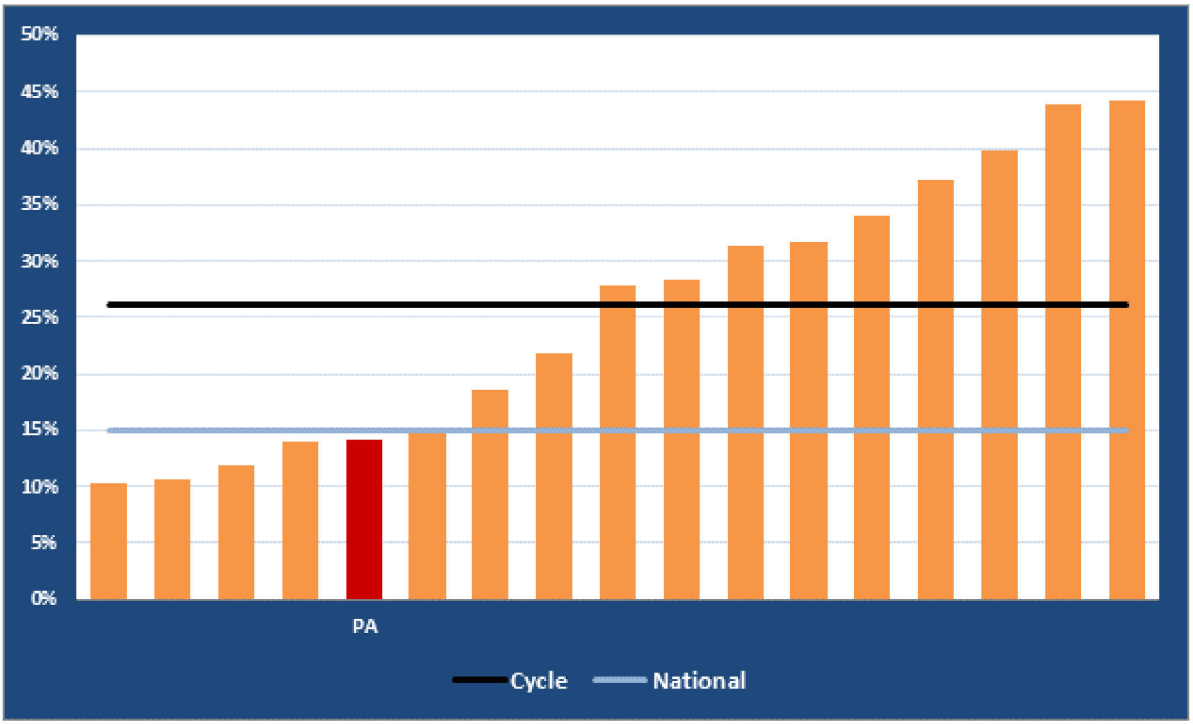
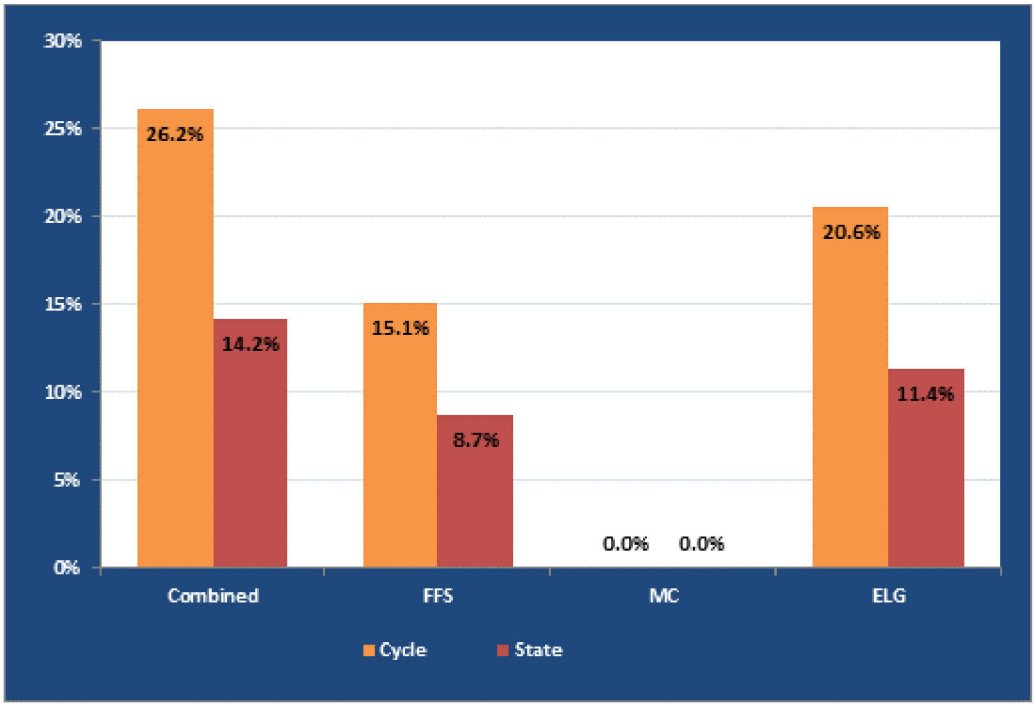


Figure 2 compares Cycle 1 and Pennsylvania on the combined Medicaid federal improper payment rate and the component Medicaid federal improper payment rates.

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



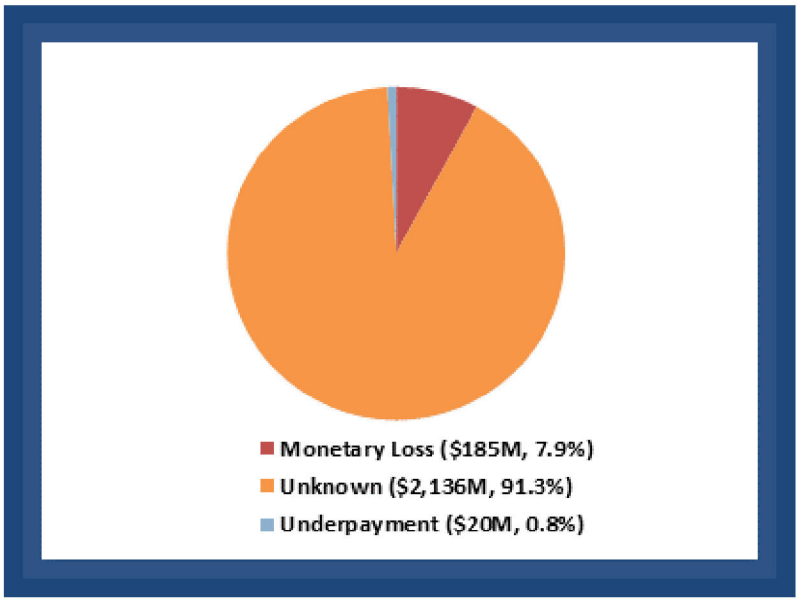
Please note that the PERM FFS review includes payments made to individual providers, while the managed care review only looks at capitated payments made by states to managed care organizations, not payments made by managed care organizations to providers. Therefore, the managed care measurement does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

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

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

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

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



D. Sample Medicaid Findings and Projected Federal Dollars in Error

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

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

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

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

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

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

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

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

	# of Sample Errors		Sample Federal Dollars in Error		Projected Federal Dollars in Error	
	State	Cycle	State	Cycle	State	Cycle (in Millions)
Data Processing Technical Deficiency (DTD)	14	154	$0	$0	**$0**	**$0**
Total	65	1,683	$78,761	$2,301,293	**$436,258,386**	**$7,229**

Note: Details do not always sum to the total due to rounding. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanations of error types can be found in Appendix A Error Type Definitions.

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

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

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

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

Note: Details do not always sum to the total due to rounding. Also, deficiencies (discrepancies found in the review of the claim or of the medical record that did not result in a payment error) are included in the number of sample errors and number of sample claims in error counts throughout this report. Additionally, multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. Overlaps between error categories are reported in all relevant categories, which may result in double counting in this table. Further explanations of error types can be found in Appendix A Error Type Definitions.

E. Medicaid Medical Review and Data Processing Findings

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

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

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

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

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

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

a. Medicaid FFS Medical Review – Error Type Analysis

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

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

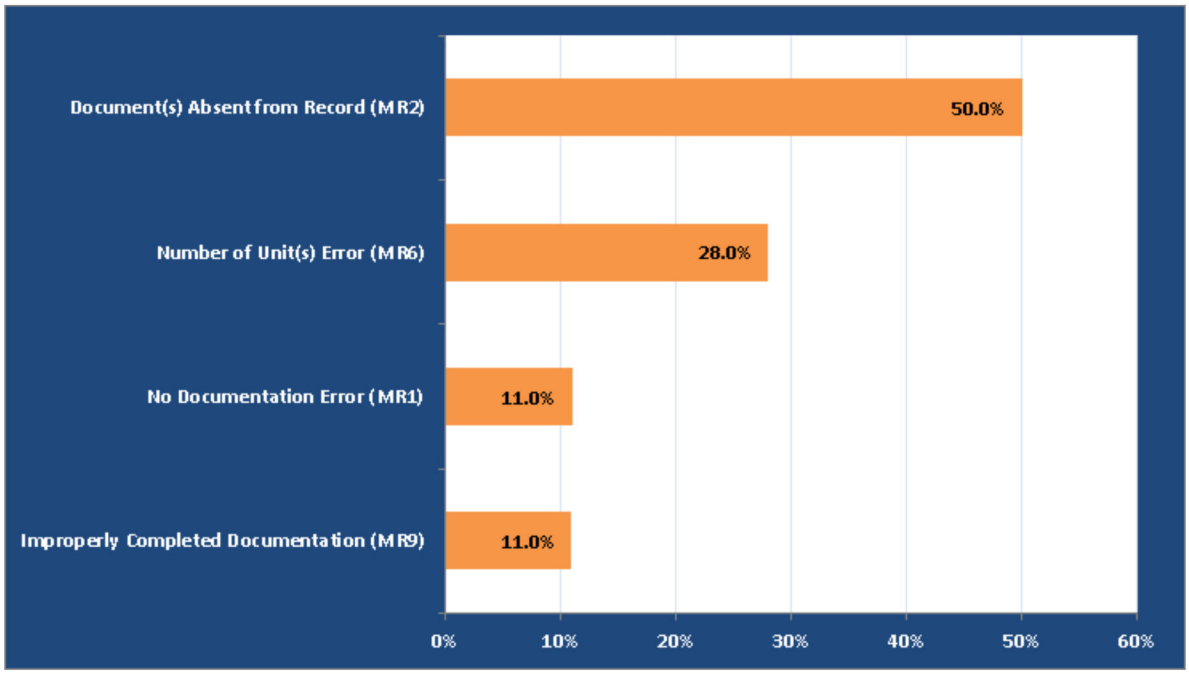


Table 5 contains information on the number of Medicaid FFS medical review errors and federal dollars in error by error type and percentage of total medical review errors.

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

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

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

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

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

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

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

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

FFS Medical Review Error Descriptions by Error Type

No Documentation Error (MR1)

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

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

Document(s) Absent from Record Error (MR2)

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

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

Number of Unit(s) Error (MR6)

Number of units billed not supported by number of units documented

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

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

Improperly Completed Documentation Error (MR9)

Required provider signature and/or credentials are not present

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

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

b. Medicaid FFS Medical Review – Service Type Analysis

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

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

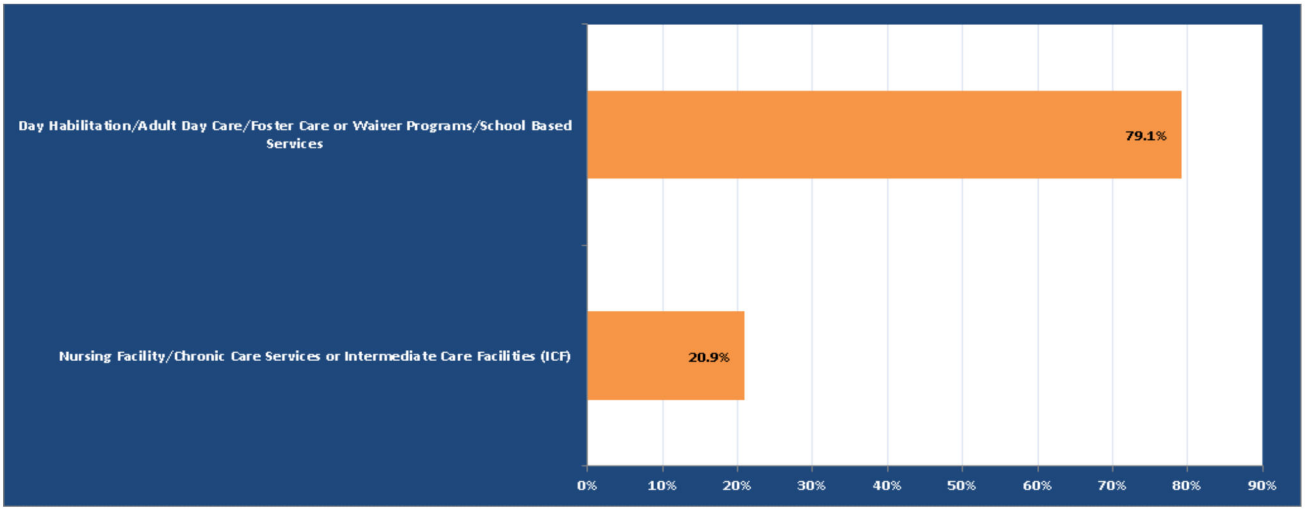


Table 7 provides information on the number of Medicaid FFS medical review errors and federal dollars in error for service type by percentage of total medical review errors.

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

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

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

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

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

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

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

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

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

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

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

FFS Medical Review Error Descriptions by Service Type

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

Ten errors were cited for this service type:

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

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

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

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

Three errors were cited for this service type:

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

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

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

c. Medicaid FFS Data Processing Review – Error Type Analysis

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

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

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

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

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

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

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

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

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

FFS Data Processing Error Descriptions by Error Type

Provider Information/Enrollment Error (DP10)

Attending provider NPI required, but not submitted on institutional claim

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

Missing provider license information

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

Missing provider risk-based screening information

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

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

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

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

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

Data Processing Technical Deficiency (DTD)

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

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

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

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

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

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

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

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

d. Medicaid FFS Data Processing Review – Service Type Analysis

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

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

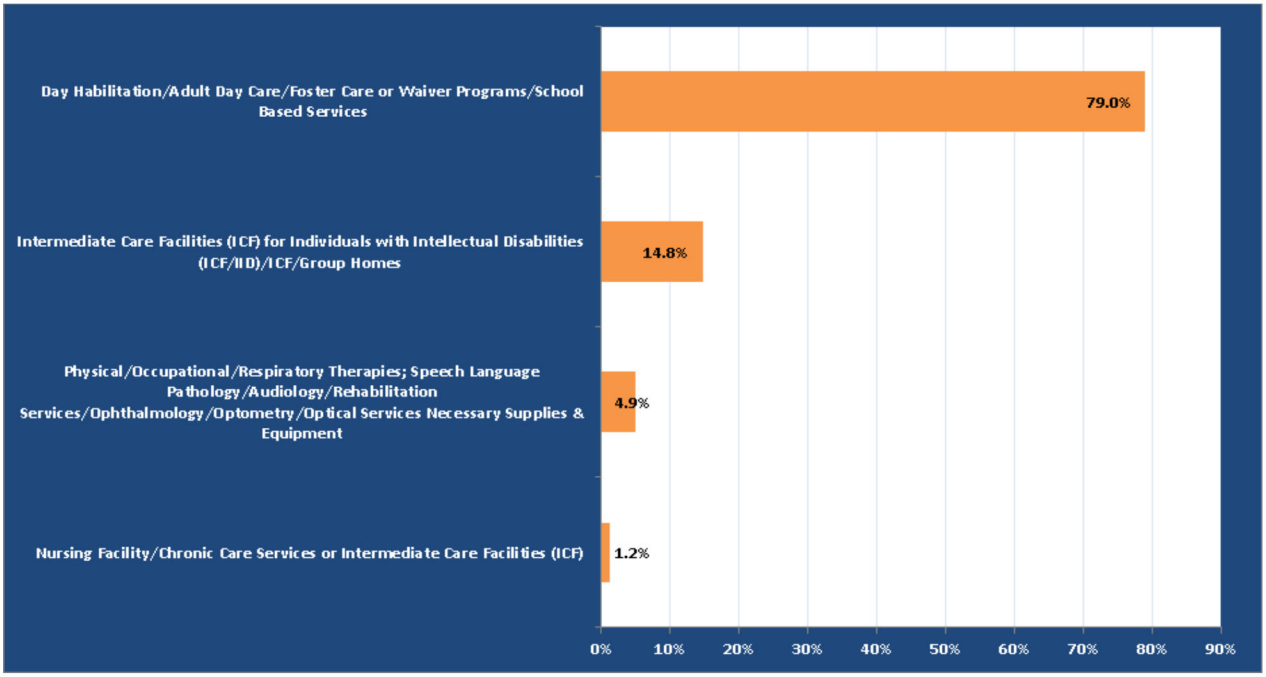


Table 13 includes information on the number of Medicaid FFS data processing review errors and federal dollars in error for service type by percentage of total data processing review errors.

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

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

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

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

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

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

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

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

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

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

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

FFS Data Processing Error Descriptions by Service Type

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

Forty errors were cited for this service type:

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

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

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

One deficiency was cited for this service type:

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

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

Nine errors were cited for this service type:

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

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

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

One error was cited for this service type:

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

Eleven deficiencies were cited for this service type:

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

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

One error was cited for this service type:

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

Prescribed Drugs

Two deficiencies were cited for this service type:

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

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

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

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

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

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

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

2. Medicaid Managed Care Data Analyses

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

3. Types of Payment Errors

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

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

Pennsylvania Figure 7: Medicaid Types of Payment Errors

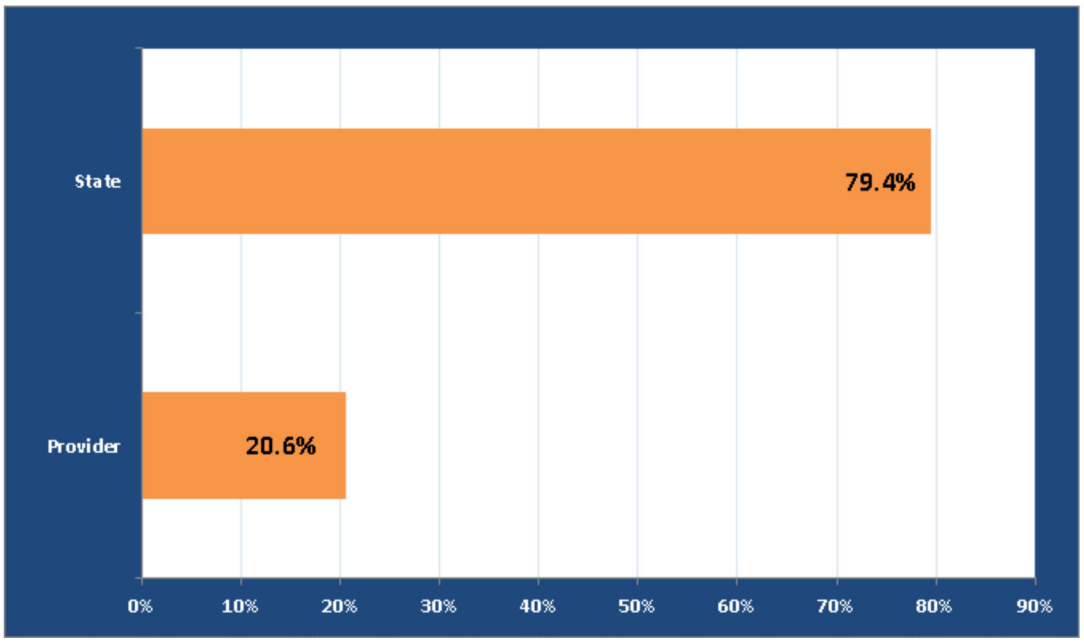


Table 17 shows how the errors aggregate into state and provider payment errors.

Pennsylvania Table 17: Medicaid Types of Payment Errors

Error Type	State or Provider Error	# of Sample Errors	% of Total # of Sample Errors	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
Medical Review Errors	Provider	13	16.67%	$15,457	16.41%	**$112,967,691**	20.57%
Data Processing Errors	State	65	83.33%	$78,761	83.59%	**$436,258,386**	79.43%
Note: Multiple errors on a claim are counted separately in this table and may not match tables that do not individually count these errors. This also applies to Figure 7, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.							

4. Comparison of Medicaid FY 2015 and RY 2019

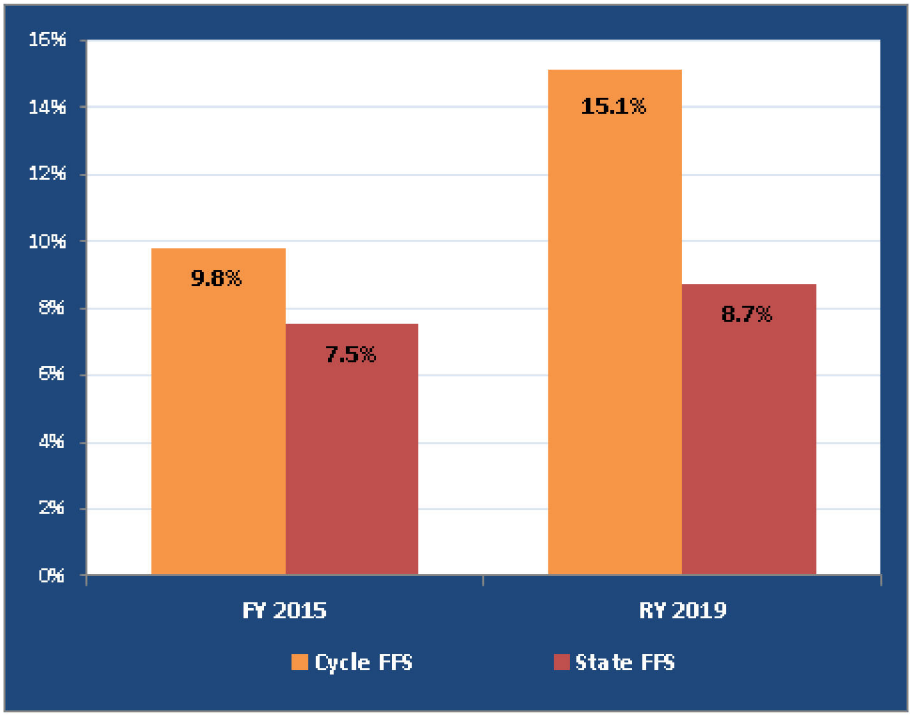
This section provides a brief comparison of the sample findings for Pennsylvania in FY 2015 and RY 2019 for Medicaid.

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

Pennsylvania's Medicaid FFS Findings

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

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



Sample Medicaid FFS Comparisons

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

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

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

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

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

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

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

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

Sample Medicaid Managed Care Comparisons

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

F. Medicaid Eligibility Review Findings

1. Medicaid Eligibility Data Analyses

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

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

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

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

a. Medicaid Eligibility Review – Error Type Analysis

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

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

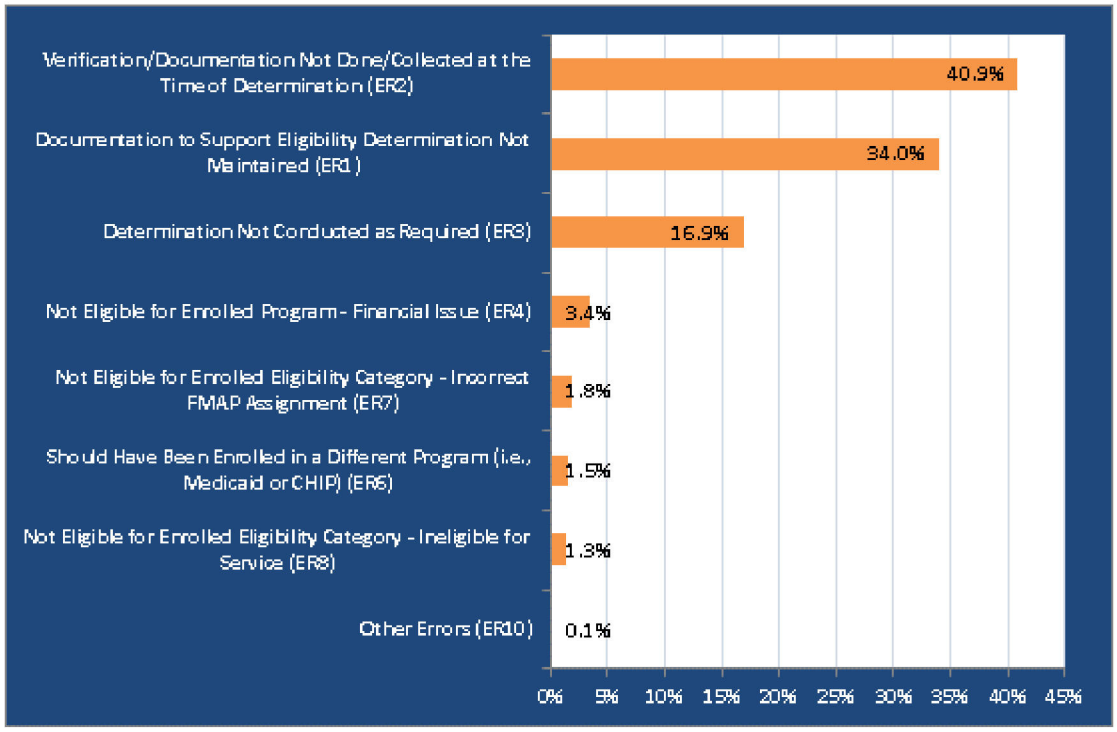


Table 21 contains information on the number of Medicaid eligibility review errors and federal dollars in error for error types by overpayments, underpayments, and percentage of total Medicaid eligibility review errors.

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

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

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

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

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

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

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

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

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

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

Eligibility Review Error Descriptions by Error Type

Documentation to Support Eligibility Determination Not Maintained (ER1)

Blindness/disability determination documentation not on file/incomplete

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

Income verification not on file/incomplete

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

Level of care determination not on file/incomplete

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

Other required forms not on file/incomplete

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

Record of signature not on file - caseworker

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

Resource verification not on file/incomplete

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

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

Income not verified - caseworker

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

Income not verified - system

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

Other element not verified – caseworker

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

Other eligibility process(es) not followed - caseworker

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

Resources not verified – caseworker

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

Signature not recorded at initial application - caseworker

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

State did not do required disability/blindness determination - caseworker

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

When appropriate, signature not recorded at renewal - caseworker

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

Determination Not Conducted as Required (ER3)

Initial determination not conducted

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

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

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

Not Eligible for Enrolled Program - Financial Issue (ER4)

Resources incorrectly calculated - caseworker

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

Resources incorrectly included/excluded - caseworker

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

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

Countable income incorrectly excluded – system

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

Income incorrectly calculated; other – caseworker

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

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

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

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

Other non-financial error - caseworker

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

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

Countable income incorrectly excluded - caseworker

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

Other Errors (ER10)

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

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

Other error

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

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

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

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

Not eligible for enrolled program; financial issue

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

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

Countable income incorrectly excluded; eligible for enrolled category - caseworker

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

Countable income incorrectly excluded; eligible for enrolled category - system

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

Exempt income incorrectly included; eligible for enrolled category - system

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other financial deficiency - caseworker

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

Other non-financial deficiency - caseworker

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

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

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

Resources incorrectly calculated; eligible for enrolled category - caseworker

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

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

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

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

b. Medicaid Eligibility Review – Eligibility Category Analysis

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

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

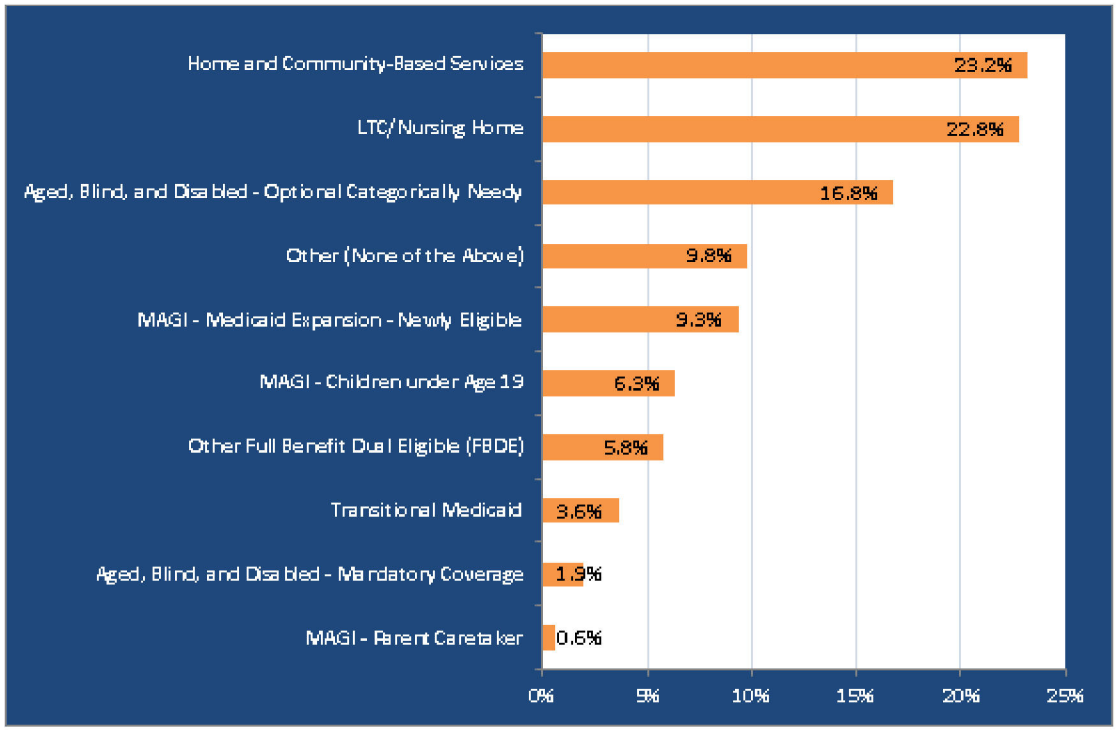


Table 23 contains information on the number of Medicaid eligibility review errors and federal dollars in error by eligibility category by overpayment, underpayments, and percentage of total eligibility review errors.

Pennsylvania Table 23: Medicaid Eligibility Review Errors by Eligibility Category

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligibility Review Error Descriptions by Eligibility Category

Aged, Blind, and Disabled - Mandatory Coverage

One error was cited for this eligibility category:

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

Aged, Blind, and Disabled - Optional Categorically Needy

Thirteen errors were cited for this eligibility category:

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

Eight deficiencies were cited for this eligibility category:

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

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

Home and Community-Based Services

Twenty-one errors were cited for this eligibility category:

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

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

Thirty-five deficiencies were cited for this eligibility category:

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

LTC/Nursing Home

Twenty-three errors were cited for this eligibility category:

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

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

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

Thirty-five deficiencies were cited for this eligibility category:

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

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

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

MAGI - Children under Age 19

Nine errors were cited for this eligibility category:

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

Fifteen deficiencies were cited for this eligibility category:

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

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

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

MAGI - Medicaid Expansion - Newly Eligible

Four errors were cited for this eligibility category:

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

Forty-three deficiencies were cited for this eligibility category:

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

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

MAGI - Medicaid Expansion - Not Newly Eligible

One deficiency was cited for this eligibility category:

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

MAGI - Parent Caretaker

One error was cited for this eligibility category:

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

Five deficiencies were cited for this eligibility category:

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

MAGI - Pregnant Woman

Two deficiencies were cited for this eligibility category:

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

Other (None of the Above)

Eight errors were cited for this eligibility category:

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

One deficiency was cited for this eligibility category:

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

Other Full Benefit Dual Eligible (FBDE)

Seven errors were cited for this eligibility category:

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

Three deficiencies were cited for this eligibility category:

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

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

Qualified Individuals

One deficiency was cited for this eligibility category:

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

Transitional Medicaid

Three errors were cited for this eligibility category:

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

Five deficiencies were cited for this eligibility category:

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

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

2. Types of Payment Errors

a. Medicaid Eligibility Review – MAGI Analysis

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

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

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

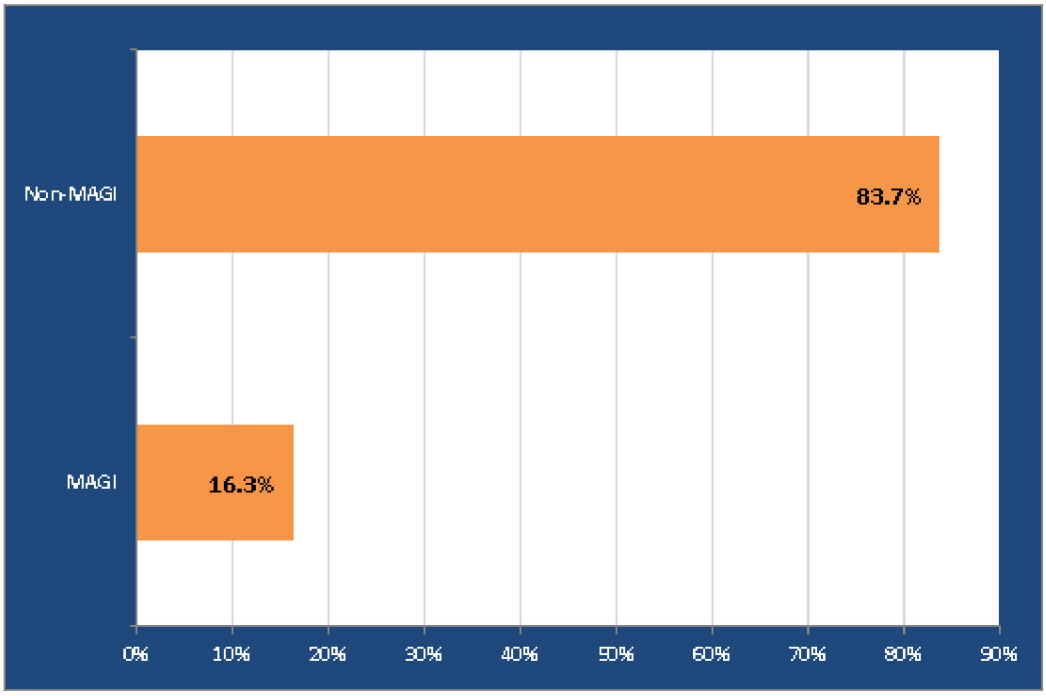


Table 26 shows how the errors aggregate into MAGI and Non-MAGI payment errors.

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

MAGI or Non-MAGI Error	# of Sample Claims in Error	% of Total # of Sample Claims in Error	Sample Federal Dollars in Error	% of Sample Federal Dollars in Error	Projected Federal Dollars in Error	% of Projected Federal Dollars in Error
MAGI	68	33.83%	$2,521	2.62%	**$296,290,565**	16.27%
Non-MAGI	133	66.17%	$93,639	97.38%	**$1,524,865,569**	83.73%
Note: Multiple errors on a claim are not counted separately in this table and may not match tables that do individually count these errors. This also applies to Figure 11, above. Also, deficiencies are included in the number of sample errors and number of sample claims in error counts throughout this report.						

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

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

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

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

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

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

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

b. Medicaid Eligibility Review – Claim Type Analysis

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

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

Pennsylvania Figure 12: Medicaid Eligibility Errors by Claim Type

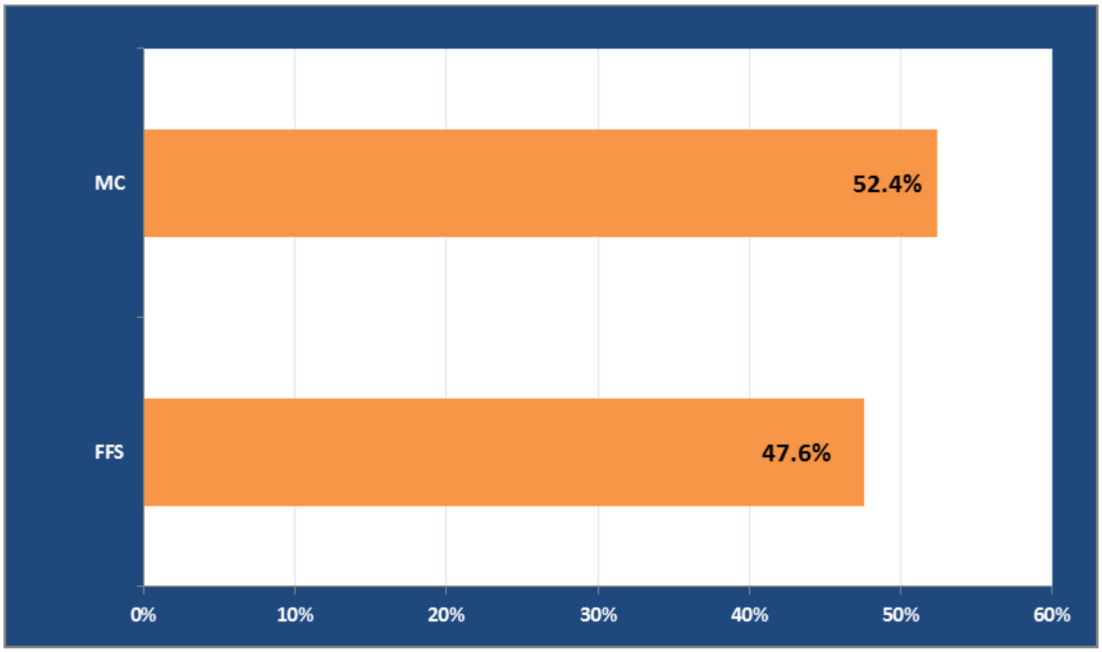


Table 29 shows how the errors aggregate into FFS and managed care payment errors.

Pennsylvania Table 29: Medicaid Eligibility Errors by Claim Type

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

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

c. Medicaid Eligibility Review – Case Action Analysis

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

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

Pennsylvania Figure 13: Medicaid Eligibility Case Action Errors

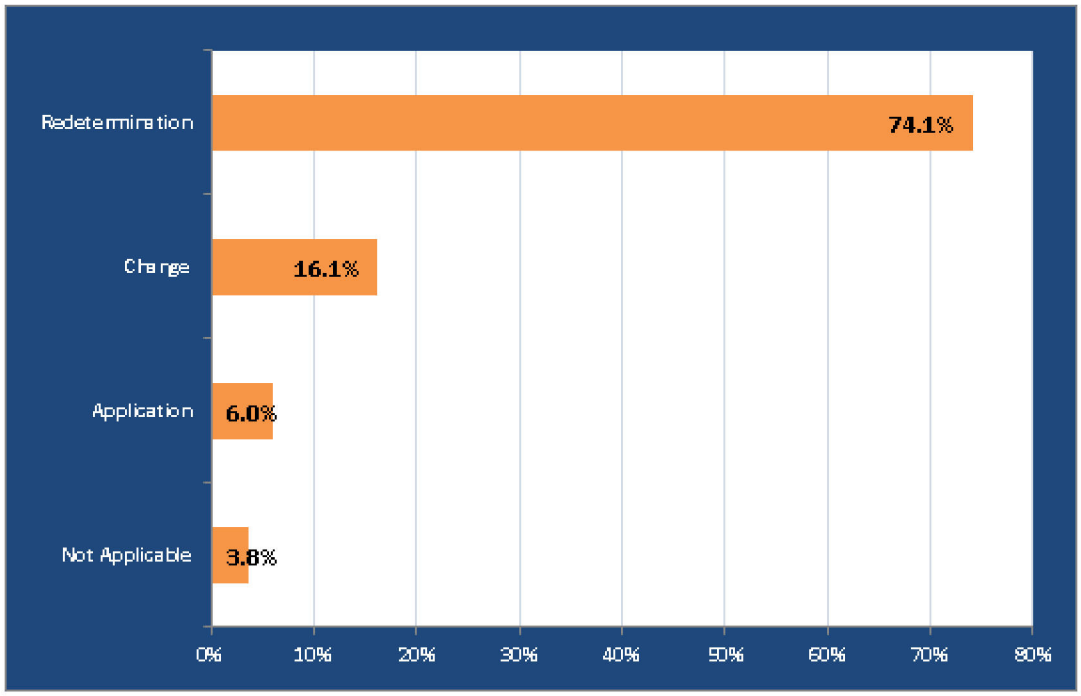


Table 30 shows how the errors aggregate into case action payment errors.

Pennsylvania Table 30: Medicaid Eligibility Case Action Errors

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

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

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

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

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

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

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

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

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

3. Comparison of Medicaid FY 2015 and RY 2019

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

Sample Medicaid Eligibility Comparisons

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

Appendix

A. Error Type Definitions

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

Pennsylvania Appendix Table 1: Medical Review Error Codes

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

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

Pennsylvania Appendix Table 2: Data Processing Error Codes

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

Pennsylvania Appendix Table 3: Eligibility Review Error Codes

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

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

Pennsylvania Appendix Table 4: Acronym Glossary

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

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

B. List of PERM IDs

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

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

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

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

Return to Medicaid Medical Review and Data Processing Findings

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

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

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

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

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

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

Return to Medicaid Medical Review and Data Processing Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Return to Medicaid Eligibility Review Findings

C. Recoveries

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

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

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

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

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

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

D. Next Steps

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

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

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

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

Payment Error Rate Measurement (PERM)
RY 2019 Medicaid Corrective Action Plan
Pennsylvania

Table of Contents

Medicaid Corrective Action Cover Page

This document serves as a template for the state to enter its plan for corrective actions. The template will guide Pennsylvania in reporting the root cause for each error and deficiency found in the RY 2019 measurement and the appropriate corrective actions to resolve them. Please refer to the state's Cycle Summary report for a full analysis and breakdown of the findings that contribute to Pennsylvania's improper payment rate through the PERM program. Please note that the definition of an improper payment is derived from the Improper Payments Information Act (IPIA) of 2002, as amended, and 42 CFR 431.958. Please keep in mind that corrective actions should focus on how to prevent the same improper payment (or deficiency) from occurring again. Please also keep in mind that the Corrective Action Plan (CAP) is not a venue to dispute errors or deficiencies cited. For more information on completing this template, please refer to the CAP template instructions.

A. (State): Pennsylvania **Fiscal Year:** 2019

B. (Date): 2/24/2020

C. State Contact: Jean Lettich
Phone number: 717.772.4616
Email address: jlettich@pa.gov

D. Medicaid Federal Improper Payment Rate: 14.24%
Fee-For-Service Rate: 8.74%
Managed Care Rate: 0.00%
Eligibility Rate: 11.36%

Next Cycle Fee-For-Service Target: 5.12%
Next Cycle Managed Care Target: 0.00%
Next Cycle Eligibility Target: 3.00%

E. Summary of Medicaid Error Causes[1]

Fee-For-Service:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
No Documentation Error (MR1)	1	$30.03	$12.46
Document(s) Absent from Record (MR2)	7	$13,245.87	$56.46
Number of Unit(s) Error (MR6)	4	$201.40	$31.65
Improperly Completed Documentation (MR9)	1	$1,979.86	$12.40
Provider Information/Enrollment Error (DP10)	51	$78,760.55	$436.26
Data Processing Technical Deficiency (DTD)	14	$0.00	$0.00

[1] Multiple errors on a claim are counted separately, which may result in a discrepancy when compared to the Cycle Summary Report results by type of error.

Managed Care:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
There are no Managed Care errors	0	$0.00	$0.00

Eligibility:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	32	$64,921.14	$725.85
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	28	$20,536.11	$873.71
Determination Not Conducted as Required (ER3)	18	$8,307.26	$359.87
Not Eligible for Enrolled Program - Financial Issue (ER4)	3	$5,815.26	$72.91
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	2	$75.46	$31.48
Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)	2	$623.17	$38.56
Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)	1	$365.60	$28.79
Other Errors (ER10)	4	$448.54	$3.16
Incorrect Case Determination, But There was No Payment on Claim (ERTD1)	3	$0.00	$0.00
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	151	$0.00	$0.00

F. Optional State Medicaid Corrective Action Discussion

Click here to enter text.

RY 2019 Medicaid FFS Federal Improper Payment Rate: 8.74%

As noted in your Cycle Summary Report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Medical Review (MR)[2]

FFS Finding Category #1: No Documentation Error (MR1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Provider responded that he or she did not have the beneficiary on file or in the system	1	$30.03	$12.46
Total	1	$30.03	$12.46

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

[2] No response is needed for No Documentation (MR1) errors that are cited for providers under fraud investigation.

Qualifier #1: Provider responded that he or she did not have the beneficiary on file or in the system

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904F158	$30.03	$12.46

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The provider failed to identify that they had the information on this recipient. The Provider had no direct access to the medical records. The Medical Record Supervisor requested that Children and Youth provide the required documentation. A Request for Records letter was sent to the Law Department for Children and Youth per the Medical Record Supervisor. No response was received from Law Department.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit

procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.

7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and

Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.

15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementa-tion has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle. Request number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainin

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					gs%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	On-going process	OLTL	Conducts periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Detection System (FADS)					reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.

4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (

1920SBAPStatewideTraining.pdf

Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #2: Document(s) Absent from Record (MR2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
One or more documents are missing from the record that are required to support payment	7	$13,245.87	$56.46
Total	7	$13,245.87	$56.46

State may provide additional Data Analysis here (optional)

Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: One or more documents are missing from the record that are required to support payment

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F055	$2,645.50	$7.17
PAM1902F004	$5,613.47	$7.67
PAM1903F035	$3,388.86	$4.03
PAM1903F131	$473.59	$10.71
PAM1903F167	$46.92	$14.22
PAM1904F077	$849.68	$7.09
PAM1904F128	$227.84	$5.57

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Seven (7) instances of MR2 errors-Insufficient Documentation. These errors fell under the Nursing Facility/Intermediate Care Facilities Service Type. Nursing Facility/Intermediate Care Facilities accounted for 23% of total projected dollars in errors and Habilitation/Waiver Programs/School Services accounted for 79% of the total projected dollars in error. The errors

occurred with multiple providers with insufficient documentation to support the claim, missing Individual Education Plans, and failure to submit additional documentation as requested. Two (2) of the errors fell under the Nursing Facility/Intermediate Care Facilities Service Type. The errors occurred from different Providers: one was missing a Progress record within the required 60 day period, and one lacked a signature on a Physician Order. This Provider submitted Interim and Telephone orders which were not signed by the Physician.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

Qualifier #1: Provider failed to Provide a signed Physician order for that Date of Service

PERM ID	Federal Dollars in Error
PAM1901F055	$2,645.50

Qualifier #2: Provider failed to Provide a record with daily documentation of specific tasks performed for that Date of Service

PERM ID	Federal Dollars in Error
PAM1902F004	$5,613.47

Qualifier #3: Provider failed to Provide a progress note for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F035	$3,388.86

Qualifier #4: Provider failed to Provide a time sheets for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F131	$473.59
PAM1904F128	$227.84

Qualifier #5: Provider failed to Provide an Individual Education Plan, record with daily documentation of specific tasks and a physician's order for that Date of Service

PERM ID	Federal Dollars in Error
PAM1903F167	$46.92

Qualifier #6: Provider failed to Provide an Individual Service Plan, and a prior Authorization for that Date of Service

PERM ID	Federal Dollars in Error
PAM1904F077	$849.68

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.
7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.

10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.
15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

Implementation and Monitoring: *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or*

next milestone to establish a plan/goal going State has responded that they will conduct provider education on maintaining records and submitting documentation.

- *forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	**Status (Implemented/ Not Implemented/Pending)**	**Implementation Date**	**Estimated Completion Date**	**Responsible Party**	**How state plans to monitor the corrective action**
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or **if** errors **are** still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider **reviews;** Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners,	Pending	Upon request of medical records in the PERM	TBD	BPI	Compare the FY2022 PERM audit with the

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Bulletins, Quick Tips		2022 cycle; date TBD			RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts **quarterly** mandatory newly enrolled provider training sessions for our Home and	Implemented	On-going process	On-going process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Community Based Services (HCBS) waiver providers.					
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.

7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook
Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (

1920SBAPStatewideTraining.pdf

Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #3: Number of Unit(s) Error (MR6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Number of units billed not supported by number of units documented*	4	$201.40	$31.65
Total	4	$201.40	$31.65

State may provide additional Data Analysis here (optional):

This error resulted in an identified total overpayment of $201.40 and accounted for 31% of the total errors identified during the medical records review and 1.3% of the total sample dollars in error. This error fell under the Service Type of Habilitation/Waiver Programs/School Services. Habilitation/Waiver Programs/School Services accounted for 79% of the total projected dollars in error

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Number of units billed not supported by number of units documented*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F115	$37.94	$0.80
PAM1901F126	$83.39	$1.76
PAM1903F095	$10.12	$0.07
PAM1904F167	$69.96	$29.02

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The documentation submitted by the provider did not support the number of units billed for the procedure code. The Provider billed for an incorrect number of units. The submitted documentation supporting the units of the procedure code billed was less than the billed amount. The provider failed to verify that the number of units billed was supported by the submitted document.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in

violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.

4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.
7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the

ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.

12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.
15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website updated with RY19 audit findings	Pending	Website will be updated with startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?	April 2022	BPI	Compare the identified errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts **quarterly** mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	Ongoing process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance

Corrective Action	Status (Implemented/ Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.
3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf

PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020
Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - (1920SBAPStatewideTraining.pdf Bulletin 35 17 01 School Base Provide

Return to Top

FFS Finding Category #4: Improperly Completed Documentation (MR9)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Required provider signature and/or credentials are not present	1	$1,979.86	$12.40
Total	1	$1,979.86	$12.40

State may provide additional Data Analysis here (optional):
This error resulted in an identified total overpayment of $1,979.86 and accounted for 7.7% of the total errors identified during the medical record review and 12.8% of the total sample dollars in error. The error occurred in the Nursing Facility/Intermediate Care Facilities Service Type. The documentation submitted by the provider lacked a signature by the Practitioner.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Required provider signature and/or credentials are not present

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F074	$1,979.86	$12.40

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The provider failed to provide the signed physician's 60 day visit progress note written by the physician for the sampled date of service as required by the regulations. Contact was made with the provider on multiple occasions and the provider was able to submit the other required documentation, but not the physician note for that Date of Service. The provider explained that they had scheduled meetings with their Corporate Compliance Officer, Medical Record Supervisor and Chief of Staff for Physicians to improve the documentation process.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. BPI will assess the providers' understanding of the MA rules, regulations, billing guides and handbooks, during the course of any on-site review or desktop review. On the Department of Human Services (DHS) website, all of this information is available for review by all Providers.
2. Additionally, information is disseminated in the form of Medical Assistance (MA) Bulletins, Quick Tips, and Remittance Advice Banners to explain DHS requirements and regulations.
3. Review staff will: educate providers on all of the required documentation components and requirements as well as on the consequences of non-compliance with program requirements; offer technical assistance in the form of training, resources and references that will enhance provider compliance; request a corrective action plan (CAP) for each provider that has been found to be in violation of MA regulations; and provide information about Medicaid fraud and abuse. Our efforts to educate providers to achieve compliance with Medicaid policies and regulations is ongoing.
4. PA's DHS Website contains information on the individual offices in DHS. Each individual office has a website that provides information, including training info, FAQs, reference documents such as policy and procedure documents, and contact information. Providers are notified regularly of the need to supply documentation for audit. DHS will continue to provide education on maintaining records and submitting documentation -PA PROMISe Provider Handbook released October 2017: 6.5 Record Keeping and Onsite Access (p. 66) 6.5 Record Keeping and Onsite Access Providers must retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries and that meet the criteria established in regulations. Please refer to 55 Pa. Code §1101.51(e) for more information. http://www.pacode.com/secure/data/055/chapter1101/s1101.51.html.
5. When CMS notifies BPI of the final determination of the PERM errors, the providers with medical record errors receive a letter from the BPI PERM Coordinator, under the Bureau Director's signature, explaining the error and informing them that repayment of the claim will occur. The PERM Coordinator and Claims supervisor work with the Comptroller's Office to process the claims and provide correct information on the CMS-64 Form. A corrective action plan is requested for each identified error.
6. BPI has a MA Provider Self-Audit Protocol. The Provider Self-Audit Protocol, implemented in February 2001, encourages all providers to implement compliance plans and to utilize self-audit

procedures to periodically review their records for possible billing violations and overpayments. These procedures seek to foster a working partnership between DHS and providers and serve the common interest of protecting the financial integrity of the MA program. In addition, as an incentive to MA providers, the Self-Audit Protocol provides that DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith. MA regulations also require providers to return any overpayments to DHS.

7. The DHS PERM Website will be updated with the RY19 PERM Final Findings for providers to review the common violations identified during the audit that contributed to the error rate. A reminder to providers will be posted on the website that our state will participate in the PERM audit again in 2022 and their compliance is necessary for a successful audit outcome.
8. Information about the PERM FY2022 audit will be disseminated through bulletin releases, Quick Tips, Remittance Advice banners, and the DHS PERM website. Providers selected for the PERM 2022 audit will be contacted to invite them to attend a PERM Educational Webinar conducted by CMS (when scheduled).
9. On-going provider education and knowledge assessment are being conducted for providers, through speaking engagements and training sessions held in conjunction with other state agencies responsible for the management and oversight of providers, particularly waiver program providers and School Based ACCESS Program/Early Intervention providers. Medical Assistance Bulletin 35-19-02 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement.
10. BPI conducts quarterly audits of public schools. Three providers are randomly chosen, and quarterly records of selected students are reviewed for compliance with regulations and policies.
11. The Office of Developmental Programs issued ODP Bulletin 00-07-01 Provider Billing Documentation Requirements for Waiver Services that provides details on what the provider must maintain to document the provision of the service. A self-monitoring tool can be completed by the provider prior to an ODP Onsite. This allows the provider an opportunity to remediate and ask questions about billing requirements. A CAP is required for any deficiencies identified during the onsite visit. Bulletin 00-12-05 Individual Support Plans (ISPs) was released on 10/19/12 and outlines the requirements of the ISP Manual. The Manual identifies services and definitions and the standardized process for preparing, completing documentation, implementing, and monitoring the ISPs for providers. Applications for waiver services are available on the website, along with contact information. The website www.myodp.org provides training and resources for providers/consumers.
12. Annual onsite education seminars are conducted across the state with BPI and our Local Education Agencies (LEA) to review regulations and requirements. These seminars are a joint effort by BPI, Office of Social Programs (OSP), Bureau of Policy and Procedure (BPAP), PA Department of Education (PDE), and the state's contracted vendors who process the claims and conduct cost reconciliation. Contact information is provided to the providers.
13. The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. OLTL conducts periodic webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
14. Physical and Behavioral Health MCO Organizations have the opportunity to attend an Annual Provider Compliance Meeting to learn about technology, trends, and BPI oversight. Additionally, BPI has quarterly calls with all of the Physical Health, Behavioral Heath, and

Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud, waste, and abuse schemes. DHS also holds an annual training for fraud, waste, and abuse, in addition to the annual meeting held by the Medicaid Fraud Control Section (MFCS). Retrospective review of MCO encounters to monitor for provider compliance and possible fraud, waste, abuse are conducted by BPI.

15. BPI utilizes the Fraud and Abuse Detection System (FADS) as a data mining tool to discover possible areas of provider fraud and abuse through billing practices. FADS is an analytical tool that pulls data from the PA PROMISe system into an Oracle data warehouse. The Business Objects tool is used to review and build reports on the data in FADS. Referrals are then made to the appropriate sections for review of the providers.
16. SafeGuard Services (SGS) was appointed as the NE UPIC. BPI and SGS hold monthly meetings to discuss project ideas, status of current projects, and what projects/investigations other states have initiated in regard to fraud, waste, and abuse.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Onsite Visits and Desktop Reviews	Implemented	On-going process	On-going process	Bureau of Program Integrity (BPI)	Compare findings of provider to last review to see if corrective actions are being followed or if errors are still occurring; utilize FADS data; referral tips from other agencies, MCOs, and hotline calls to select provider reviews; Medical Assistance Bulletin 35-17-

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					01 School Based ACCESS Program Provider Handbook issued 9/19/2019: 5.2 Records Retention Requirement
MA Bulletins, Quick Tips, Remittance Advice Banners, Provider Manuals, Trainings	Implemented	On-going process	On-going process	BPI	On-sites to provider locations and retrospective desktop reviews https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
DHS Website	Implemented	On-going process	On-going process	BPI	Provide information such as training info, FAQs, reference documents such as policy and procedures and contact information
Final Action Letters and CAPS for providers identified with errors	Implementation has begun	Feb 2020	October 2020	BPI	Review CAPS received from the providers
DHS PERM Website	Pending	Website will be updated with	April 2022	BPI	Compare the identified

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
updated with RY19 audit findings		startup of the 2022 PERM cycle. With change to fiscal year, start April 2021?			errors of the 2019 cycle to the identified errors of the 2022 cycle; request the number of providers who call in to attend the educational webinars
FY2022 PERM Banners, Bulletins, Quick Tips	Pending	Upon request of medical records in the PERM 2022 cycle; date TBD	TBD	BPI	Compare the FY2022 PERM audit with the RY19 PERM audit
MA Provider Self-Audits	Implemented	February 2001	On-going process	BPI	Review submitted self-audits; suggest self-audit to providers where potential errors are discovered during desktop retrospective reviews and/or from FADS data
Annual regional training sessions for local education agencies (LEA)	Implemented	On-going process	On-going process	BPI; ODP; OLTL	Compare quarterly LEA audits for compliance with regulations. https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					%20Pennlink.pdf
The Office of Long-Term Living (OLTL) conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers.	Implemented	On-going process	On-going process	OLTL	Conduct periodic OLTL webinars to address current issues such as policy changes/clarifications, billing information, and quality management review information
Physical and Behavioral Health MCO	Implemented	Last meeting December 12, 2019	On-going process	BPI; MCO	BPI has quarterly compliance calls with all the Physical Health, Behavioral Health, and Community Health Choices (CHC) MCOs to discuss any topics of interest pertaining to fraud, waste, and abuse, including specific fraud,

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					waste, and abuse schemes.
Fraud and Abuse Detection System (FADS)	Implemented	On-going process	On-going process	BPI	Conduct desktop retrospective reviews; conduct staff training on FADS utilization
NE UPIC SGS (Safeguard Services)	Implemented	On-going	On-going process	BPI	Coordinate review activities and provider specific reviews with SGS (our NE UPIC); BPI and SGS hold monthly meetings (review ideas, status of all reviews & what other states are doing)

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. DHS will continue to conduct retrospective reviews to assess compliance with regulations on an on-going basis.
2. DHS stays current on an on-going basis with fraud, waste, and abuse trends by: reviewing the OIG Workplan for targeted areas of review; reading current newsletter resources such as Fierce Health Payer and CMS MLN Connects; searching for current news articles; reviewing the Medicaid Integrity Institute monthly RISS reports for fraud, waste, and abuse occurrences in other states; collaborating with our contracted vendors such as our UPIC Contractor SGS; and collaborating with other Bureaus and Offices within the state, such as Fee For Service Provider Enrollment and Office of Long Term Living.

3. DHS will conduct quarterly audits on Local Education Agencies (LEAs) and compare previous audits for improvement. DHS works with a contracted vendor, PCG, who processes the claims before they are submitted to DHS's PROMISe system for payment. DHS, in collaboration with other state agencies, conducts annual trainings for LEAs and MCOs.
4. BPI conducts on-going retrospective reviews and will monitor for an increase in compliance as compared to previous reviews.
5. The OLTL conducts quarterly mandatory newly enrolled provider training sessions for our Home and Community Based Services (HCBS) waiver providers. Online training modules are maintained on the DHS website and validates the Promise MAID number given for the tracking of the online modules against our master provider training spreadsheet. The master spreadsheet is updated monthly to encompass any new enrollments from the previous months, prior to a provider's face-to-face attendance. The trainings are tracked for compliance, and reports are generated by the contracted vendor for training services. In addition, OLTL's Quality Management Efficiency Teams (QMET) monitor providers who have billed within the most recent two years to ensure compliance with the on-going requirements outlined in the Long-Term Living Home and Community Based Services.
6. Agencies have web pages that providers can access to view regulations, handbooks, training opportunities, resources, contact information and applications to assist with compliance with MA.
7. BPI works with Fee For Service Provider Enrollment to review and evaluate provider applications marked as having past licensing actions, Federal health-care program exclusions and debarments, and criminal convictions.
8. BPI also assists with FFS Provider Screening failed on-sites to conduct further case research.
9. For all four of the identified MR errors, there is not only one single specific action that will be taken to reduce the errors but, rather, a combination of actions as listed above to achieve compliance with the regulations.
10. DHS will educate providers on Medicaid PERM policies regarding record retention and submission of proper documentation.
11. Copy of transmittal, bulletin, remittance advice banner, newsletter, provider education training material, provider letter, or link on the website that refer to the requirements.

Medical Assistance Bulletin 35-17-01 School Based ACCESS Program Provider Handbook issued 2/28/2017: 5.2 Records Retention Requirement
https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OSP/c_259033.pdf
PROMISe Frequently Asked Questions DHS Provider Website:
PA DHS - PROMISe Frequently Asked Questions
https://paaccess.pcgus.com/documents/FY%2018-19%20Trainings%20-%20Pennlink.pdf
https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
School Based ACCESS Program (SBAP) Breakout Session C: Compliance FY2019-2020 Statewide Training as well as SBAP Statewide Training 19-20
https://www.dhs.pa.gov/providers/Documents/School-Based%20ACCESS%20Program/c_266550.pdf
https://www.dhs.pa.gov/providers/Providers/Pages/School-Based-ACCESS/

2018-6-26 SBAP Breakout Session C - 1920SBAPStatewideTraining.pdf Bulletin 35 17 01 School Base Provide

Return to Top

Data Processing (DP)

FFS Finding Category #5: Provider Information/Enrollment Error (DP10)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Attending provider NPI required, but not submitted on institutional claim	3	$14,121.58	$18.19
Missing provider license information	1	$206.88	$5.05
Missing provider risk-based screening information	5	$17,077.78	$41.69
ORP Type 1 NPI required, but not listed on the claim	1	$65.83	$21.38
Provider not screened using risk based criteria prior to claim payment date	41	$47,288.47	$349.94
Total	51	$78,760.55	$436.26

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Attending provider NPI required, but not submitted on institutional claim

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F006	$4,621.37	$6.33	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1902F025	$3,149.27	$4.31	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required
PAM1903F019	$6,350.95	$7.56	Type 2 (organizational) NPI on the claim, but Type 1 (individual) is required

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM190F006, PAM1902F025, PAM19023F019: An Edit was built into the system to validate that an individual was listed not a group.

Qualifier #2: Missing provider license information

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1904F129	$206.88	$5.05	Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1904F129: Unable to locate provisional license during the audit.

Qualifier #3: Missing provider risk-based screening information

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F119	$654.91	$13.83	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1901F160	$1.33	$0.62	Revalidated provider; Limited risk provider; NPPES not present; Billing provider
PAM1902F016	$6,910.34	$9.45	Revalidated provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1904F026	$8,803.13	$11.88	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider
PAM1904F079	$708.07	$5.91	Newly enrolled provider; Limited risk provider; No required database documentation was present; Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1901F119: Revalidation 11/08/17 documented in PEAP contained the required database documentation

PAM1901F160: This provider enrolled prior to the addition of NPPES to the checklist
PAM1902F016: Revalidation 12/11/15 nothing documented.
PAM1904F026: Checklist completed 05/17/2016 Missing System for award Management (SAMS), Medicheck, Provider Enrollment, Chain, and Ownership System (PECOS).
PAM1904F079: All screenings were completed between 8/10-8/29/2017 and are contained in PROMISe.

Qualifier #4: ORP Type 1 NPI required, but not listed on the claim

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1902F168	$65.83	$21.38	No NPI on the claim

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAM1902F168: Early Intervention did not set Ordering, Referring and Prescribing requirements (ORP) edits. When the claim was processed, system logic was not in place to require an NPI on the claim. DHS has since created system edits requiring an NPI on a claim.

Qualifier #5: Provider not screened using risk based criteria prior to claim payment date

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F015	$6,914.96	$9.47	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F092	$960.21	$4.99	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F093	$875.95	$4.55	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F096	$2,102.38	$10.92	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F107	$575.73	$12.16	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F110	$399.51	$8.44	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F120	$546.12	$11.54	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F130	$659.53	$13.93	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F139	$343.37	$7.25	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1901F169	$10.95	$5.08	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1902F007	$3,792.29	$5.18	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F025	$3,149.27	$4.31	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F076	$1,626.07	$10.18	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F082	$920.45	$5.76	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F086	$708.07	$4.43	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1902F092	$1,057.38	$6.62	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F119	$200.82	$4.63	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F127	$264.44	$6.10	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F129	$219.72	$5.07	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F133	$525.25	$12.12	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F135	$381.31	$8.80	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1902F141	$202.77	$4.68	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F156	$166.92	$54.21	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F031	$5,278.88	$6.28	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F078	$1,016.76	$6.78	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F084	$657.49	$4.38	Newly enrolled provider; Moderate risk provider; On-site visit not conducted; Billing provider
PAM1903F088	$1,273.65	$8.49	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)	Sub-qualifier(s)
PAM1903F089	$1,106.38	$7.37	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F092	$795.29	$5.30	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F106	$655.42	$4.37	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F109	$428.80	$9.69	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F116	$209.18	$4.73	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F118	$567.82	$12.84	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F131	$473.59	$10.71	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F134	$323.69	$7.32	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F145	$18.99	$5.76	Newly enrolled provider; Moderate risk provider; SAM/EPLS not checked; On-site visit not conducted; Billing provider
PAM1903F159	$3.74	$1.13	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1903F167	$46.92	$14.22	Revalidated provider; Limited risk provider; NPPES not checked; Billing provider
PAM1904F016	$6,459.52	$8.72	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1904F092	$660.81	$5.52	Revalidated provider; Limited risk provider; No required databases were checked; Billing provider
PAM1904F102	$708.07	$5.91	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Provider enrollment process failed to accurately track and maintain sufficient provider enrollment documentation.
PAM1901F015, PAM1901F092: Checklist completed in 2015 and does not indicate SAMs, Medicheck, PECOS
PAM1901F093, PAM1901F107, PAM1901F110, PAM1901F120, PAM1901F130, PAM1901F139, PAM1901F169, PAM1902F007, PAM1902F076, PAM1902F082, PAM1902F127, PAM1902F133, PAM1902F141, PAM1902F156, PAM1903F078, PAM1903F088, PAM1903F089, PAM1903F092, PAM1903F106, PAM1903F109, PAM1903F116, PAM1903F118, PAM1903F131 PAM1904F092: These

are the same Provider. These claims are linked to application processed in 2012 by OMAP prior to having a separate document for verification of background checks. ODP PEPs not open, billing for OLTL.
PAM1901F096: This provider was initially enrolled by OMAP in 2014 prior to having a separate document for verification of background checks. ODP processed a revalidation of this site in 2019, the background checks were completed, and the documentation was collected at that time.
PAM1902F025, PAM1902F086: Documentation of screening was not uniform across program offices, poral not in place during enrollment.
PAM1902F092: Revalidation in 2016 on paper no checklist scanned with documents.
PAM1902F119: Checklist not scanned with enrollment in 2013. This claim is related to an application processed thru the Portal with some checks being completed automatically and some completed manually. The system will not allow the application to be processed and enrolled without the completion of all the checks. There is no separate document to be added into the PEAP archives. This could be a document that we could look at creating in the future MMIS system for more easily identifiable documentation.
PAM1902F127: This claim is linked to an application processed in 2012 by OMAP prior to having a separate document for verification of background checks.
PAM1902F129: Does not show a separate document of results in the PEAP archives as the checks are done manually and electronically and indicated automatically in the summary of the application in the Portal as part of the mechanism of processing. They are completed, but without a separate document to verify.
PAM 1902F135, PAM1903F031, PAM1903F084, PAM1903F134, PAM1903F145, PAM1903F159, PAM1903F167, PAM1904F016, PAM1904F102: The provider enrollment documentation process failed as each program office documented different information.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

Qualifier1: Need to make this edit verify type 1 NPI is used not type 2- would require a system change. Edit needs to verify type 1 NPI enrolled and used not Type 2.
Qualifier2: Knowledge reinforcement issue regarding scanning/imaging policy.
Qualifier 3: Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices, and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of paper applications and the applications thru the portal require the background checks as a condition of processing the application. A future document could be created as part of the new MMIS system. The enrollment process was consolidated to make certain all checks are documented every time; the checklist was updated in 2016 after the PERM audit.
Qualifier 4: Since processing of the identified claim on 12/8/17, system edits (ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual) were created to enforce NPI requirements. The edits were implemented on 4/30/18.
Qualifier 5: Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices, and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of

paper applications and the applications thru the portal require the background checks as a condition of processing the application. The checklist was updated in 2016 after the PERM audit. The enrollment process was consolidated on 8/1/2019 to make certain all checks are documented every time. When the provider revalidates in 2020, an updated checklist will be completed by provider enrollment.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/ Not Implemented/ Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
ORP Type 1 NPI required, but not listed on the claim	Implemented	4/30/2018	N/A	MMIS Vendor/DHS	On-going review of edits
Standard Checklists for processing paper applications thru the Portal require the background checks as a condition of processing the application.	Implemented	January 2019	Ongoing	MMIS Vendor/DHS	On-going review of edits

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

DHS reviews edits on an ongoing basis to ensure alignment with NPI requirements.

Return to Top

FFS Finding Category #6: Data Processing Technical Deficiency (DTD)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Provider not screened prior to enrollment determination date but screened prior to claim payment date	14
Total	14

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the deficiency(ies) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the deficiency(ies).*

Qualifier #1: Provider not screened prior to enrollment determination date but screened prior to claim payment date

PERM ID	Sub-qualifier(s)
PAM1901F048	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F058	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F066	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F071	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1901F137	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1902F058	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1902F102	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1902F148	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F009	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider

PERM ID	Sub-qualifier(s)
PAM1903F038	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F048	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F051	Newly enrolled provider; Limited risk provider; LEIE not checked; SAM/EPLS not checked; Billing provider
PAM1903F064	Newly enrolled provider; Limited risk provider; No required databases were checked; Billing provider
PAM1903F093	Newly enrolled provider; Limited risk provider; DMF not checked; SAM/EPLS not checked; ORP

- **Enter the root causes of deficiency(ies) identified above. *Simply re-stating the qualifier does not explain what caused the deficiency.***

The applications were processed prior to the ACA requirements being implemented, which led to the implementation of a checklist being a required document of the application package. Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within DHS varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices and the provider applications in question were not among the offices who completed the checklist.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

We now have a standard checklist for processing of paper applications and the applications thru the Portal require the background checks as a condition of processing the application. The checklist was updated in 2016 after the PERM audit. The enrollment process was consolidated to make certain all checks are documented every time. When the provider revalidates in 2020, an updated checklist will be completed by provider enrollment.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Standard Checklists for processing paper applications thru the Portal require the background checks as a condition of processing the application.	Implemented	January 2019	On-going	MMIS Vendor/DHS	On-going review of edits

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, and number of deficiencies. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an on-going monthly random sample review of enrollment packages done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Medicaid FFS Target Rate

Next Cycle Medicaid FFS Target: 5.12%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.

PA will continue to utilize a comprehensive approach to monitor claims for correct payment compliance supported by the medical record documentation. MCO reviews for 2019 have been initiated by BPI. The Medical Record Review error rate increased by 0.25% in the RY19 Cycle, while the number of claims reviewed increased by more than 200%. The Data Processing errors increased as a result of the lack of background checks as well as lack of NPI in the current PERM RY19 Cycle. The implementation of an Online Application Portal, already in effect, and the planned payment edit to deny a claim if the ordering, referring, or prescribing fields are blank is anticipated to decrease the number of Data Processing errors. Also, the MMIS system edits ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual that were created to enforce NPI requirements were implemented on 4/30/2018. Reviewing a small sampling has shown that approximately 40 claims have been denied since these edits were activated. Re-education of providers as to the requirements of the MA Bulletin 99-11-05 will be undertaken. https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx

Medicaid FFS Evaluation of FY 2015 Previous Cycle Corrective Actions

	RY 2019 (Federal)[3]	FY 2015 (Total Computable)
Number of Errors	78	24
Number of Claims in Error	75	24
Number of Claims Sampled	761	332
Dollars in Error	$90,548	$48,938
Projected Dollars in Error	$519,992,086	$694,150,441
Improper Payment Rate	8.74%	7.55%
Target Rate	4.52%	1.67%

Please refer to the state Cycle Summary Report for additional information on cycle comparisons.
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one DP or MR error on the claim. However, for RY 2019, the number of errors row counts all errors found on a claim. For FY 2015, multiple DP or MR errors are not counted, but one DP and one MR error is included per claim, if applicable. Additionally, states are cautioned from making direct comparisons between the cycles, since review requirements and program structure may have changed.

Evaluation of Implemented Corrective Actions

The implementation of the Corrective Actions for the medical record reviews was successful with a decrease in the number of errors identified. This RY19 Cycle identified areas of vulnerability relating to the implementation of the ACA: required enrollment screening of providers based on risk criteria; NPI requirement of all ordering/referring/prescribing providers; and verification that provider licenses are current. DHS has since created system edits requiring an NPI on a claim. System edits ESC 1248 - referring provider required and ESC 1249 - referring provider must be an individual were created to enforce NPI requirements. These edits were implemented on 4/30/18.

[3] Dollars in error, projected dollars in error, improper payment rate, and target rate are all based on federal dollars in error for RY 2019 and total computable dollars for FY 2015.

Discussion of Corrective Actions Not Implemented
NA

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
NA

Component: Managed Care (MC)

There were no MC errors sampled in Pennsylvania.

Component: Eligibility

RY 2019 Medicaid Eligibility Federal Improper Payment Rate: 11.36%

As noted in your Cycle Summary report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Eligibility Review (ER)

Eligibility Finding Category #1: Documentation to Support Eligibility Determination Not Maintained (ER1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Blindness/disability determination documentation not on file/incomplete	6	$2,497.53	$142.55
Income verification not on file/incomplete	1	$39.90	$14.16
Level of care determination not on file/incomplete	10	$38,068.19	$307.12
Other required forms not on file/incomplete	1	$6,914.96	$22.42
Record of signature not on file - caseworker	4	$3,162.09	$80.70
Resource verification not on file/incomplete	10	$14,238.47	$158.91
Total	32	$64,921.14	$725.85

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Blindness/disability determination documentation not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M067	$190.49	$36.23

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M003	$732.09	$15.86
PAM1902M018	$721.74	$15.64
PAM1902M059	$176.30	$26.85
PAM1903M045	$427.79	$33.98
PAM1904M043	$249.12	$13.98

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise staff on policy of imaging paperwork to the case record. Failure to train/supervise to correctly apply the ex-parte policy and failed to train/supervise on correct follow up on the reported disability. Failure to supervise correct review and understanding of federal Bendex exchanges. Failure to distribute work effectively to ensure staff can correctly follow up on disability.

Qualifier #2: Income verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M081	$39.90	$14.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The worker did not follow policy that was clearly defined. Training/Supervisory issue.

Qualifier #3: Level of care determination not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F109	$444.73	$21.55
PAM1901F156	$84.82	$110.23
PAM1902F015	$11,094.62	$37.89
PAM1902F028	$6,029.79	$20.59
PAM1902F058	$2,474.87	$17.36
PAM1903F042	$2,772.09	$18.13
PAM1904F026	$8,803.13	$33.84

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904F031	$3,458.01	$13.29
PAM1904F040	$2,664.49	$19.14
PAM1904F127	$241.64	$15.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Confusion over purging/storage during conversion of paper records to electronic files. Procedure regarding who should process waiver renewals not clear. Training/supervisory issue regarding what forms are required at renewal and what should be updated in system. Training/Supervisory issue regarding scanning/imaging policy.

Qualifier #4: Other required forms not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F015	$6,914.96	$22.42

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Confusion over purging/storage during conversion of paper records to electronic files.

Qualifier #5: Record of signature not on file - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F099	$1,699.36	$26.69
PAM1903F093	$725.44	$11.46
PAM1903F119	$495.65	$27.45
PAM1904F127	$241.64	$15.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy

Qualifier #6: Resource verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F005	$4,908.37	$16.76
PAM1902F033	$3,391.14	$11.58
PAM1902F086	$708.07	$11.12
PAM1902F089	$1,562.20	$24.53
PAM1902F116	$252.88	$13.89
PAM1902M074	$138.62	$21.11
PAM1903F103	$819.34	$12.94
PAM1904F070	$1,988.16	$14.28
PAM1904F160	$3.81	$6.54
PAM1904M049	$465.88	$26.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Training/Supervisory issue regarding verification requirements of resources. Training/supervisory issue regarding that resource verification cannot be used from a previous SNAP renewal.
PAM1902F005: Initially enrolled in 2012 by OMAP prior to use of separate verification document being included with the application package. Revalidation of the same site completed 12/23/15 and verification of background checks included in that application package.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: Office policy reviewed to ensure that all verification, including MRT certifications are to be scanned to record upon receipt. Images are to be reviewed prior to shredding of hard copy.
Qualifier #2: Internal memo sent to all staff advising of the error which included the Verification Desk Guide. Discussed error at Supervisor's meeting and reviewed verification of income requirements for SNAP and MA. Supervisors were instructed to review with their areas.
Qualifier #3: Review policy 815.1 and 476.2, scanning and imaging procedures and findings and cause of error with staff and next staff meeting. Sent e-mail to Maximius independent broker for PA 1768, waiting for a response.
Qualifier #4: Assuring that all renewals are being stamp dated upon receipt. Checking all cases before renewals are sent to verify that all required documents are scanned to the case, if documents are missing, they will be requested with the renewal packet.
Qualifier #5: Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form

where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
Qualifier #6: Managers have added to the agenda of the next scheduled unit meetings to review resource verification Medicaid policy requirements.
Prior to January 25, 2016, all provider enrollment applications were processed via paper. The operations protocol followed by the various program offices within the Department varied slightly. While all offices did manually validate enrollments against the standard federal files, some offices utilized a paper checklist to track all database validations. Unfortunately, this practice did not span across all offices and the provider applications in question were not among the offices who completed the checklist. We now have a standard checklist for processing of paper applications and the applications thru the Portal require the background checks as a condition of processing the application. A future document could be created as part of the new MMIS system.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Random Sample of Quality Control Reviews
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Random Sample of Quality Control Reviews

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #2: Verification/Documentation Not Done/Collected at the Time of Determination (ER2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income not verified - caseworker	1	$197.17	$30.37
Income not verified - system	1	$43.06	$14.00
Other element not verified - caseworker	2	$1,263.97	$45.27
Other eligibility process(es) not followed - caseworker	2	$853.14	$37.22
Resources not verified - caseworker	6	$5,950.51	$207.47
Signature not recorded at initial application - caseworker	3	$4,543.79	$50.75
State did not do required disability/blindness determination - caseworker	1	$72.85	$35.33
When appropriate, signature not recorded at renewal - caseworker	12	$7,611.62	$453.29
Total	28	$20,536.11	$873.71

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M070	$197.17	$30.37

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR

Qualifier #2: Income not verified - system

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904M082	$43.06	$14.00

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR

Qualifier #3: Other element not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M021	$541.38	$29.62
PAM1902M004	$722.59	$15.66

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision of DAP referral requirements. Lack of training and supervision regarding requesting medical documents for a child and processing renewal without said documents.

Qualifier #4: Other eligibility process(es) not followed - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M092	$51.04	$21.29
PAM1904F090	$802.10	$15.93

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

System error caused by system not correctly enrolling TMA budgets into SAR.

Qualifier #5: Resources not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F044	$2,555.20	$16.13
PAM1901F112	$317.14	$15.36
PAM1901F156	$84.82	$110.23

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F058	$2,474.87	$17.36
PAM1903M079	$53.42	$22.29
PAM1904M047	$465.06	$26.10

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding resource policy and requirements. Lack of training and supervision regarding "ex parte" rules. Lack of policy/guidelines explaining required scanning and imaging procedure for LTC/waiver cases

Qualifier #6: Signature not recorded at initial application - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903F008	$4,287.85	$14.92
PAM1903M073	$157.15	$24.20
PAM1904M075	$98.79	$11.62

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy

Qualifier #7: State did not do required disability/blindness determination - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901M086	$72.85	$35.33

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision on procedure to follow when "J" SSI budget closes

Qualifier #8: When appropriate, signature not recorded at renewal - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F069	$2,454.30	$15.49
PAM1901F109	$444.73	$21.55
PAM1901F156	$84.82	$110.23
PAM1901F178	$3.23	$4.68
PAM1902F053	$2,841.67	$19.94
PAM1902M077	$75.30	$26.72
PAM1902M081	$39.90	$14.16
PAM1902M082	$35.23	$12.50
PAM1903M039	$762.74	$60.59
PAM1903M051	$780.65	$62.01
PAM1904F157	$54.94	$94.35
PAM1904M084	$34.11	$11.09

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of policy/guidelines explaining required scanning and imaging procedure for LTC/waiver cases. Lack of training/supervision regarding policy requirements on verification requirements. Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days from the initial 6-month review.
Qualifier #2: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days from the initial 6-month review.
Qualifier #3: A DAP Tip Sheet was developed as a quick reference for workers when reviewing for disability Medicaid categories and DAP referrals. This sheet was distributed via email. The DAP TIP sheet along with program eligibility for disability related Medicaid categories and DAP referral process is on the agenda to be reviewed at the next scheduled staff meetings. Office wide training was completed by all workers and supervisors on DAP procedures including presumptive eligibility requirements.
Qualifier #4: System fix put in to enroll TMA budgets into SAR. Also, an alert is generated to the caseworker in month and is due 60 days for the initial 6-month review.
Qualifier #5: Multiple reviews done in the Rushmore database on a local level to ensure policy is being applied correctly. Conduct office wide training regarding resources on LTC cases.

Qualifier #6: Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
Qualifier #7: Supervisors will review training/materials with each worker at their next unit meeting. Training with supervisors on Extended NMP categories.
Qualifier #8: Sent e-mail to Maximus independent broker for PA 1768, waiting for a response. review policy, scanning and imaging procedures and findings and cause of error with staff and next staff meeting. Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly sample of Quality Control Reviews
Statewide mentoring Calls	Implemented	Jan 2019	On-going	Division of Corrective Action	Monthly sample of Quality Control Reviews

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #3: Determination Not Conducted as Required (ER3)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Initial determination not conducted	13	$1,041.97	$252.50
Redetermination was not conducted within 12 months before date of payment for services - caseworker	5	$7,265.29	$107.37
Total	18	$8,307.26	$359.87

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Initial determination not conducted

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F170	$3.01	$3.91
PAM1901M075	$99.96	$19.01
PAM1901M081	$44.91	$21.78
PAM1901M085	$91.77	$44.51
PAM1901M088	$44.91	$21.78
PAM1901M093	$43.46	$21.08
PAM1902M063	$91.32	$13.91
PAM1903M062	$98.79	$15.22
PAM1903M063	$91.18	$14.04
PAM1903M076	$90.07	$13.87

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M089	$86.84	$36.23
PAM1904M046	$208.15	$11.68
PAM1904M086	$47.60	$15.48

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

While the calculation is not shown for the MA eligibility when TANF is opened, households eligible for TANF are eligible for MA.

Qualifier #2: Redetermination was not conducted within 12 months before date of payment for services - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F030	$3,782.77	$12.26
PAM1901F127	$228.47	$11.07
PAM1903F060	$2,330.93	$15.25
PAM1903F080	$849.68	$13.42
PAM1903F155	$73.44	$55.36

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of supervision/training on policy of when to close a case if client does not provide verification timely and to not update renewal dates when doing maintenance on a case.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: System changes are being made so that the MA calculation and category will show separately from the TANF eligibility.

Qualifier #2: The error, case details, root cause, and ways to possibly prevent errors like this will be discussed during the June 2019 Corrective Action Committee Meeting. Individual staff conferences and trainings. Renewal supervisors have been instructed that all renewals need to be completed in the month they are due, no longer holding renewal up to day -45 for closure. LTIS is receiving additional workers and monitoring renewals for timeliness.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic*

approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Corrective Action Committee Meetings	Implemented at County Level	June 2019	On-going	County Offices	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Individual Staff Conferences and Trainings	Implemented at County Level	Continuous	On-going	County Offices	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Statewide Mentoring Calls	Implemented	January 2019	On-going	January 2019	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #4: Not Eligible for Enrolled Program - Financial Issue (ER4)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Resources incorrectly calculated - caseworker*	2	$3,746.45	$40.23
Resources incorrectly included/excluded - caseworker*	1	$2,068.81	$32.68
Total	3	$5,815.26	$72.91

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Resources incorrectly calculated - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902F089	$1,562.20	$24.53
PAM1904F057	$2,184.25	$15.69

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding verification requirements of exempt resources. Lack of training/supervision regarding if eligibility could be granted, and then overpayment filed if resources exceed the limit.

Qualifier #2: Resources incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903F085	$2,068.81	$32.68

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Many staff out of the office resulting in higher workload and fewer hours to process work items timely and accurately resulting in data entry errors.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: The CAO attempted to obtain verification of irrevocable burial reserve by issuing a PA253 (Request for Verification) notice in order to have documentation in the case record. The next CAO staff meeting will include reviewing verification of resources and case comments requirements. IMCW supervisors discussed error with IMCWs who processed the application to review one-on-one the policy and procedures for resource verification including when resources should be excluded and narrating how resources were calculated. Discussion of errors was also included as part of the Area Corrective Action unit meeting agenda. The Unit discussion reminded staff that policy states authorization of benefits is not allowed if eligibility verification is still needed; client needs to be eligible before the renewal is processed. Staff, worker and unit discussions included reviewing LTC HB 440.721 when a recipient can pre-pay for expenses when over the resource limit. LTC HB 440.73 for completing overpayments when client does not report resources by sending a request to the Office of State Inspector General to recoup the amount the client was over the resource limit. The workers did not follow federal guidelines for determining eligibility of benefits.
Qualifier #2: County Caseworker Supervisor will complete 2-4 targeted Rushmore Reviews per month. The sample cases will be LTC/Waiver. The review will solely target "Resources." Supervisor will review policy and procedure with all IMCW staff. Policy/References: (1) Using CIS - Chapter 5, CAPERS:

Availability (AV) - Y or N. (2) eCIStance, "How do I add a resource in Maintenance?" Specific attention on "Shared Resources" and "Available." (3) Chapter 440.3, Personal Property.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #5: Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Countable income incorrectly excluded - system*	1	$39.90	$16.65
Income incorrectly calculated; other - caseworker*	1	$35.56	$14.84
Total	2	$75.46	$31.48

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M094	$39.90	$16.65

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of supervision/training on procedure to review income being counted before authorizing medical benefits

Qualifier #2: Income incorrectly calculated; other - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M088	$35.56	$14.84

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

IMCW failed to update income at SAR.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: 1) Meet with the supervisor of this worker to go over this finding and talk about the root cause, which is, to make sure each case is reviewed in full (income, resources, etc.) before submitting the case. I will explain the importance of checking for input errors so that the correct determination and program category is authorized. 2) I will instruct the supervisor to meet with the individual privately to go over this information also. The supervisor will then have a unit meeting reminding staff the importance of checking to make sure the information is correct before submitted a case. 3) I will follow up with the supervisor to make sure the worker is still consistently checking work before submitting.
Qualifier #2: MA 312.1 HB updated to provide clarification on properly processing a MG19. The system is correctly working to follow policy.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
and Trainings					Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Meeting with policy and DAPS regarding handbook and system changes	Implemented	June 2019	Ongoing	Policy, DAPS	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #6: Not Eligible for Enrolled Eligibility Category - Incorrect FMAP Assignment (ER7)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Household composition/tax filer unit or tax filer status incorrect - caseworker*	1	$159.74	$18.79
Other non-financial error - caseworker*	1	$463.43	$19.77
Total	2	$623.17	$38.56

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Household composition/tax filer unit or tax filer status incorrect - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1904M069	$159.74	$18.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Caseworker failure to follow policy and procedures for establishing proper household composition and tax filing status.

Qualifier #2: Other non-financial error - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1903M033	$463.43	$19.77

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Caseworker failure to follow policy and procedures regarding the transition of a disabled child to a disabled adult.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: A corrective conference was held with worker. It will be discussed at the next staff meeting and E-Blast has been developed and emailed to all staff to remind them of about household composition rules/ wages matches how to use them for MA.
Qualifier #2: Error and its cause will be reviewed at a supervisor's meeting. Policy at 319.32 will be reviewed. The supervisor will be reminded of the in-house CAP for these budgets. The CAP will be reviewed. The supervisors will take this information and review at their next unit meeting. A conference was held with the worker who caused the error. Policy at 319.32 was reviewed with the worker to ensure disability determinations for PH categories was understood. The exchange was also reviewed as the worker mis-read the information. The worker was reminded to update all resource and income information in the system that is provided as it may affect future eligibility. The worker was also reminded to review all case information at each renewal even though she may be familiar with the case. The in-house procedure for the authorization and renewal of PH and PW budgets was reviewed as well.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
and Trainings					reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such can continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #7: Not Eligible for Enrolled Eligibility Category - Ineligible for Service (ER8)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Countable income incorrectly excluded - caseworker*	1	$365.60	$28.79
Total	1	$365.60	$28.79

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1902M044	$365.60	$28.79

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding caseworkers following of policy.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Six Rushmore reviews conducted by local supervisors. Local manager will conduct Management Rushmore Re-Reviews in April and/or May on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual report a change in situation including income variances and job starts. Staff meetings conducted.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #8: Other Errors (ER10)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker*	2	$165.86	$1.37
Other error	2	$282.68	$1.78
Total	4	$448.54	$3.16

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Contribution to care calculated incorrectly resulting in a partial payment difference - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F089	$50.19	$0.62
PAM1903F067	$115.67	$0.76

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding scanning and imaging and narration.

Qualifier #2: Other error

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAM1901F049	$259.56	$1.64
PAM1901F059	$23.12	$0.15

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding LTC policy and procedure for processing renewals

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Qualifier #1: The PERM finding was discussed in detail during this morning's CAC Meeting. Both the root cause and ways to prevent future errors of this type were discussed. A worker conference was held with the IMCW that processed the last renewal. The finding and root cause were discussed in detail.
Qualifier #2: Supervisors meeting to be held to review QC findings and policies cited.
Unit meeting to be held to review 468.34 and the need to review client responsibility to report changes. 5 targeted Rushmore reviews to be completed by worker and immediate Supervisor. Staff meeting to be held to review findings, 468.34, the need to review client responsibility to report changes, determine income, resources and needs for Client Spouse at renewal and narrating. The error, root cause, and ways to prevent future errors of this type will be discussed in detail during the June 2019 CAC meeting on 6/20/2019 at 9:30 am. A worker conference was held by the IMCW Supervisor with the IMCW that took the case action. LTC HB chapter 476 & 468.34 were reviewed.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such can continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level

Return to Top

Eligibility Finding Category #9: Incorrect Case Determination, But There was No Payment on Claim (ERTD1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility	2
Not eligible for enrolled program; financial issue	1
Total	3

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Documentation to support eligibility determination not maintained; unable to determine beneficiary eligibility

PERM ID
PAM1901F151
PAM1901F162

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding required verification

Qualifier #2: Not eligible for enrolled program; financial issue

PERM ID
PAM1903F171

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/Supervision regarding income limits

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

Local offices to conduct trainings to ensure staff is current on policy/procedure. Rushmore reviews to be conducted to verify staff is aware of policy.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For*

the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff Conferences and Trainings	Implemented	Continuous	On-going	County Management	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented	June 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Eligibility Finding Category #10: Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Countable income incorrectly excluded; eligible for enrolled category - caseworker	9
Countable income incorrectly excluded; eligible for enrolled category - system	5
Exempt income incorrectly included; eligible for enrolled category - system	1
Exempt income incorrectly included; not eligible for enrolled category - caseworker	1
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	15
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	12
Income deduction incorrectly included/excluded; eligible for enrolled category - system	1
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	1
Income incorrectly calculated; other; eligible for enrolled category - caseworker	36
Income incorrectly calculated; other; eligible for enrolled category - system	1
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	4
Other financial deficiency - caseworker	1
Other non-financial deficiency - caseworker	7
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker	5

Qualifiers	Number of Deficiencies
Resources incorrectly calculated; eligible for enrolled category - caseworker	43
Resources incorrectly included/excluded; eligible for enrolled category - caseworker	8
Total	151

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901M007
PAM1901M014
PAM1901M060
PAM1902M054
PAM1902M088
PAM1903M040
PAM1903M065
PAM1904F187
PAM1904M069

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding taking proper action (sending a 253), doing a narrative upon clearing an Exchange 1 New Hire Hit and reviewing Exchanges (specifically Exchange 1) prior to processing an ex-parte renewal. Lack of training and supervision regarding comprehensive review of the renewal form and all supporting documents prior to case processing.

Qualifier #2: Countable income incorrectly excluded; eligible for enrolled category - system

PERM ID
PAM1901M073
PAM1903M040
PAM1903M044
PAM1903M054
PAM1903M056

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding reviewing case comments prior to running the SAR, and data entering income correctly.

Qualifier #3: Exempt income incorrectly included; eligible for enrolled category - system

PERM ID
PAM1902M044

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding following correct policy and procedures

Qualifier #4: Exempt income incorrectly included; not eligible for enrolled category - caseworker

PERM ID
PAM1901M084

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding income being counted that should have been excluded.

Qualifier #5: Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker

PERM ID
PAM1901M051
PAM1901M076
PAM1902M049
PAM1902M087
PAM1903F021
PAM1903M046
PAM1903M058
PAM1903M060
PAM1904M014
PAM1904M042
PAM1904M056
PAM1904M058
PAM1904M088
PAM1904M091
PAM1904M095

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding reviewing the application in detail to notice any discrepancies between what was noted on the application and what verification was provided, verification that the tax relationships were entered correctly, and image notifications not being addressed timely.

Qualifier #6: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system

PERM ID
PAM1903M042

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding scanning and imaging policy.

Qualifier #7: Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901M054
PAM1902M051
PAM1902M064
PAM1902M070
PAM1902M093
PAM1903M032
PAM1903M054
PAM1903M058
PAM1904M042
PAM1904M045
PAM1904M077
PAM1904M078

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise regarding applying the deductions allowed for self-employment, understanding and evaluation of the 1040 and Schedule C Forms, understanding of terminology of various items on these tax documents, and entering pre-tax deductions.

Qualifier #8: Income deduction incorrectly included/excluded; eligible for enrolled category - system

PERM ID
PAM1902M046

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise policy regarding self-employment tax deductions.

Qualifier #9: Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker

PERM ID
PAM1903M090

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise policy regarding counting income derived from Self-Employment and calculating gross sales and allowable income deductions for MAGI MA.

Qualifier #10: Income incorrectly calculated; other; eligible for enrolled category - caseworker

PERM ID
PAM1901F022
PAM1901F025
PAM1901F054
PAM1901F079
PAM1901F104
PAM1901F156
PAM1901M031
PAM1901M041
PAM1901M046
PAM1901M055
PAM1901M058
PAM1901M064
PAM1901M070
PAM1901M080
PAM1901M082
PAM1902F101
PAM1902F192
PAM1902M051

PERM ID
PAM1902M060
PAM1902M068
PAM1902M077
PAM1903F075
PAM1903F093
PAM1903M035
PAM1903M053
PAM1903M058
PAM1903M069
PAM1903M081
PAM1904F031
PAM1904F033
PAM1904F085
PAM1904F090
PAM1904M040
PAM1904M045
PAM1904M061
PAM1904M092

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Failure to train/supervise scanning and imaging procedure, proper ex-parte procedure and verifications required, and proper resource verification at renewal.

Qualifier #11: Income incorrectly calculated; other; eligible for enrolled category - system

PERM ID
PAM1901F107

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding what income is exempt and why at application, and at renewal.

Qualifier #12: Income incorrectly calculated; other; not eligible for enrolled category - caseworker

PERM ID
PAM1902M025
PAM1902M049
PAM1903M075
PAM1903M090

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training and supervision regarding timely action on imaging alerts, and actually taking action when alert is cleared. Lack of training and supervision on taking proper action when verification is required.

Qualifier #13: Other financial deficiency - caseworker

PERM ID
PAM1903M002

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding timely updating of income information to cases when received by worker.

Qualifier #14: Other non-financial deficiency - caseworker

PERM ID
PAM1901M047
PAM1901M065
PAM1902M001
PAM1902M023
PAM1903F075
PAM1903M090
PAM1904M039

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Policy issue as verbiage in MAHB 339.2 is distinct from verbiage in pre-ACA handbooks. Pre-ACA handbooks specifically noted that the month of closing for NMP-F does not count as one of the three months out of six. This language is absent from the current handbook. Lack of training and supervision regarding correctly counting income derived from Self-Employment. Errors occurred in calculating gross sales and allowable income deductions for MAGI MA.

Qualifier #15: Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - caseworker

PERM ID
PAM1901F072
PAM1901M067
PAM1902F086
PAM1903F103
PAM1904F065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

No plan in place on how to effectively handle renewals timely when received on the last day of the month. Failure to have an effective scanning and imaging procedure in place. Some offices were under the impression they had 45 days to complete a renewal.

Qualifier #16: Resources incorrectly calculated; eligible for enrolled category - caseworker

PERM ID
PAM1901F005
PAM1901F025
PAM1901F056
PAM1901F074
PAM1901F089
PAM1901F097
PAM1901F099
PAM1901F124
PAM1901F156

PERM ID
PAM1901F162
PAM1901M023
PAM1902F015
PAM1902F055
PAM1902F068
PAM1902F096
PAM1902F111
PAM1902F111
PAM1902F166
PAM1902F174
PAM1903F010
PAM1903F067
PAM1903F075
PAM1903F090
PAM1903F124
PAM1903F144
PAM1903F173
PAM1904F008
PAM1904F033
PAM1904F062
PAM1904F070
PAM1904F085
PAM1904F111
PAM1904F111
PAM1904F116
PAM1904F121
PAM1904F129
PAM1904F171

PERM ID
PAM1904F192
PAM1904M003
PAM1904M004
PAM1904M012
PAM1904M013
PAM1904M015

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Local office did not have an effective plan in place to handle the volume of documents received and get them scanned to the cases timely for worker to review. Lack of training and supervision on timely scanning of documents to a case.

Qualifier #17: Resources incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAM1901F061
PAM1901F064
PAM1902F023
PAM1902F111
PAM1902F187
PAM1903F057
PAM1904F033
PAM1904F065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

Lack of training/supervision regarding policy pertaining to shared resources. Lack of training and supervision regarding accurate data entry of bank accounts and real estate.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

Qualifier #1: Ongoing IMCW Supervisors will do 5 targeted Rushmore Reviews for the months of March, April, and May to review that Exchange 1 New Hire hits are processed correctly. Review policy 312.71 Verification and 310.1 General with MA staff. QC error specifics to be reviewed and discussed at Supervisors meeting.
Qualifier #2: Review of similar cases found this error appears to be worker specific. As worker has retired, no further action is required.
Qualifier #3: Manager will conduct Management Rushmore Re-Reviews on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual report a change in situation including income variances and job starts. CAO SNAP/MA Supervisors will conduct 1 Rushmore Review each on MA cases to verify that a case review and appropriate case actions were taken as soon as possible but no later than 10 calendar days when an individual reports a change in situation including income variances and job starts for a total of 6 reviews. Supervisors will discuss these findings and the information reviewed at their Unit Meetings.
Qualifier #4: Internal memo sent to all staff advising of the error which included the Verification Desk Guide. Discussed error at Supervisor's meeting and reviewed verification of income requirements for SNAP and MA. Supervisors were instructed to review with their areas.
Qualifier #5: Review with staff MA policy a.312.16: Adults Ages 19-64b.312.22: MAGI Filer/Non-Filer Rules for Household Composition. Discuss with staff how to correctly determine what the MAGI household composition should be using the tax filing status that is reported on application & renewal forms. CAO will follow DCA recommendations and review the finding with all MA staff and the MA Policy @ MAEH 312.22 MAGI Filer/Non-Filer Rules for HH composition. The review will take place during one of our upcoming March 2020 Manager/Supervisors meetings. Supervisors will then conduct group meetings with MA caseworkers to review the same.
Qualifier #6: The PERM finding was discussed in detail during CAC Meeting. Both the root cause and ways to prevent future errors of this type were discussed. A worker conference was held with the IMCW that processed the last renewal. The finding and root cause were discussed in detail.
Qualifier #7: Staff meeting held 12/17/18 to review the need to enter the self-employment deductions on the SE Screen whether they are needed for household to be eligible or not. Supervisory conference held 12/12/18.
Qualifier #8: Advise staff of the system issue regarding expenses not calculating properly for self-employment. Ensure staff know that they need to manually compute the net income in order to determine eligibility for self-employment calculations that are not computed correctly by the system. This issue was the self-employment tax deduction did not compute properly. If the system is incorrectly calculating the self-employment income, a manual notice may be necessary to inform the client of eligibility or ineligibility.
Qualifier #9: Staff meeting held to review the need to enter the self-employment income and deductions on the SE Screen needed for household to be eligible or not. Supervisory conference also held.
Qualifier #10: Requested and received information from the Facility Reimbursement Officer in Harrisburg who gave us information for May 2017 which was not used for the 06/2017 Renewal. The Facility Reimbursement Officer used 04/2017 information for this renewal. I would like to point out that the CAO does not receive income/resource verifications for individuals in ICF facilities. All information is sent from the Guardian's Office at the Center (or client representative) to the Facility Reimbursement Office in Harrisburg. The Facility Reimbursement Officer completes the Compass Renewal/Application for these individuals and submits the Compass Renewal/Application to the CAO for processing. Since the Facility Officer has verified the resources/income the IMCW inputs what is on the Compass Renewal/Application. The CAO only contacts the facility, the individual's representative, or family members if the information presented is unclear or inconsistent or not verified. The error and its cause

will be reviewed at the next supervisor's meeting. Renewal policy at LTC 440 &476 and MA 340 & 376 will be reviewed. The ex-parte policy and desk guide will be reviewed. It will be stressed that an ex-parte review is not a re-hash of the last renewal completed. The workers must review the case, exchanges, imaging, and narratives. Of discussion will be the policy that MA budgets with resources cannot be renewed by ex-parte when current resource verification is not in the record because the resources must be verified at each renewal. The office renewal procedure will be reviewed. The requirement to review IEVS at each renewal will also be discussed. All updates to income must be made. The supervisors will discuss this material at their next unit meeting.

Qualifier #11: The error and its cause was reviewed in a supervisor's meeting. Policy including LTC 450.2, 450.24, 476.2, 476.21, and MAH 350.3, 305.27, and 376.24. Requirements to thoroughly review case and outcomes at both renewal and application were reviewed. Workers are to ensure their data-entry is correct and the correct outcome is received. This will require a review of the eligibility outcomes after eligibility is ran in the system. A review of DAC and proper data-entry to build the category was also discussed. The supervisors will review this information in their next unit meeting.

Qualifier #12: The case/error was reviewed with the worker for understanding, reviewing MHB 312.2 (MAGI household) and 312.5 (income); a unit and staff meeting was also held. Review policy 312.5 Income. Review policy 312.72 Reasonable Compatibility. Review proper procedures to follow up on income requests when a client reports new or changed income.

Qualifier #13: Individual and staff meetings and trainings held.

Qualifier #14: Deficiency will be discussed at Area Manager meeting. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed with the Executive Director that the "error" should be challenged. The worker data entered information as presented on the PA600R with respect to the recipient's marital status. Per policy, the spouse's earned income was considered in the eligibility determination and TMA was authorized. Office-wide staff meetings conducted on March 19th & 21st during which the deficiency was used as an example of (1) better defining errors that fall under the "Failure to Act" umbrella, and (2) current expectations for case management.

Qualifier #15: CAO is in the Process of restructuring the Unit. New CW in the unit just finished LTC training. CAO also just promoted a new LTC Supervisor in November of 2018. LTC unit should be restructured and trained by the end of May. Staff training held during staff meeting to review proper procedures for timely completion of renewals. Philadelphia LTIS is working towards processing all renewals within the month the are due. Previously instructions were given to hold renewals until day -45 before closure. Working on a cleanup project projected completion date 9/30/2019. Review the findings and the cause of error with MA staff members. All units have reviewed 476.1 and 476.2, confirmation received.

Qualifier #16: LTC/Waiver Supervisor will conduct staff training with all LTC/Waiver workers to focus on policy from LTC 440.31 Verification of Personal Property, 440.33 Verification of Life Insurance, 476.21 CAO responsibilities at renewal and proper procedure regarding Scanning and Imaging of documents to case records. Requested and received information from the Facility Reimbursement Officer in Harrisburg who gave us information for May 2017 which was not used for the 06/2017 Renewal. The Facility Reimbursement Officer used 04/2017 information for this renewal. I would like to point out that the CAO does not receive income/resource verifications for individuals in ICF facilities. All information is sent from the Guardian's Office at the Center (or client representative) to the Facility Reimbursement Office in Harrisburg. The Facility Reimbursement Officer completes the Compass Renewal/Application for these individuals and submits the Compass Renewal/Application to the CAO for processing. Since the Facility Officer has verified the resources/income the IMCW inputs what is on the Compass Renewal/Application. The CAO only contacts the facility, the individual's representative, or family members if the information presented is unclear or inconsistent or not verified. Luzerne is scheduled to participate in a LTC Process Review office visit during which DCA staff will present and discuss additional corrective actions to improve case and payment accuracy. Director met with LTC Supervisors to review the deficiency and the expectation that all resources must be verified, and data entered at the point of application and again at

renewal. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed that the worker failed to verify resource information at the time of transition from Healthy Horizons to PAN. The Committee discussed worker actions considering MAHB 440.31 Verification of Personal Property and MAHB 440.33 Life Insurance. Several Departmental and County actions have been taken to address an unacceptable LTC error rate. An Information Memorandum released September 1, 2017 instituted a statewide MA LTC Process Review. LTC Process Review I sampled 4 cases from Luzerne, none of which had an error related to resources (100%). LTC Process Review II sampled 14 cases from Luzerne, 3 of which had errors related to resources (79%). Luzerne and Lackawanna LTC management met with Philadelphia LTC management to discuss best practices in a meeting facilitated by the area managers of Areas 1, 2 & 6. LTC/HCBS budgets were sampled for the March Rushmore Review. Of 27 cases reviewed, six cases had resource-related deficiencies (78%). Staff meetings conducted in September 2017 and March 2019 specifically highlighted LTC process review concerns. CAO staff participated in mentoring calls in August and November 2017, March and May 2018 and January 2019 that dealt with LTC/HCBS issues and concerns.

Qualifier #17: Supervisors meeting to be held to review and discuss accurate data entry of resources. Unit meeting to be held to review and discuss accurate data entry of resources. 5 Rushmore reviews for resources on LTC cases. Staff meeting to be held to review QC finding and discuss accurate data entry of resources. Director met with LTC Supervisors to review the deficiency and the expectation that all resources must be verified, and data entered at the point of application and again at renewal. Luzerne Corrective Action Committee reviewed the results of the Payment Error Rate Measurement and discussed potential corrective actions. The Committee agreed that the worker failed to data enter information known to the CAO in the form of a resident bank account during the March 2018 renewal. The Committee discussed worker actions in not closing the budget until after the due date has passed under LTC HB 476.23, and of reconsidering the late submitted renewal per LTC HB 479.3 and found no inconsistency with policy. 14 LTC cases were reviewed in November 2018 as part of the LTC Process Review. 2 cases were found to be in error due to failure to verify resources. Office-wide staff meetings conducted on March 19th & 21st during which the deficiency was used as an example of (1) the result of failing to reconcile information known to the CAO with what is reported on the renewal/SAR/or application document, and (2) current expectations for case management. Individual worker conference was conducted to reinforce the need to accurately and thoroughly data enter resources. LTC HB 440.31 "Verification of Personal Property" was reviewed as was the E-Mail Blast distributed in November 2018 "Money, Money Everywhere."

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Individual Staff	Implemented	Continuous	On-going	County Management	Monthly Sample of

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Conferences and Trainings					Quality Control reviews. Rushmore Reviews at County Level.
E-Blasts to County Staff targeting error trends	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Statewide Mentoring Calls	Implemented	January 2019	On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.
Knowledge Reinforcement Sessions	Implemented		On-going	Division of Corrective Action	Monthly Sample of Quality Control reviews. Rushmore Reviews at County Level.

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

We have an ongoing monthly random sample of reviews done by Quality Control and as such are able to continuously track and monitor the error rate and error trends. We also ask local offices to use the Rushmore Database and target a specific area identified to see if results are improving on a County level.

Return to Top

Medicaid Eligibility Target Rate

Next Cycle Medicaid Eligibility Target: 3.00%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.

Most of the eligibility errors fall under the category of "failure to act". If a worker "fails to act" or fails to do their job, usually the cause is either a lack of proper training or supervision. We feel that an approach ensuring that workers in the office get the training they need, AND the supervision they need will help us meet the target rate. First, County Supervisors will identify if the workers in question have work performance issues. If so, that will be handled accordingly. If not, then the real issue is an underlying root cause to a system or process that is causing a quality worker to 'fail to act". We feel that if County Management in these cases does a thorough and proper root cause analysis to address these issues, these workers will be able to effectively do their jobs, and we will meet the target rate.

	RY 2019
Number of Errors	244
Number of Claims in Error	201
Number of Claims Sampled	677
Sampled Federal Dollars in Error	$96,160
Projected Federal Dollars in Error	$1,821,156,133
Improper Payment Rate	11.36%
Target Rate	3.00%
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one ER error on the claim.	

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).

With regard to the failure to act errors in the eligibility category, an Information memo was released to the county offices 4/24/19 stating the following: Root Cause Analysis is an expectation of the Commonwealth when submitting a statewide Corrective Action Plan (CAP) to Food and Nutrition Services (FNS) for the SNAP program, and Center for Medicare and Medicaid Services (CMS) for Medicaid. BPE relies upon each County Assistance Office (CAO) to do a thorough Root Cause Analysis when they receive an error finding from Quality Control (QC) or any other BPE review. Failure to provide a root cause to BPE prevents the Bureau from meeting the federal requirements of our statewide CAP.

Moving forward, BPE can no longer accept "worker error", "worker oversight", "worker failed to act", or "worker failed to follow policy" as a root cause. Types of statements like these are not the actual root cause of why an error occurred. If BPE receives a response such as this from a CAO, a request will be made to further analyze the error and resubmit the response. A proper root cause analysis involves identifying the factors that resulted in the worker error, or worker oversight.

Appendix A: Acronym Glossary

CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
DMF	Social Security Death Master File
DOS	Date Of Service
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Estimate
POC	Plan Of Care
SAM/EPLS	System for Award Management/Excluded Parties List System
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TD	Technical Deficiency
TPL	Third Party Liability

Payment Error Rate Measurement (PERM)
RY 2019 CHIP Corrective Action Plan
Pennsylvania

Table of Contents

CHIP Corrective Action Cover Page

This document serves as a template for the state to enter its plan for corrective actions. The template will guide Pennsylvania in reporting the root cause for each error and deficiency found in the RY 2019 measurement and the appropriate corrective actions to resolve them. Please refer to the state's Cycle Summary report for a full analysis and breakdown of the findings that contribute to Pennsylvania's improper payment rate through the PERM program. Please note that the definition of an improper payment is derived from the Improper Payments Information Act (IPIA) of 2002, as amended, and 42 CFR 431.958. Please keep in mind that corrective actions should focus on how to prevent the same improper payment (or deficiency) from occurring again. Please also keep in mind that the Corrective Action Plan (CAP) is not a venue to dispute errors or deficiencies cited. For more information on completing this template, please refer to the CAP template instructions.

A. (State): Pennsylvania **Fiscal Year:** 2019

B. (Date): 2/24/2020

C. State Contact: Virginia Perry
Phone number: 717-772-1110
Email address: virperry@pa.gov

D. CHIP Federal Improper Payment Rate: 20.67%
Fee-For-Service Rate: 0.00%
Managed Care Rate: 11.31%
Eligibility Rate: 10.55%

Next Cycle Fee-For-Service Target: 0.00%
Next Cycle Managed Care Target: 6.15%
Next Cycle Eligibility Target: 3.00%

E. Summary of CHIP Error Causes[1]

Fee-For-Service:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
There is no Fee-For-Service program	N/A	N/A	N/A

Managed Care:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Administrative/Other Error (DP12)	5	$965.37	$68.83

Eligibility:

Type of Errors	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Documentation to Support Eligibility Determination Not Maintained (ER1)	7	$1,432.34	$13.20
Verification/Documentation Not Done/Collected at the Time of Determination (ER2)	8	$1,397.79	$16.66
Determination Not Conducted as Required (ER3)	2	$205.68	$4.84
Not Eligible for Enrolled Program - Financial Issue (ER4)	1	$175.74	$1.02
Not Eligible for Enrolled Program - Non-Financial Issue (ER5)	3	$347.72	$6.33
Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)	17	$2,142.20	$33.65
Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)	123	$0.00	$0.00

F. Optional State CHIP Corrective Action Discussion

Click here to enter text.

[1] Multiple errors on a claim are counted separately, which may result in a discrepancy when compared to the Cycle Summary Report results by type of error.

Component: Fee-For-Service (FFS)

There is no FFS program in Pennsylvania.

Component: Managed Care (MC)

RY 2019 CHIP MC Federal Improper Payment Rate: 11.31%

As noted in your Cycle Summary Report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

MC Finding Category #1: Administrative/Other Error (DP12)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Other	5	$965.37	$68.83
Total	5	$965.37	$68.83

State may provide additional Data Analysis here (optional):

The five errors listed in this section were overturned on 9/12/2019. The Office of CHIP received a PERM Alert email on August 03, 2019, notifying us of the PERM error. The Office of CHIP provided requested documentation on August 6, 2019 to AdvanceMed. The Sampling Unit Disposition (SUD) report on September 6 indicated that the information provided was incorrect. CHIP immediately contacted AdvanceMed to clarify information required. The Office of CHIP requested a Difference Resolution for all five cases and provided new information as requested by AdvanceMed. The errors were overturned on 9/12/19 by CMS within the State Medicaid Error Rate Finding (SMERF) system. Therefore, the Office of CHIP has no further corrections regarding the five errors listed in this report because the errors have been overturned.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Other

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M015	$252.46	$13.26
PAC1904M019	$239.70	$15.54
PAC1904M027	$188.96	$12.25
PAC1904M053	$141.72	$13.85
PAC1904M061	$142.54	$13.93

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

When alerted to the error, AdvanceMed advised CHIP to provide the capitation rates for the month of service. Upon further review, AdvanceMed actually needed the capitation rates within the Managed Care Contracts, the capitation rates paid in the prior month of service, and rates paid in the month after the service, as well as the full contracts for three of the MCOs. Had this information been initially requested by AdvanceMed, the error would not have occurred. After the Difference Resolution review, CMS found in CHIP's favor and these errors were overturned within the SMERF system as of 9/12/19.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

There is no corrective action plan for these categories because there are no errors.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected*

implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
none					

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

  There are no proposed corrective action plans so there is no need for evaluation.

Return to Top

CHIP MC Target Rate

Next Cycle CHIP MC Target: 6.15%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.
There are no proposed corrective action plans because there were no errors.

CHIP MC Evaluation of FY 2015 Previous Cycle Corrective Actions

	RY 2019 (Federal)[2]	FY 2015 (Total Computable)
Number of Errors	5	1
Number of Claims in Error	5	1
Number of Claims Sampled	41	241
Dollars in Error	$965	$224
Projected Dollars in Error	$68,828,125	$1,275,579
Improper Payment Rate	11.31%	0.33%
Target Rate	0.33%	1.04%

Please refer to the state Cycle Summary Report for additional information on cycle comparisons.
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one DP or MR error on the claim. However, for RY 2019, the number of errors row counts all errors found on a claim. For FY 2015, multiple DP or MR errors are not counted, but one DP and one MR error is included per claim, if applicable. Additionally, states are cautioned from making direct comparisons between the cycles, since review requirements and program structure may have changed.

Evaluation of Implemented Corrective Actions
None

Discussion of Corrective Actions Not Implemented
None

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
None

[2] Dollars in error, projected dollars in error, improper payment rate, and target rate are all based on federal dollars in RY 2019 and total computable dollars in FY 2015.

Component: Eligibility

RY 2019 CHIP Eligibility Federal Improper Payment Rate: 10.55%

As noted in your Cycle Summary report, further detail is provided about errors considered a monetary loss to the program. These monetary loss errors are indicated below with an asterisk (*).

Eligibility Review (ER)

Eligibility Finding Category #1: Documentation to Support Eligibility Determination Not Maintained (ER1)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income verification not on file/incomplete	3	$675.95	$6.05
Other required forms not on file/incomplete	2	$436.62	$3.15
Record of signature not on file - caseworker	2	$319.77	$4.00
Total	7	$1,432.34	$13.20

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income verification not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M024	$254.13	$1.15
PAC1902M001	$266.70	$3.02
PAC1904M059	$155.12	$1.88

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M024: The root cause was human error in not retaining required records. The MCO did not follow the policy and procedure regarding record retention as required by its agreement with the Department. The MCO failed to keep or provide copies of paystubs used to determine eligibility.
PAC1902M001: Caseworker did not correctly obtain the most recent tax return to determine the household's self-employment income. A copy of a 2015 tax return was used instead of a 2016 tax return. Caseworker misunderstood policy and incorrectly concluded that it was appropriate to utilize the 2-year-old tax return as income verification.
PAC1904M059: Caseworker completed an ex-parte review for MA benefits for child and used mother's income already on file in the Client Eligibility System (eCIS) due to no-response from client regarding renewal of Medical Assistance (MA) benefits. Caseworker lacked training failed to follow the outlined policy and procedures on how to complete an ex-parte review.

Qualifier #2: Other required forms not on file/incomplete

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M004	$262.50	$1.11
PAC1903M044	$174.12	$2.04

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M004: The root cause was human error in not retaining required records. The MCO worker did not follow the policy and procedure regarding record retention required by its agreement with the Department. The MCO failed to keep or provide copies of the renewal packet used to

determine eligibility
PAC1903M044: Case was an inter-county transfer to Berks County Assistance Office (CAO). CAO used household information obtained during client walk-in to new county to re-open benefits. Caseworker lacked knowledge of and failed to follow inter-county transfer policy and procedures to complete a new application in the new county of residence.

Qualifier #3: Record of signature not on file - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M024	$254.13	$1.15
PAC1902M076	$65.64	$2.85

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M024: The root cause was human error in not retaining required records. The MCO worker follow the policy and procedure regarding record retention required by its agreement with the Department. The MCO failed to keep or provide copies of paystubs used to determine eligibility.
PAC1902M076: COMPASS application received from telephone application services contractor Inspiritec. Once COMPASS application was received, caseworker failed to send a signature page to client for completion prior to authorizing benefits due to worker confusion regarding signature page requirements when application submitted by a contractor.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce the areas of the MCO agreement regarding retention of documentation relating to eligibility determination. The Policy Clarification will also reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of

CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.

3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.

10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above
13. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
14. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
15. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews and provide Policy Clarification

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Implement SMART tool for case review monitoring	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews
SMART tool update to focus on PERM QC errors	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification.
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1. Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to the MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.
2. Case review for SMART: The Office of CHIP will pull sample cases and review the MCOs' ability to determine eligibility. We will measure the MCOs' incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of an MCO as well as the measurement of compliance, with lack of compliance being one of the steps to a sanction.
3. Trainings: The Office of CHIP will track MCO training and follow-up with any MCOs that have failed to complete the requirement.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
4. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
5. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
6. Open communication with CAOs to determine if developed tools and training have been helpful

Return to Top

Eligibility Finding Category #2: Verification/Documentation Not Done/Collected at the Time of Determination (ER2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Citizenship not verified - caseworker	1	$254.13	$1.15
Household composition/tax filer status not verified - caseworker	2	$349.90	$4.56
Other element not verified - caseworker	1	$138.25	$2.95
Signature not recorded at initial application - caseworker	1	$52.38	$1.14
When appropriate, signature not recorded at renewal - caseworker	3	$603.13	$6.86
Total	8	$1,397.79	$16.66

State may provide additional Data Analysis here (optional):

PAC1902M025: In this case, the mother died during the eligibility period. The PA CHIP State Plan Amendment, section 4.1.8 provides that enrollees will maintain their eligibility for a period not to exceed 12 months. This SPA section is interpreted by both CMS and PA CHIP to mean that enrollees found eligible will maintain their eligibility for a period of 12 consecutive months with few exceptions. If an enrollee does not meet the stated exceptions, the Office of CHIP does not re-evaluate the eligibility without a request from the Enrollee or until the renewal period.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Citizenship not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M020	$254.13	$1.15

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

CHIP:PAC1901M020: The Office of CHIP does not agree that this is an error. Citizenship was verified through an automatic system connection with the Social Security Administration. The CAPS system allowed the case to continue with the citizenship verified but there was not action recorded or needed by a caseworker for the verification process. This is the reason that the system did not keep a decent record of the verification.

Qualifier #2: Household composition/tax filer status not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M025	$175.78	$2.78
PAC1904M044	$174.12	$1.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M025: The Office of CHIP does not agree that this is an error. Based on the Office of CHIP's CMS-approved annual eligibility determination policy, the child's case was run, and the child became eligible for a year of coverage. The child's parent died, and this information was put into the system, however the household did not ask for a reassessment of the eligibility. The enrollees have the right to keep their annual eligibility at the same level as determined at the beginning unless certain changes/issues occur.
PAC1904M044: The Client reported the daughter moved to North Carolina to seek employment but did not stay there and returned home. Caseworker failed to determine how long the daughter was out of the household when temporarily moved to North Carolina.

Qualifier #3: Other element not verified - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M061	$138.25	$2.95

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M061: COMPASS FFM Transfer application received. Caseworker failed to determine eligibility for MA for potentially eligible household members due to failure to follow policy and procedures on handling FFM transferred applications.

Qualifier #4: Signature not recorded at initial application - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M070	$52.38	$1.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M070: Policy does not specifically direct caseworkers in the field to obtain client signatures on the application where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy.

Qualifier #5: When appropriate, signature not recorded at renewal - caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M044	$156.38	$2.84
PAC1903M001	$276.56	$2.03
PAC1903M040	$170.19	$1.99

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M044, PAC1903M001, and PAC1903M040: Policy does not specifically direct caseworkers in the field to obtain client signatures on the application to renew benefits where the client/applicant acknowledges agreement to Rights and Responsibilities as directed by federal policy .

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category**

CHIP:

There is no corrective action for PAC1902M025. The Office of CHIP received approval from CMS to perform eligibility in this way through the State Plan Amendment

OIM:

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household) and May 2017 (MA SAVE). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate

data entry and properly applying policy to eligibility determinations.

10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above.
13. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
14. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
15. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
16. Internal OIM face-to-face discussion occurred on June 13, 2019 between the Bureau of Policy and Bureau of Program Evaluation for handbook update. Policy to update handbook to become consistent with federal policy and notify staff on changes. Handbook will be updated to specifically state the client's signature must be contained on the application or renewal form where the Rights and Responsibilities are outlined for client acknowledgement and acceptance of these terms.
17. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
18. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected*

implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures	Implemented	Continuous	Ongoing	OIM	Reviews for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
CAO staff are to follow					

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
4. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
5. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
6. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #3: Determination Not Conducted as Required (ER3)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Redetermination was not conducted within 12 months before date of payment for services - caseworker	2	$205.68	$4.84
Total	2	$205.68	$4.84

State may provide additional Data Analysis here (optional):
Click here to enter text.

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Redetermination was not conducted within 12 months before date of payment for services – caseworker

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M063	$128.25	$2.74
PAC1903M066	$77.43	$2.10

- **Enter the root causes of error(s) identified above. *Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M063: Caseworker failed to process renewal timely due to worker oversight and not failure to keep case processing work up to date.
PAC1903M066: Client failed to provide renewal packet and information timely which caused the caseworker to process renewal untimely. Lack of caseworker training on policy to close a case if client does not provide verification timely.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

- **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and

tip sheets.

2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the month of December 2017 (MA Closings). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
4. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #3 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
5. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
6. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
7. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
8. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
9. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
10. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
11. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
12. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #3 above.
13. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
14. Daily Status D-17072001 issued July 20, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
15. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to

increase accuracy.

16. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
17. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.

7. Open communication with CAOs to determine if developed tools and training have been helpful

Return to Top

Eligibility Finding Category #4: Not Eligible for Enrolled Program - Financial Issue (ER4)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Income deduction incorrectly included/excluded - caseworker*	1	$175.74	$1.02
Total	1	$175.74	$1.02

State may provide additional Data Analysis here (optional):

This case involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the requirements of 42 U.S.C. § 1397bb(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Income deduction incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M048	$175.74	$1.02

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M048: Caseworker failed to use pre-tax deduction as an income deduction and incorrectly determined household ineligible for MA benefits due to lack of knowledge of this deduction and not following policy and procedures.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring
3. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
4. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
5. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
6. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
7. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
8. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
9. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
10. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors

regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample issued by DCA.

11. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
12. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
13. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
14. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.
15. Contacting the Bureau of Operations if additional trends are identified or reported in order to implement statewide and/or local CAO corrective action initiatives.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers

continue to be problematic.

3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits
7. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #5: Not Eligible for Enrolled Program - Non-Financial Issue (ER5)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Beneficiary had Third Party Insurance (CHIP only) - caseworker*	3	$347.72	$6.33
Total	3	$347.72	$6.33

State may provide additional Data Analysis here (optional):

This case involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the requirements of 42U.S.C. § 139766(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Beneficiary had Third Party Insurance (CHIP only) - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1903M054	$155.12	$2.14
PAC1904M065	$122.92	$2.68
PAC1904M068	$69.68	$1.52

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M054, PAC1904M065 and PAC1904M068: Caseworkers failed to identify client's ineligibility for CHIP coverage due to having insurance through a parent's employer and incorrectly referred case to CHIP. Caseworkers failure to follow policy and procedures and correctly identify and data enter this information in eCIS

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

  - **Enter the corrective action(s) for the finding category.**

1. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
2. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
3. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.
4. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
5. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
6. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
7. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate

data entry and properly applying policy to eligibility determinations.

8. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
9. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
10. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
needed updates					
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM

agencies for resolution

5. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
6. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
7. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #6: Should Have Been Enrolled in a Different Program (i.e., Medicaid or CHIP) (ER6)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Errors	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
Beneficiary had Third Party Insurance (CHIP only) - caseworker*	1	$123.01	$2.63
Exempt income incorrectly included - system*	2	$140.57	$3.06
Household composition/tax filer unit or tax filer status incorrect - caseworker*	4	$454.11	$6.77
Income correctly calculated; below/above income limit - system*	3	$588.05	$5.76
Income deduction incorrectly included/excluded - caseworker*	4	$545.41	$10.36
Income incorrectly calculated; other - caseworker*	1	$49.71	$2.16
Other non-financial error - caseworker*	2	$241.34	$2.91
Total	17	$2,142.20	$33.65

State may provide additional Data Analysis here (optional):

This category, except for PAC1901M042, involves an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshakes allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the regulations of 42U.S.C. § 139766(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and 42 CFR 457.340(d)(3).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Beneficiary had Third Party Insurance (CHIP only) - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M056	$123.01	$2.63

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M056: Caseworkers failed to identify client's ineligibility for CHIP coverage due to having insurance through a parent's employer and incorrectly referred case to CHIP. Caseworker failure to follow policy and procedures and correctly identify and data enter this information in eCIS

Qualifier #2: Exempt income incorrectly included - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1904M067	$74.93	$1.63
PAC1904M069	$65.64	$1.43

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M067: Caseworker incorrectly included monthly sponsor income and incorrectly determined household ineligible for MA.
PAC1904M069: Caseworker incorrectly included non-taxable monthly adoption assistance, but a system glitch incorrectly counted exempt income and incorrectly determined the household ineligible for MA.

Qualifier #3: Household composition/tax filer unit or tax filer status incorrect - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M043	$175.74	$1.02
PAC1902M043	$160.93	$2.92
PAC1903M069	$51.80	$1.40
PAC1904M069	$65.64	$1.43

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M043: A PID referral was received for one child in the household as the sibling was already authorized for medical assistance. Caseworker failed to include both children in the PID referred MA determination and incorrectly rejected household for MA and referred household to CHIP. This error occurred due to lack of training on correct policy and procedure to follow for PID referrals.
PAC1902M043: Newborn notification was received and the caseworker authorized benefits for the newborn. An eligibility determination was processed with the additional member to increase the household size and a CHIP referral was incorrectly made. Caseworker failed to follow procedure outlined in policy for adding additional household member.
PAC1903M069: Caseworker incorrectly excluded one of the three children in the household when determining eligibility for MA because caseworker was rushing to process case and data entered an incorrect eligibility code for the child which caused an incorrect referral to CHIP.
PAC1904M069: Caseworker incorrectly included an absent father who recently moved out of household in the budget which caused the household o be incorrectly determined ineligible for MA. Caseworker failed to correctly process in case maintenance mode to remove household member

Qualifier #4: Income correctly calculated; below/above income limit - system*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1901M042	$175.74	$1.02
PAC1902M061	$138.25	$2.95
PAC1904M009	$274.06	$1.79

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M042: Caseworker appears to have calculated the parent's income correctly and was waiting for wage information of 18-year-old which was not received. System glitch incorrectly sent application for a CHIP referral when rejected for failure to provide verification.
PAC1902M061: COMPASS FFM Transfer application received. Caseworker appears to have correctly calculated income, but caseworker needed income verification from household which was not received. System glitch incorrect sent application for a CHIP referral.
PAC1904M009: Medical assistance cascade incorrectly placed child in incorrect MA category. System glitch caused an incorrect MA category assigned to child.

Qualifier #5: Income deduction incorrectly included/excluded - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M015	$236.91	$2.68
PAC1902M053	$135.78	$2.90
PAC1902M056	$123.01	$2.63
PAC1902M079	$49.71	$2.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M015: Client received self-employment income from rental property and trucking business. Caseworker incorrectly excluded the deductible portion of the self-employment tax because failure to follow policy and procedures outlined in handbook to determine self-employment deductions.

PAC1902M053, PAC1902M056 and PAC1902M079: Caseworkers failed to use failed to use pre-tax deductions for medical insurance premiums and/or retirement contributions as income deductions and incorrectly determined household ineligible for MA benefits. Caseworkers lacked knowledge and training of policy to identify income deductions.

Qualifier #6: Income incorrectly calculated; other - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1902M079	$49.71	$2.16

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M079: Caseworker failed to use pre-tax deductions for medical insurance premiums as income deductions and incorrectly determined household ineligible for MA benefits. Caseworker lacked knowledge and training of policy to identify income deductions.

Qualifier #7: Other non-financial error - caseworker*

PERM ID	Federal Dollars in Error	Federal Projected Dollars in Error (in millions)
PAC1903M026	$188.96	$1.77
PAC1904M070	$52.38	$1.14

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M026: Caseworker failed to correctly calculate household income and incorrectly determined household over income limits due to failure to properly compute income that resulted from a mathematical error.
PAC1904M070: Caseworker failed to identify household was incorrectly authorized and open for both MA and CHIP benefits at the same time. Caseworker lacked training on how to process a case that is already receiving CHIP benefits.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce the areas of the MCO agreement regarding retention of documentation relating to eligibility determination. The Policy Clarification will also reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.
3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Any system caused errors are reported to the Division of Automation Planning and Support for research to fix the issue and develop future system enhancements to avoid repetition of errors.
2. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
3. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs' aware of errors, in an attempt to prevent these errors from occurring.
4. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAOs in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
5. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #4 above for

the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.

6. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff'
7. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
8. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
9. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
10. Supervisory staff in CAO's where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
11. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
12. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
13. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #4 above.
14. Daily Status D-17072001 issued September1, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
15. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
16. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
17. Daily Status D-18020201 issued February 2, 2018 identified a system glitch where 2018 COLA income limit updates were not properly calculated on MA cases that were processed January 13, 2018 through January 31, 2018. Cases that were close to the 2017 income limit for their current medical benefits may have had their current MA benefit levels incorrectly decreased or closed after January 13 due to this issue. Cases were identified and fixed that had this issue.
18. Daily Status D-18032601 issued March 26, 2018 identified instances where self-employment expenses are entered along with

tax deductions for the individual in the case, the system is ignoring self-employment expenses. MAGI income calculations were incorrect causing incorrect budgets to pass or fail. The daily status outlined the manual procedural steps caseworkers had to use to correctly determine self-employment income.

19. Daily Status D-18032705 issued March 27, 2018 identified a system glitch where the system is not calculating allowable self-employment income offsets when a net loss is reported correctly which results in incorrect income calculations for MA budgets. The daily status provided a temporary work around for caseworkers to use to correctly data enter self-employment income.
20. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
21. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Implement SMART tool for case	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
review monitoring					
SMART tool update to focus on PERM QC errors	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
					Control (QC) errors
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1. Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.
2. Case review for SMART: The Office of CHIP will pull sample cases and review the MCO's ability to determine eligibility. We will measure the MCO's incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of the MCO as well as be the measurement of compliance with lack of compliance being one of the steps to a sanction.
3. Trainings: The Office of CHIP will track MCO training and follow-up with any MCOs that have failed to complete the requirement.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Assisting DAPS in ascertaining if any system enhancements implemented have negatively or positively impacted the number of MA errors.
5. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
6. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
7. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
8. Participating in various workgroups for system initiatives and possible resolution techniques for future system releases.
9. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top

Eligibility Finding Category #7: Finding Noted With Case, But Did Not Affect Determination or Payment (ERTD2)

- **Data Analysis Results:** *Results of the data analysis for Pennsylvania are shown here.*

Qualifiers	Number of Deficiencies
Countable income incorrectly excluded; eligible for enrolled category - caseworker	2
Countable income incorrectly excluded; not eligible for enrolled category - caseworker	5
Countable income incorrectly excluded; not eligible for enrolled category - system	1
Exempt income incorrectly included; eligible for enrolled category - caseworker	3
Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker	9
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - caseworker	2
Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system	1
Income correctly calculated; below/above income limit; eligible for enrolled category - system	1
Income correctly calculated; below/above income limit; not eligible for enrolled category - caseworker	2
Income correctly calculated; below/above income limit; not eligible for enrolled category - system	3

Qualifiers	Number of Deficiencies
Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker	37
Income deduction incorrectly included/excluded; eligible for enrolled category - system	2
Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker	4
Income incorrectly calculated; other; eligible for enrolled category - caseworker	35
Income incorrectly calculated; other; not eligible for enrolled category - caseworker	13
Other financial deficiency - system	2
Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - system	1
Total	123

State may provide additional Data Analysis here (optional):

These cases involve an electronic process titled the "Healthcare Handshake". This electronic process helps to facilitate the moving of applications between Medical Assistance and CHIP. Once the family is determined ineligible for Medical Assistance, the application is electronically forwarded from the MA system to the CHIP system for eligibility review. Conversely, if the Office of CHIP determines an applicant is not eligible for CHIP, then the application is electronically forwarded to MA for review. The Healthcare Handshake allows CHIP to conduct an eligibility review using information already verified in the MA application process. Families benefit from this process because they do not need to submit multiple applications or provide verification more than once. This process is outlined in PA CHIP's State Plan under section 4.4.3 and follows the regulations of 42 U.S.C § 1397bb(a)(1), (a)(2), and (c)(2), 42 CFR 431.636(b)(4), and42 CFR 457.340(d)(3).

This category involves the PA CHIP State Plan Amendment, section 4.1.8 provides that enrollees will maintain their eligibility for a period not to exceed 12 months. This SPA section is interpreted by both CMS and PA CHIP to mean that enrollees found eligible will maintain their eligibility

for a period of 12 consecutive months with few exceptions. If an enrollee does not meet the stated exceptions, the Office of CHIP does not re-evaluate the eligibility without a request from the Enrollee or until the renewal period.

This category involves different income determination paths between CHIP and AdvancedMed. The Office of CHIP to use paystubs and electronic verification through the Equifax system, as long as it is representative of the income received by the household. AdvancedMed relied on averaging the Interstate Exchange Verification System (IEVS) quarterly income of the enrollee to determine eligibility only. Both calculations were within tolerance, meaning no change to the category of CHIP the child is to receive (free, subsidized level, or Full Cost).

- **Program Analysis:** *This is the most critical part of the corrective action process. Describe why a particular program/operational procedure caused the error(s) below and identify the root causes(s). Please provide as much detail as necessary to fully establish and explain the true root cause of the error(s).*

Qualifier #1: Countable income incorrectly excluded; eligible for enrolled category - caseworker

PERM ID
PAC1903M037
PAC1904M001

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M037: The root cause was human error. The MCO worker did not follow the proper policy and procedure. The MCO worker did not include the overtime from the paystubs or overtime YTD from the paystub to determine eligibility

PAC1904M001: The root cause was human error. The MCO worker did not follow proper policy and procedure by not including the second job in the income calculation.

Qualifier #2: Countable income incorrectly excluded; not eligible for enrolled category - caseworker

PERM ID
PAC1901M012

PERM ID
PAC1902M075
PAC1903M007
PAC1903M053
PAC1903M065

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M012: The root cause of the error was because of the decision made by the CAO caseworker. However, when the income was updated in the system, it did not change eligibly because of the Healthcare Handshake process and the12-month duration of eligibility as stated under the "Data Analysis Results" for this category.
PAC1902M075: Caseworker incorrectly excluded non-deductible rental property expenses and incorrectly determined household eligible for incorrect MA category. Caseworker lacked training on allowable self-employment deductions.
PAC1903M007 and PAC1903M065: Caseworker incorrectly excluded self-employment income that should have been calculated in eligibility determination. Caseworker lacked training on allowable self-employment deductions.
PAC1903M053: Caseworker failed to timely include new employment income in MA determination. Income was not included in budge calculation for 2 months after client reported change. Caseworker failed to follow established policy and procedure to add income to case in a certain amount of time from being reported due to worker oversight.

Qualifier #3: Countable income incorrectly excluded; not eligible for enrolled category - system

PERM ID
PAC1902M001

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M001. System logic programming incorrectly excluded this countable income when the State received the data exchange hit from Social Security Administration (SSA) with Retirement, Survivors, Disability Insurance (RSDI) income. The caseworker failed to recognize the system glitch in the MA cascade which caused the incorrect CHIP eligibility category.

Qualifier #4: Exempt income incorrectly included; eligible for enrolled category - caseworker

PERM ID
PAC1904M019
PAC1904M021
PAC1904M025

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

The root cause for these errors was the result of the Office of CHIP not providing updated requirements regarding pre-tax deductions. The pretax deduction information has not been provided in the procedure handbook, any transmittals, or training given to the MCO.

Qualifier #5: Household composition/tax filer unit or tax filer status incorrect; eligible for enrolled category - caseworker

PERM ID
PAC1901M071
PAC1902M041
PAC1903M004
PAC1903M040
PAC1903M049
PAC1903M050
PAC1903M053
PAC1904M021

PERM ID
PAC1904M066

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M004: The Office of CHIP does not believe this is an error. The stated PERM error was an adult sibling in the household that PERM claimed self-attested as not being a tax dependent. However, that is incorrect. The adult sibling was listed as a tax dependent of the household in our system until 9/12/18, after the reviewed claim's date of service of January 2018. The adult sibling was stated as filing taxes because of her employment but that does not mean that the adult sibling was not a tax dependent.
PAC1903M050: The root cause was because of human error. The MCO worker indicated that a sibling had care-and-control of the applicant instead of the applicant's father.
PAC1904M021: The root cause was because of human error. The MCO worker did include the absent child on the application and care/control but appears to have indicated they were not a tax dependent.
PAC1901M071 and PAC1903M040: Caseworker failed to include unborn child in budget group when the household indicated a pregnancy due to worker oversight not looking at information indicated on the application..
PAC1902M041: Caseworker failed to remove a sibling from eCIS when the application did not list the older sibling as being in the household and caseworker case comments state the sibling moved out. Caseworker failed to review information refreshed on household screen in eCIS due to rushing to process case.
PAC1903M049: Caseworker incorrectly removed mother and her 2 children from budget group when mother should have been a non-eligible household member due to 5-year bar limit. Caseworker lacked training on how to data enter and process a payment name that is not receiving benefits for self and only receiving on behalf of children.
PAC1903M053: System processing error occurred, and caseworker cancelled eligibility determination and started processing case over again. When caseworker processed case with a household of five, the system only included 4 household members due to the system glitch. Caseworker failed to recognize system glitch and did not follow procedure to ensure correct household established.
PAC1904M066: Caseworker incorrectly included a sibling in the budget group when the sibling was being claimed by her grandmother that was not a part of the same household. Caseworker lacked training on how to determine household composition based on tax filer status.

Qualifier #6: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - caseworker

PERM ID
PAC1902M032

PERM ID
PAC1903M047

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M032: Caseworker incorrectly included 2 siblings that were not claimed as dependents by parents in household determination. Caseworker lacked training on how to determine household composition based on tax filer status.
PAC1903M047: Caseworker correctly added newborn to household however, when running eligibility, it appears a system glitch caused the newborn not to be included in budget group. Caseworker failed to recognize system glitch and did not follow procedure to ensure correct household established.

Qualifier #7: Household composition/tax filer unit or tax filer status incorrect; not eligible for enrolled category - system

PERM ID
PAC1901M334

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M334: Caseworker failed to ensure a sibling that was previously removed from budget due to moving to Alaska, remained excluded from the budget group. System glitch incorrectly added the sibling that was previously removed.

Qualifier #8: Income correctly calculated; below/above income limit; eligible for enrolled category - system

PERM ID
PAC1904M007

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M007: Medical assistance cascade incorrectly placed child in incorrect MA category. System glitch incorrectly placed child in wrong category.

Qualifier #9: Income correctly calculated; below/above income limit; not eligible for enrolled category - caseworker

PERM ID
PAC1904M014
PAC1904M052

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M014: Case comments indicate caseworker correctly calculated wage income; however, income was not correctly data entered in eCIS due to worker failure to review information prior to transmitting off income screen.
PAC1904M052: Caseworker incorrectly averaged wages and data entered $7 above the income verification that was received. Caseworker failed to correctly compute wages due to misreading dollar amounts listed on paystubs.

Qualifier #10: Income correctly calculated; below/above income limit; not eligible for enrolled category - system

PERM ID
PAC1901M020
PAC1903M015
PAC1903M020

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M020: Caseworker case comments indicate household income did not include unemployment due to non-receipt as verified by Exchange information. The caseworker failed to ensure the system did not include unemployment compensation in category determination by worker oversights and failing to review the information refreshed on the unearned screen prior to transmitting off screen.
PAC1903M015: Caseworker failed to use the 4 paystubs provided to determine household income and incorrectly used 1 of the 4 paystubs to represent future income. Caseworker failed to follow established policy and procedures on estimating income outlined in the handbook.
PAC1903M020: Caseworker used 4 paystubs to determine household income which was over the medical assistance limit. It appears information in CAPS and Equifax verification are different. The two systems available to caseworker contained different information due to system logics established to capture wage information

Qualifier #11: Income deduction incorrectly included/excluded; eligible for enrolled category - caseworker

PERM ID
PAC1901M002
PAC1901M038
PAC1901M046
PAC1901M066
PAC1901M073
PAC1901M076
PAC1901M335
PAC1901M337
PAC1901M352
PAC1902M010
PAC1902M013
PAC1902M015
PAC1902M030
PAC1902M032
PAC1902M046
PAC1902M058

PERM ID
PAC1902M060
PAC1902M064
PAC1902M075
PAC1903M001
PAC1903M018
PAC1903M057
PAC1903M058
PAC1903M069
PAC1903M077
PAC1904M001
PAC1904M006
PAC1904M020
PAC1904M029
PAC1904M032
PAC1904M036
PAC1904M048
PAC1904M053
PAC1904M065

PERM ID
PAC1904M068
PAC1904M073
PAC1904M075

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M002: The root cause of the error was that the MCO worker did not follow policy and procedure and used an old tax return to verify current income deductions.
PAC1901M038 PAC1901M046, PAC1901M066, PAC1901M076, PAC1902M013, PAC1902M030, PAC1904M001, PAC1904M020, PAC1904M029, PAC1904M048, and PAC1904M053: The root cause of these errors was because the Office of CHIP did not provide updated requirements regarding pre-tax deductions. The pretax deduction had not been provided in the procedure handbook, in any transmittals, or any training given to the MCOs.
PAC1904M036: The root cause was human error. The MCO worker did not follow policy and procedure and included the student loan deduction.
PAC1901M073, PAC1901M335, PAC1901M337, PAC1901M352, PAC1902M010, PAC1902M013, PAC1902M015, PAC1902M032, PAC1902M046, PAC1902M058, PAC1902M060, PAC1902M064, PAC1902M075, PAC1903M001, PAC1903M018, PAC1903M057, PAC1903M058, PAC1903M069, PAC1903M077, PAC1904M006, PAC1904M029, PAC1904M032, PAC1904M036, PAC1904M048, PAC1904M053, PAC1904M065, PAC1904M068, PAC1904M073, and PAC1904M075: In all instances, the caseworker failed to allow medical vision and dental insurance premiums, retirement deductions, allowable self-employment income tax deductions, and/or rental property self-employment income deduction. Caseworkers failed to follow established policy and procedures outlined in the handbook and properly review paystubs, wage or income verification to determine allowable income deductions.

Qualifier #12: Income deduction incorrectly included/excluded; eligible for enrolled category - system

PERM ID
PAC1902M059
PAC1904M054

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1904M054: The root cause was human error. The MCO worker did not follow policy and procedure and used an older student loan deduction verification for a newer student loan year.
PAC1902M059. Caseworker failed to allow vision insurance premium and retirement deductions when calculating household income. The caseworker lacked training on how to calculate income by including these allowable deductions.

Qualifier #13: Income deduction incorrectly included/excluded; not eligible for enrolled category - caseworker

PERM ID
PAC1903M007
PAC1903M012
PAC1903M060
PAC1904M078

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1903M012: The root cause of the error was that the MCO did not follow policy and procedure and used student loan income deduction without verification.
PAC1903M007, PAC1903M060 and PAC1904M078: In all instances, a caseworker incorrectly excluded income that should have been calculated in eligibility determination. Caseworkers incorrectly data entered an income exclusion code instead of the frequency code to indicate how often the client is paid. Caseworkers rushing to process cases and failure to review information data entered on the income screen before transmitting caused errors

Qualifier #14: Income incorrectly calculated; other; eligible for enrolled category - caseworker

PERM ID
PAC1901M037
PAC1901M046

PERM ID
PAC1901M047
PAC1901M053
PAC1901M068
PAC1901M070
PAC1901M071
PAC1901M075
PAC1901M321
PAC1901M365
PAC1901M367
PAC1901M368
PAC1902M012
PAC1902M041
PAC1902M047
PAC1902M048
PAC1903M006
PAC1903M018
PAC1903M022
PAC1903M035

PERM ID
PAC1903M055
PAC1903M065
PAC1903M067
PAC1903M070
PAC1903M073
PAC1904M007
PAC1904M008
PAC1904M027
PAC1904M034
PAC1904M034
PAC1904M035
PAC1904M057
PAC1904M062
PAC1904M065
PAC1904M068

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M037: The root cause was because of human error. The Central Eligibility Unit worker miscalculated the income.
PAC1901M046: The root cause was because of human error. The MCO worker used the incorrect YTD on the available paystub; however, the difference was around ten dollars annually, or twenty cents per weekly pay.
PAC1901M047: The root cause was because of human error. The MCO worker did not follow policy and procedure regarding income and did not allow the appropriate pre-tax deductions and did not use the correct YTD income calculation.

PAC1901M068: The Office of CHIP does not agree that there is an error in this case. The Central Eligibility Unit verified income using Equifax, the electronic income verification program. The MCO worker verified the eight most recent paystubs. PERM used the State DOL quarterly wage YTD. The electronic verification and paystub calculations are acceptable processes. The calculated income difference between the methods came to an approximately sixty-two-dollar difference annually or two-and-a-half-dollar difference between paystubs.
PAC1901M075: The Office of CHIP does not agree that there is an error in this case. The MCO worker verified the income using current paystubs while PERM used the YTD on the paystubs. The paystub calculations are acceptable processes. The calculated income difference between the methods came to about an eighty-two-cent difference per month.
PAC1902M012: The Office of CHIP does not agree that there is an error in this case. The Central Eligibility Unit worker verified the income through the State DOL(IEVS) system as stated in our "comment" of the CAPS system. The worker used the same methods that the PERM used in other cases such as PAC1901M068.
PAC1903M022: The root cause was because of human error and confusion. The MCO worker excluded expense reimbursement because of the confusion of the expense being paid on business costs.
PAC1904M008: The Office of CHIP does not agree that there is an error in this case. The case's income was verified using Equifax, an electronic income verification program that verified the income while PERM used the DOL quarterly wage YTD. The electronic verification and paystub calculation are acceptable processes.
PAC1904M027: The root cause was because of human error. The MCO worker typed a "9" rather than an "8".
PAC1904M057: The root cause of the error was that the MCO did not follow policy and procedure regarding income. The enrollee stated that he had applied for Unemployment Compensation (UC) but had not received any monies or statements. The MCO worker put the UC in as one dollar and required verification, but the case should have been run without the UC since it was not currently being received.

PAC1901M053, PAC1901M070, PAC1901M071, PAC1901M321, PAC1901M365, PAC1901M367, PAC1901M368, PAC1902M012, PAC1902M041, PAC1902M047, PAC1902M048, PAC1903M006, PAC1903M018, PAC1903M035, PAC1903M055, PAC1903M065, PAC1903M067, PAC1903M070, PAC1903M073, PAC1904M007, PAC1904M034, PAC1904M035, PAC1904M057, PAC1904M062, PAC1904M065, and PAC1904M068. In all instances, the caseworker's failure to calculate income correctly included: incorrectly data entering paystub amounts; incorrectly using Exchange quarterly information to calculate an annual income amount and dividing by 12; averaging multiple paystubs to derive a monthly income amount when 30 days of income were provided so no averaging was needed and failure to double check data entry amounts and entries on each case processing screen prior to finalizing eligibility determination. Caseworkers failure to follow established policy and procedure outlined in handbook caused errors.

Qualifier #15: Income incorrectly calculated; other; not eligible for enrolled category - caseworker

PERM ID
PAC1901M061

PERM ID
PAC1901M323
PAC1902M004
PAC1903M004
PAC1903M048
PAC1904M011
PAC1904M025
PAC1904M046
PAC1904M052
PAC1904M052
PAC1904M060
PAC1904M071
PAC1904M071

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M061: The Office of CHIP does not agree that there is an error in this case. The case's income was verified using Equifax, an electronic income verification program, that verified the income while PERM used the DOL quarterly wage YTD. The electronic verification and paystub calculation are acceptable processes.
PAC1902M004: The root cause of the error was related to the CHIP system, CAPS and how it works. The CAPS system tries to perform an Ex Parte review with electronic sources if available. In this case, an Ex Parte review was tried but failed because of the household variance of income. The MCO worker sent the appropriate renewal and request for updated documentation. The MCO worker received the information and ran the case without the Department of Labor and Industry (DLI) income because it would have been double income. The calculated income by CHIP and by the PERM team both noted that the enrollee would not be eligible for standard CHIP and should be eligible for Medicaid expansion through the CAO. The reason the household is not eligible for medical assistance is the way the system pulls and updates information such as

income. The income is from seasonal employment and unemployment, the CAO must determine eligibility per month, this causes the income to be higher than the medical assistance limits. If the income is calculated annually, the family is ineligible for CHIP benefits. When the case is run and found ineligible for CHIP, it is forwarded to medical assistance eligibility and found ineligible as well, so the case stays within the CHIP system as eligible.

PAC1903M004: The Office of CHIP does not believe this is an error. The previously stated PERM error was an adult sibling in the household that PERM claimed self-attested as not being a tax dependent should have been a tax dependent. This error is stated as being that the income from that tax dependent should not be counted in the review. However, that is incorrect if the tax dependent should have been counted in the household. The adult sibling was listed as a tax dependent of the household in our system until 9/12/18, after the reviewed claim's date of service of January 2018. The adult sibling's income was in our system. The adult sibling was stated as filing taxes because of her employment but that does not mean that the adult sibling was not a tax dependent.

PAC1904M025: The root cause was because of human error. The MCO worker counted the negative self-employment as positive income.

PAC1901M323: Caseworker incorrectly used Equifax wage information instead of the paystubs submitted with renewal. Caseworker did not use the most recent wage information and did not verify the two sources of income verification matched. Caseworker lacked training on how to correctly process wage information using available information.

PAC1903M004: Caseworker failed to follow operational mandate to image verification (including application) and create case comments to explain eligibility determination. Paperwork was misplaced and was not incorporated into electronic case record.

PAC1903M048 and PAC1904M046: Caseworker data entered incorrect frequency code and incorrectly entered weekly wages and not bi-weekly. Caseworker failure to review information data entered due to rushing to process case caused error.

PAC1904M011: Caseworker incorrectly tried to average quarterly income using Exchange 1 wage information by adding quarters together and incorrectly divided by 24 instead of 12. Mathematical mistake made using an incorrect divisor and caseworker failure to double check calculation results caused error

PAC1904M052: Caseworker incorrectly used a paystub twice when calculating household income. Caseworker failed to ensure accurate amount of household wages was data entered into eCIS. A second error cited for incorrect monthly calculation caused an incorrect annual amount for household which made household still ineligible for CHIP. Both errors caused by caseworker failure to accurately data enter wage information into eCIS and review income prior to transmitting off screen.

PAC1904M060: Caseworker incorrectly tried to average monthly income using Exchange 1 wage information by adding quarters together and made a mathematical mistake in addition. Mathematical mistake and caseworker failure to double check calculations caused error.

PAC1904M071: Caseworker incorrectly allowed expenses listed on an ownership statement for rental income received from a property management company. Caseworker failed to accurately determine allowable expenses deducted from rental income received should not have included the security deposit amounts held listed on the ownership statement. Caseworker lack of training on allowable expense deduction caused error.

Qualifier #16: Other financial deficiency - system

PERM ID
PAC1902M073
PAC1903M063

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1902M073: Caseworker incorrectly added both 2016 and 2017 allowable self-employment income deductions and data entered into eCIS for eligibility determination. Caseworker failed to use just 1 tax return as verification of allowed deductions due to lack of knowledge on using tax returns for self-employment income verification contributed to error. System glitch also incorrectly did not allow self-employment income deductions data entered by caseworker.
PAC1903M063: Caseworker failed to data enter the correct tax return line item for the household adjusted gross income to determine the net monthly income and allowable deductions. Caseworker lacked training on tax return line items contributed to error. System glitch also incorrectly did not allow self-employment income deductions data entered by caseworker.

Qualifier #17: Redetermination was not conducted timely (within 12 months) before DOS, but was conducted before date of payment - system

PERM ID
PAC1901M334

- **Enter the root causes of error(s) identified above.** ***Simply re-stating the qualifier does not explain what caused the error.***

PAC1901M334: Caseworker was waiting for client to provide renewal information before processing renewal. Ex-parte review completed due to non-receipt of renewal packet. Ex-parte review completed untimely due to giving client time to provide renewal information. Caseworker was unable to follow established policy and procedure for renewals when client failed to provide information timely due to receiving system error. System glitch caused error.

- **Corrective Action:** *List the corrective actions separately (by qualifier) if the corrective actions are different.*

    - **Enter the corrective action(s) for the finding category.**

The Office of CHIP will conduct three corrective actions to remediate the findings for Eligibility Review Errors:

1. The Office of CHIP will draft a Policy Clarification to inform MCOs of the errors regarding eligibility. The Policy Clarification will reinforce sanctions that the Department may impose on MCOs who may be liable for errors they caused.
2. The Office of CHIP will perform case reviews that will focus on the findings of the CMS PERM review. This information will be housed in the PA CHIP's newly implemented SMART system (Systematic Monitoring Access Retrieval Technology). The SMART system is a central data warehouse for DHS oversight of each MCO's agreement requirements including eligibility. The SMART tool is a web-based application that provides CHIP staff with the means to review, track and evaluate the MCOs' compliance with its agreement. The Office of CHIP will update the SMART tool to focus on the recorded eligibility errors. The SMART tool will create reports for internal and CMS use regarding MCO performance in eligibility determinations.
3. The Office of CHIP has created a training to help the MCOs more accurately process eligibility. The training includes topics such as documentation and verification, pre-tax deductions, and common sections of input errors for the CAPS system. This training will be provided to the MCOs as a Web-Ex training. The training will be a requirement for all MCO staff who determine eligibility and will be delivered on an annual basis.

The Office of Income Maintenance will take the following corrective actions:

1. Any system caused errors are reported to the Division of Automation Planning and Support for research to fix the issue and develop future system enhancements to avoid repetition of errors.
2. Development or revision of statewide and local CAO corrective action tools such as e-learning modules, policy clarification memos, and tip sheets.
3. Creation and distribution of email blasts (e-blasts) documenting errors. E-blasts are electronic communications issued from the Division of Corrective Action (DCA) to all Office of Income Maintenance staff in the format of a PowerPoint slide containing policy citations and information. The e-blasts help make CAOs aware of errors, in an attempt to prevent these errors from occurring.
4. Rushmore Case Review System- DCA completes ongoing trainings for CAO Management staff on the use of the Rushmore Case Review System as a way to internally find errors in order to implement corrective actions as appropriate in individual CAOs. Internal medical assistance reviews were completed by the CAO's in the months of March 2017 (MAGI Household); December 2017 (MA Closings) and March 2018 (LTC/HCBS). For these reviews, a sample list of cases is provided to the CAO. The areas to be reviewed are determined by DCA in response to the current error trends, and to evaluate the effectiveness of statewide corrective actions.
5. A desk review guide was developed and issued with the targeted Rushmore Case Review Sample indicated in #4 above for the listed medical assistance reviews. The review guides outlined the different processing steps that supervisors should review in order to conclude that processing standards were met.
6. Medical Assistance error rates were discussed and the importance of accurately reviewing and data entering information into the Client

Eligibility System (eCIS) and following policy and procedures were emphasized during Statewide Mentoring Calls held during the PERM CAP review period. Statewide Mentoring calls are monthly conference calls facilitated by DCA to openly discuss any error trends, recent policy and procedure changes, system enhancements, etc. with CAO Management staff.

7. CAO staff has completed any available MA e-learning training contained in the Division of Staff Development website if directed.
8. CAO staff and unit meetings held in local office to review MA policy and procedures in the handbooks, operation memorandums and information memos issued by the Bureau of Operations.
9. Medical Assistance Knowledge Reinforcement Sessions (MAKRS): Bi-weekly sessions are sent directly to CAO Caseworkers, Supervisors and Managers in each office via email from DCA Headquarters to determine staff knowledge of policy and procedures.
10. Supervisory staff in CAOs where errors were found reported holding meetings with CAO staff and discussed the importance of accurate data entry and properly applying policy to eligibility determinations.
11. Individual worker conferences held with CAO management and CAO staff responsible for errors to reinforce eligibility policy and importance of accurate data entry.
12. County responsible for error of failing to accurately determine medical assistance eligibility reviewed error(s) during an office wide staff meeting.
13. Rushmore Case Review System is used by CAO to complete targeted case reviews in an effort to find and prevent similar errors regarding data entry and incorrect case processing. CAOs can complete internal case reviews at the direction of the Executive Director or Area Manager outside the monthly sample outlined in #4 above.
14. Staff meeting held in CAOs to review and retrain staff on reporting requirements and to emphasize the importance of reviewing reporting requirements with clients.
15. Operations Memorandum #17-08-03 issued on August 15, 2017 outlined the system enhancements made in response to the Affordable Care Act mandate. System changes included automated case actions, real time eligibility determinations and enhanced medical assistance renewals.
16. Daily Status D-17072001 issued July 20, 2017 explained an issue with some automated renewal packets being issued to the wrong individual and incorrect addresses. This system glitch could have resulted in untimely processing of renewals.
17. Daily Status D-17081001 issued August 9, 2017 outlined the August 2017 system enhancement release that converted and migrated various data exchange interfaces from mainframe system to an open system for our Client Information System (eCIS). This system enhancement created new eligibility screens and messages that would require adjustment in becoming familiar with the changes when processing cases by CAO staff.
18. Multiple Daily Status memos were issued in November 2017 in preparation for Community Health Choices implementation January 1, 2018. Various system enhancements were started to migrate this new mandate into eCIS. This required caseworkers to adjust and become familiar with new screens, MA codes and processing requirements.
19. Daily Status D-18010801 issued January 1, 2018 indicated a system glitch when payroll deductions are entered into eCIS for certain MA categories, the system is not properly using these deductions when calculating eligibility. This may result in budgets passing or failing incorrectly. Workers were directed to complete a system override to build the correct MA budget.
20. Daily Status D-18032601 issued March 26, 2018 identified instances where self-employment expenses are entered along with tax deductions for the individual in the case, the system is ignoring self-employment expenses. MAGI income calculations were incorrect

causing incorrect budgets to pass or fail. The daily status outlined the manual procedural steps caseworkers had to use to correctly determine self-employment income.

21. Daily Status D-18032705 issued March 27, 2018 identified a system glitch where the system is not calculating allowable self-employment income offsets when a net loss is reported correctly which results in incorrect income calculations for MA budgets. The daily status provided a temporary work around for caseworkers to use to correctly data enter self-employment income.
22. Continue discussions with the Bureau of Operations to identify error prone areas in case processing that can be further streamlined to increase accuracy.
23. BPE will continue to develop desk guides, tipsheets, e-blast, MAKRS and other tools to assist CAO staff in adhering to proper determination of MA benefits.

- **Implementation and Monitoring:** *Complete each column of the implementation schedule for each corrective action, leaving no spaces blank or filled in with Not Applicable (N/A). Describe a systematic approach for tracking and reporting the status of the corrective actions until successful implementation and closure. Please provide as much detail as possible if a specific implementation and/or completion date is not established (if unable to provide an exact date, please indicate the estimated quarter/year or next milestone to establish a plan/goal going forward). If an action is pending, please provide more information in the above corrective action section on next steps toward an expected implementation date. States should be prepared to update this table when CMS follows up on CAP implementation. For the monitoring column, please make sure to describe the plan for tracking the progress of the implemented corrective action to completion, including a frequency.*

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Policy Clarification regarding PERM errors and Sanctions	Not implemented	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews; issue Policy Clarification
Implement SMART tool for case review monitoring	Implemented	Continuous	Ongoing	Office of CHIP	On-site monitoring; sample case reviews

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	On-site monitoring; sample case reviews
Provide training to MCO staff via Web-Ex	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	Office of CHIP	Online attendance verification
Require all current MCO eligibility staff and supervisors to complete new training	Pending	1st/2nd quarter 2020	1st/2nd quarter 2020	MCO staff	Requirement to complete will be part of the policy clarification above. Will record attendance at any training held and have an online copy for further review.
Desk Guides and Tipsheets	Implemented	Continuous	Ongoing	OIM	Review for additional Quality Control (QC) errors

Corrective Action	Status (Implemented/Not Implemented/Pending)	Implementation Date	Estimated Completion Date	Responsible Party	How state plans to monitor the corrective action
Statewide Mentoring Call	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Learning modules review for needed updates	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
E-Blast	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Rushmore Reviews	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors
Communica-tion with various OIM Bureaus regarding policy and procedures CAO staff are to follow	Implemented	Continuous	Ongoing	OIM	Review for additional QC errors

- **Evaluation:** *Describe how your state plans to evaluate the effectiveness of the corrective action(s) above and assess improvements in operations, efficiencies, number of errors, and improper payments. The evaluation should clearly determine if the corrective actions are achieving the expected results.*

CHIP:

1 Policy Clarification regarding PERM errors and Sanctions: The Office of CHIP will send a Policy Clarification to MCOs, which outlines the PERM errors found along with potential sanctions. These documents will be the foundation for future actions with the MCOs.

2 Case review for SMART: The Office of CHIP will pull sample cases and review the MCO's ability to determine eligibility. We will measure the MCO's incorrect to correct determination ratio of household composition, eligibility outcome, and any documentation or verification used for determining eligibility. The score derived from this ratio will be part of the overall evaluation of the effectiveness of the MCO as well as be the measurement of compliance with lack of compliance being one of the steps to a sanction.

3 Trainings: The Office of CHIP will track MCOs who have performed the training and follow-up with those who haven't to ensure completion of the training.

OIM:

1. Reviewing any available additional sources that would assist in identifying error prone areas outside of BPE and CAO case record reviews. Examples include monthly Statewide Mentoring calls with CAO management staff identifying case processing errors that are occurring in the CAOs and the Bureau of Operations statewide system release calls that occur when major system enhancements are performed to ensure no new problems arise as a result of the system upgrade. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
2. Analyzing results of Quality Control and other DCA MA reviews will determine if inaccurate processing errors identified in the qualifiers continue to be problematic.
3. Contacting the Bureau of Operations if additional trends are identified or reported.
4. Assisting DAPS in ascertaining if any system enhancements implemented have negatively or positively impacted the number of MA errors.
5. Compiling examples of any error trends identified by BPE reviews or reported by CAO staff and timely report to other DHS and/or OIM agencies for resolution.
6. Reviewing MA errors of CAOs cited with errors identified in the qualifiers after the CAO has implemented their corrective action activities to determine if the activities have been effective. If not, contact the CAO to conclude other resources and activities the CAO should utilize to further assist in the reduction of the errors.
7. Utilizing MAKRS responses from CAO staff to gauge policy understanding of properly processing and determining eligibility for MA benefits.
8. Participating in various workgroups for system initiatives and possible resolution techniques for future system releases.
9. Open communication with CAOs to determine if developed tools and training have been helpful.

Return to Top(CMS)

CHIP Eligibility Target Rate

Next Cycle CHIP Eligibility Target: 3.00%

Provide a brief discussion of how the proposed corrective actions will assist your state in meeting the target rate.
The Office of CHIP believes that with the addition of pre-tax deductions into our handbooks and MCO training, the MCOs will no longer make the same error. The number of errors for pretax deductions should drop by sixteen.
The Office of CHIP disagreed with eight eligibility errors stated by the PERM review. These errors included calculating income and the duration of eligibility that was approved by the SPA. Only four of the cases that had federal dollars in error were completed by CHIP, totaling $692.41 out of the $5,018.00. CHIP disagrees with one of these errors is one that because of the approved method in the SPA.

	RY 2019
Number of Errors	161
Number of Claims in Error	126
Number of Claims Sampled	317
Sampled Federal Dollars in Error	$5,018
Projected Federal Dollars in Error	$64,242,267
Improper Payment Rate	10.55%
Target Rate	3.00%
Note: The number of claims in error and the dollars in error do not count multiple errors on a claim separately. A claim is considered to have an error if there is at least one ER error on the claim.	

In addition, please provide a brief discussion of any planned program, legislative, system, or other changes that have been implemented since the commencement of this cycle measurement or that are expected to be implemented by your next cycle (e.g., move to managed care, new MMIS, etc).
Click here to enter text.

Appendix A: Acronym Glossary

CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
DMF	Social Security Death Master File
DOS	Date Of Service
DRG	Diagnosis-Related Group
E/M	Evaluation and Management
FCBC	Fingerprint-based Criminal Background Check
FFE-D	Federally Facilitated Exchange - Determination
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
ISP	Individual Service Plan
ITP	Individual Treatment Plan
LEIE	List of Excluded Individuals/Entities
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
ORP	Ordering and Referring Physicians and other professionals
PA	Prior Authorization
PECOS	Provider Enrollment, Chain, and Ownership System
PERM	Payment Error Rate Estimate
POC	Plan Of Care

SAM/EPLS	System for Award Management/Excluded Parties List System
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TD	Technical Deficiency
TPL	Third Party Liability