

# **Medicaid and CHIP Eligibility Review Pilot Guidance**

Pilot: 2<sup>nd</sup> Round, Due December 2014  
Issued: May 2014

## **Background**

The State Health Official Letter 13-005 issued on August 15, 2013 directs states to implement Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility reviews for fiscal years (FY) 2014 – 2016. States will conduct four streamlined pilot measurements over the three year period. The pilot measurement results should be reported to CMS by the last day of June 2014, December 2014, June 2015, and June 2016.

This guidance is intended for the second round of pilots due December 2014. Guidance for subsequent pilots will be released at a later date.

## **Round 2 Overview**

Similar to Round 1, the Medicaid and CHIP Eligibility Review Pilots consist of two independent components. States are required to:

1. Pull a sample of actual eligibility determinations made by the state and perform an end to end review from initial application/point of transfer to the final eligibility determination (also referred to as 'caseworker action review')
2. Run test cases (provided by CMS)

Guidance for running and reporting on the test cases will be issued separately and will remain on a separate track and timeline. Guidance for Round 2 pilot proposals for the review of state eligibility determinations follows below.

The Round 2 caseworker action review covers a six month review period from April 2014 through September 2014. The minimum sample size for this six month review period is 200. As in Round 1, Round 2 will focus on MAGI eligibility determinations for Medicaid and CHIP. However, Round 2 should include both initial determinations and redeterminations for states that are conducting MAGI renewals. States have the option to focus on problem areas identified in Round 1, if appropriate, and are encouraged to use this opportunity to evaluate corrective actions that may have already been implemented.

These pilots are not PERM/MEQC reviews; therefore, states should not conduct pilot reviews in accordance with old PERM/MEQC methodologies as these methodologies do not reflect changes made by the Affordable Care Act (ACA). Please keep in mind that states will need to utilize a review methodology, error codes, etc. that provide the best information for identifying and correcting issues with new processes and systems.

Please note that CMS made changes to the Round 2 guidance based on lessons learned from Round 1. States should anticipate updating pilot approaches for Round 2 and may not be able to continue with the same approach as Round 1.

## **Eligibility Support Contractor (ESC) Pilots**

States participating in the ESC pilots will not need to submit a Round 2 pilot proposal as the ESC pilots will serve as the Round 2 caseworker action pilots. However, ESC pilot states are still required to:

- Run and report on test cases for Round 2; and
- Provide updates to Round 1 caseworker action review corrective actions in December 2014.

## **Due Dates**

Pilot proposals for Round 2 are due to CMS no later than July 31, 2014 (CMS anticipates being able to accept proposals as early as July 1, 2014). States will use the PERM Eligibility Tracking Tool (PETT) website to submit Round 2 pilot proposals. CMS will also provide a Word version of the pilot proposal template containing the information states are required to enter on the PETT website should states elect to start developing their proposals prior to July 1. Website instructions and training will be provided prior to the proposal submission period.

States are required to enter their pilot proposal directly on the PETT website. An upload function will not be available and CMS will not accept emailed versions of the template. However, to make the PETT submission process easier, users will be able to save the findings as a draft before submitting a final version to CMS. More information regarding PETT registration will be provided to the states.

Once pilot proposals are submitted to CMS, the review and approval process will be managed through the PETT website. CMS will review and provide comments or approval within 2 weeks. If CMS does not approve the proposal, states will have 1 week to revise the proposal based on CMS comments. If during the course of the pilot reviews states see the need to change their approach, a modification to approved pilot proposal should be submitted to CMS, documenting the necessary changes.

Pilot findings are due to CMS no later than December 31, 2014. Detailed reporting guidance will be issued at a later date.

### **ALERT! Change from Round 1**

States are required to enter the Round 2 pilot proposal directly to the PETT Website. CMS will not accept proposals through email.

## **Caseworker Action Review Requirements**

To evaluate caseworker action, states will pull a random sample of eligibility determinations for review. The caseworker action review will include the State's review of MAGI eligibility determinations from initial point of application/point of transfer to the final eligibility determination. This includes a review of the end to end process as it applies to your State. States

should look at all reviewable actions. Reviewable actions could include review of actual caseworker action as well as review of information available through screen shots of electronic sources that the State is utilizing throughout the eligibility determination process. The sampling and review requirements are provided below.

In the pilot proposals, states should provide information on CMS-approved mitigation plans or strategies, delayed renewal waivers in place, or any other information that impacts the eligibility review process or pilot approach. CMS understands that all states may not be able to comply with all requirements below. In those cases, states should clearly identify those requirements and provide an explanation of the states' limitations in meeting them.

## Sampling Frame

States must construct sampling frames (i.e., universes) from which to draw cases for review. The sampling frames must consist of MAGI-based Medicaid and CHIP eligibility determinations (both active and negative actions) made within the six month review period (April 2014 through September 2014).

For Round 2, in addition to initial eligibility determinations, **the sampling frame must also include MAGI-based redeterminations**. States will be asked to indicate the date that they are implementing MAGI redeterminations in the pilot proposal. If this date is prior to October 2014, the sampling frame must include redeterminations. Conversely, if states are not implementing redeterminations (renewals) until after September 2014, redeterminations are not required to be in the state's sampling frame. However, most states that have delayed implementation of annual renewals for MAGI-based population are acting on changes in circumstances. These States may include redeterminations that are processed as a result of a change in circumstances.

### **ALERT! Change from Round 1**

Round 2 pilot sampling frames must include MAGI-based redeterminations (in addition to initial determinations) if the state is conducting MAGI-based redeterminations during the review period. Round 1 pilots did not include redeterminations.

## Sampling Unit

The sampling unit is a determination (initial determination or redetermination). States may consider using either an individual or a household determination and must specify in their proposal which sampling unit will be used.

The exact definition of determination types could be state-specific. In general, CMS considers the following as reasonable guidelines for defining each determination type for purposes of this pilot:

- Active vs. Negative Determinations
  - Active determination - a MAGI-based determination that approved a new applicant enrollment in Medicaid or CHIP or continued a beneficiary's Medicaid or CHIP enrollment.

- Negative determination - a MAGI-based determination that denied a new applicant enrollment in Medicaid or CHIP or terminated a beneficiary from Medicaid or CHIP.
- Initial vs. Redeterminations
  - Initial determination – a MAGI-based determination where the state took action to determine eligibility based on an initial application. This includes determinations made for applicants that left the program and later reapplied.
  - Redetermination – a MAGI-based determination where the state took action to continue eligibility for a beneficiary or terminate eligibility for a beneficiary. These include annual redeterminations and redeterminations made outside the annual renewal process that are a result of a change in circumstances that require redetermination of eligibility.

The state should define their determinations and include a clear description in the pilot proposal.

### **Sampling Frame Construction**

At a minimum, states must build and sample from three separate sampling frames (i.e. universes):

- Medicaid active determinations
- CHIP active determinations
- Negative determinations

States can sample from additional sampling frames if they choose. For example, states can choose to sample from separate Medicaid negative and CHIP negative sampling frames. States could also sample from separate initial determination and redetermination sampling frames (i.e. Medicaid active initial determinations, Medicaid active determinations, etc.)

For initial determinations, states should ensure the sampling frame only includes determinations that were made by the state Medicaid or CHIP agency (or contracted vendor for CHIP). As such, the sampling frames will differ depending on the state's marketplace model (and delegation authority).

- **Federally Facilitated Marketplace (FFM) determination** states should include only those initial eligibility determinations made directly by the state. Sampling frames should not include any initial determinations made by the FFM and transferred to the state for enrollment.
- **FFM assessment** states should only include initial eligibility determinations made directly by the state. This includes any cases transferred from the FFM for which the state made the final determination.
- **State-Based Marketplace (SBM)** states should include all eligibility determinations made directly by the state regardless of application source.

Cases covering the presumptive eligibility period should not be included in the sampling frame. Presumptive eligibility cases should be included at the point when the state makes a full eligibility determination.

A description of the state's sampling frame should be included in the pilot proposal. This description should indicate how all sampling frame requirements will be met as well as specify

what systems and data sources will be used to develop the sampling frame, how cases will be identified (e.g., aid category), what entity will pull the data, and how the data will be pulled (e.g., SQL query).

**ALERT! Changes from Round 1**

- States must build at least three separate sampling frames (Medicaid active, CHIP active, negative). There is no longer an option to sample from one combined sampling frame.
- Presumptive eligibility cases should only be included in the sampling frame at the point when the state makes a full eligibility determination after the initial presumptive eligibility period ends.

**Timeframe**

States must sample from eligibility determinations made between April 2014 and September 2014. States may choose to sample from smaller timeframes within this six month review period as long as the minimum sample size is met (e.g., State A samples from initial MAGI determinations made during the first week of August 2014 and from MAGI redeterminations made the last two weeks of September 2014; State B samples from all MAGI determinations and redeterminations made in the entire six month period). States can (but are not required to) pull monthly samples as in PERM and MEQC.

Please note that the parameter states should use when developing the sampling frame is the determination date (i.e., decision date) and not the eligibility effective dates. States should be sampling determinations/redeterminations made within a specific timeframe, not individuals eligible during a specific timeframe. For example, State A elects to sample MAGI determinations/redeterminations from the month of August 2014. If recipient X was on the Medicaid rolls during August based on a determination made in January 2014, recipient X should not be included in the sampling frame. State A's sampling frame should only include determinations and redeterminations that occurred in August 2014.

States should indicate, in the pilot proposal, the timeframe of determinations (including initial determinations and redeterminations) from which the state is sampling and when the state plans to begin the sample selection process.

**ALERT! Changes from Round 1**

- Round 2 review timeframe = April 2014 – September 2014
- States must sample determinations/redeterminations made within the review timeframe, not individuals eligible during the timeframe (i.e. develop sampling frame by determination/decision date and not the eligibility dates)

## **Exclusions**

States must exclude certain types of cases from the sampling frame. Required exclusions include:

- Administrative transfers (the facilitating of enrollment through administrative transfers of eligibility data from other programs [e.g., using income data from SNAP to renew Medicaid eligibility], as outlined in the CMS targeted enrollment strategies guidance provided on May 17, 2013. The states must have a CMS approved targeted enrollment strategy to exclude these cases.);
- Cases not matched with Title XIX or Title XXI federal funds including state-only cases;
- Determinations that are not MAGI-based;
- Express lane eligibility cases; and
- Determinations made by the FFM.

Cases under active fraud investigation should not be included in the sample. States should specify if they are able to exclude these cases from the sampling frame or if these cases will be dropped if sampled.

States may propose to exclude other types of determinations from the sampling frame and should include a full description of sampling frame exclusions and reasons for proposing the exclusions in their pilot proposal. For example, States may have identified areas to focus on in Round 2 as a result of Round 1 reviews. It would be reasonable to exclude MAGI categories for which no errors were identified in Round 1 and the likelihood for errors to occur is minimal.

States should also explain how required exclusions will be excluded from the sampling frame in their pilot proposal, providing specific detail on how excluded cases can be identified and how the state will ensure those cases are removed prior to sampling.

## **Stratification**

States may elect to stratify the sampling frame prior to sampling to ensure representation from particular characteristics or to allow focus on potential “problem areas” based on errors found in Round 1 pilots.

Examples of potential stratification approaches are:

- By required pilot analysis
  - Point of application (state agency/delegated entity, transferred from SBM/FFM, renewals)
  - Type of application (single streamlined application, multi-benefit applications)
  - Channel (in person, telephone, online, mail, transferred from marketplaces)
- By initial determinations vs. redeterminations
- By areas that had issues identified in Round 1 of the pilots

If stratifying, states should include a description of their stratification approach in the pilot proposal. For states that stratify, information in the sampling methodology section should reflect stratification.

## Quality Control Procedures

States are expected to perform some quality control checks on the sampling frame to ensure completeness and accuracy. Some examples of quality control checks include (but are not limited to):

- Select a preliminary test sample to ensure excluded cases have been removed from the universe;
- Compare total count of pilot determinations in the sampling frame (and total count of pilot determinations in each stratum, if applicable) against existing benchmarks to assess reasonableness and completeness prior to sampling; and
- Review sampling frame totals (and strata totals, if applicable) in each month of the sampling timeframe to identify inconsistencies from month to month.

States should include a description of sampling frame quality control procedures in their pilot proposal.

## Sampling

### Sample Size

The minimum sample size is 200 determinations. This minimum sample size is for the entire six month review period of the Round 2 pilot to be reported in December 2014 and is inclusive of Medicaid, CHIP, active determinations, negative determinations, initial determinations, and redeterminations.

States can choose to and are encouraged to sample more than the minimum amount of determinations. In the pilot proposal, states are required to specify the sample size to be pulled from each sampling frame (i.e., universe) and explain how the state determined the sample size for each sampling frame. Therefore, at a minimum, the state must provide the sample size for their Medicaid active, CHIP active and negative sampling frames. If a state is using additional sampling frames (e.g. separate sampling frames for initial determinations and redeterminations), they must report a sample size for each sampling frame.

There is no proportional requirement as in Round 1. However, it is important that states fully explain how they determined their sample sizes in the pilot proposal and specify how both Medicaid and CHIP are appropriately reflected in the sample so CMS can evaluate for reasonableness.

### **ALERT! Changes from Round 1**

- No sample size requirements for timeframes within April 2014 – September 2014 (i.e. the sample size from April – June does not have to equal the sample size from July – September)
- No requirement for the Medicaid and CHIP sample sizes to be proportionate to the number of determinations for each program

## **Sampling Methodology**

States must utilize a random sampling methodology. For example, states can use a simple random sample or the “skip” factor method. States should include a description of their sampling methodology in the pilot proposal.

Oversampling is not required but states choosing to sample the minimum 200 may need to oversample to meet the minimum 200 if a case is dropped after the sample is pulled.

## **Reviews**

### **Case Review Overview**

States should be performing an end to end review of MAGI eligibility determinations from initial point of application/point of transfer to the final eligibility determination. States should look at all reviewable action, including review of actual caseworker action as well as review of information available through screen shots of electronic sources that the State is utilizing throughout the eligibility determination process.

Review requirements, at a minimum, are listed below:

- Medicaid and CHIP should be reviewed as separate entities.
- Reviews should look at all reviewable action, including review of actual caseworker action as well as review of information available in the electronic account or through screen shots of electronic sources that the State is utilizing throughout the eligibility determination process.
- Reviews should take into consideration state policies, state verification plans, federal requirements, and approved mitigation strategies.
- Reviews should include an assessment of any action performed by the caseworker in determining eligibility including discrepancies or inconsistencies identified in the automated process. For example, the state’s system identifies a discrepancy in the application. The application would be pulled from the system and the caseworker would review/clear the application. After the caseworker reviews/clears the application, it would be entered back into the automated process. The review would include the actions the caseworker took while reviewing/clearing the application.
- Reviews should include an evaluation of whether information received was used correctly and state policies were accurately followed. For example, if a state verification plan says the state will verify an aspect of eligibility using certain data sources, the review should include a check to ensure the caseworker acted in accordance with the verification plan or an approved mitigation strategy.
- Reviews should include all elements necessary to evaluate correctness of overall program eligibility as well as eligibility category. Reviews should also address the specific questions listed below.
- Reviews should allow states to report on all elements specified in the reporting section below.

If state and federal requirements allow for self-attestation of an eligibility factor, the reviews do not have to independently verify that information, although states may choose to do so. Although

not required, states may choose to perform a more robust review and look beyond caseworker action as long as that review is within federal regulations.

## **Errors**

For purposes of these pilots, states should consider a determination to be in error if the answer to question #1 below is “no.” States should identify a deficiency if the answer to any of the questions #2 – 9 below is “no” but the decision about program eligibility was correct. States will need to report on and develop corrective actions for both errors and deficiencies.

- 1. Was the decision about program (i.e. Medicaid or CHIP) eligibility correct?** The answer to this question should be no if an individual was:
  - determined eligible for Medicaid but should have been eligible for CHIP or not eligible at all
  - determined eligible for CHIP but should have been eligible for Medicaid or not eligible at all
  - determined not eligible for Medicaid or CHIP but should have been eligible for Medicaid or CHIP
- 2. Was the decision about eligibility group correct?** States should review for appropriate group and subcategories of coverage as applicable to the state. This review should also ensure the correct hierarchy was used when placing the individual in their eligibility category (e.g. individuals were not placed in the new adult group if eligible for any other group).
- 3. If the decision has been finalized and eligibility denied, was the case transferred to the FFM appropriately?**
- 4. If the decision has been finalized and eligibility denied, have appropriate notices been sent?**
- 5. In assessment states, if the application was transferred from the FFM, were there appropriate steps taken to ensure appropriate reuse of information?** The review should include confirmation that information obtained from the FFM is used in the determination process in accordance with Medicaid and CHIP regulations and a state’s verification plan.
- 6. Did the state conduct verifications in accordance with its verification plan?** The review should include a determination of whether or not appropriate attestations/verifications were made for data collected in the application/renewal as identified in the state’s verification plan. The review should determine whether or not any additional information sought from the applicant/beneficiary was properly requested based on attestation/verifications or existing data and utilized properly.
- 7. Based on the information supplied, attested and verified, was the household composition for the applicant properly established?** The review for this element should include examination of the tax filing status.

- 8. Based on the information supplied, attested and verified, was the income level for the applicant properly established?**
- 9. Based on the information supplied, attested and verified, was the citizenship or immigration status for the applicant properly established?**

States are only required to conduct a payment review for errors related to question #1 where the decision about program eligibility was not correct (see payment review section below).

States have flexibility in determining the classification of errors and deficiencies. States are encouraged to develop codes specific to the state's review process to classify errors and deficiencies. States should keep in mind that they will need to report on all analysis and discussion questions listed in the guidance.

**ALERT! Change from Round 1**

Definition of an error = if the answer to questions #1 listed above is "no"  
Definition of a deficiency = if the answer to any of the questions #2 – 9 above is  
"no"

**Pilot Proposal Requirements**

States are required to include the following in their round 2 pilot proposals:

- A general description of the review process – This description should indicate the staff conducting the review, what information they will access, how they will access that information, how they will be assigned cases, how they will capture and record review results, and so forth.
- A description of how the reviews will be conducted – This description should indicate the reviewable actions the state will be reviewing and how they will be reviewed.
- A description of what the state will review for each required question – For each of the questions #1-9 above, the state will need to indicate what process the state will use and what information the state will access to review for that question.
- A description of additional elements the state will review for – This description should indicate all other elements the state is reviewing for in addition to questions #1-9. Detail should also be provided on how states will review for other required reporting elements described in the reporting section below including analysis by point of application, type of application, and channel (i.e. how these characteristics are captured and recorded during the review process).
- Clear description of how errors and deficiencies will be identified and classified – this description should indicate what codes will be used and what errors/deficiencies will fit into each code for both active and negative determinations.

States that are utilizing a case review checklist/worksheet are encouraged to submit this document to the CMS pilot email box (listed below) to supplement their proposal (but not in lieu of their proposal).

### **Payment Reviews**

States are required to conduct a payment review to identify improper payments. At a minimum, this payment review must report payments made for active case errors where the decision about program eligibility was incorrect. States should specify the timeframe of payments that are being collected for errors in their pilot proposal. Examples of possible approaches include:

- State A is sampling determinations made in August 2014. For any ineligible active cases, State A will collect payments for services received in September 2014 and paid before November 30, 2014.
- State B is sampling determinations made in August 2014. For any ineligible active cases, State B will collect any payments made by October 31, 2014 for any services received after the determination date.

Since the purpose of these pilots is not to calculate an annual error rate as in PERM, the payment review timeframe does not have to equal the sampling timeframe (i.e., if you sample a determination made in April 2014, you don't have to look at April 2014 payments for that recipient).

States may also choose to conduct a more comprehensive review of all active cases to identify payments in error due to recipient liability being over/understated, ineligible services, etc.

States do not need to model the payment review after the previously used PERM and MEQC reviews. States may choose their own payment review strategy and are required to describe their payment review methodology in their pilot proposal.

While the reviews must verify the recipient was placed in the correct eligibility group/category, states are not required to verify that the correct federal match was claimed. However, states do have the option to expand the scope of the pilots to include this type of review (i.e., states are not required to verify claiming 100% Federal Financial Participation (FFP) for newly eligible individuals in the new adult group but may choose to do so).

#### **ALERT! Change from Round 1**

At a minimum, states must conduct payment reviews for errors related to question #1 where the decision about program eligibility was not correct

### **Quality Control**

States are required to implement quality control measures to ensure accuracy of the reviews and to describe such measures in the pilot proposals. Examples of such measures would be performing a re-review on 10% of the sampled cases, on all errors, etc.

## **Reporting Results**

Pilot results are due no later than December 31, 2014.

CMS will issue more detailed reporting and corrective action guidance including a reporting template at a later date. States will not submit monthly case by case review findings as required in PERM, but instead will submit final findings and corrective actions to CMS. States will be required to confirm that the reported results are accurate and specify the state staff member designated to attest to the accuracy of the results.

So states can design pilots that lead to the required results, reporting requirements for the caseworker action reviews are included below.

### **Overall Numbers and Results**

States must provide the following figures broken out by initial determinations and redeterminations:

- Number of Medicaid active cases reviewed
- Number of Medicaid active cases correct
- Number of Medicaid active cases in error
- Number of Medicaid active cases with a deficiency
- Amount of Medicaid improper payments identified
- Number of Medicaid negative cases reviewed
- Number of Medicaid negative cases correct
- Number of Medicaid negative cases in error
- Number of Medicaid negative cases with a deficiency
- Number of CHIP active cases reviewed
- Number of CHIP active cases correct
- Number of CHIP active cases in error
- Number of CHIP active cases with a deficiency
- Amount of CHIP improper payments identified
- Number of CHIP negative cases reviewed
- Number of CHIP negative cases correct
- Number of CHIP negative cases in error
- Number of CHIP negative cases with a deficiency

### **Analysis and Discussion**

States must include a discussion/analysis of the types of errors and deficiencies identified. States must provide analysis of errors and deficiencies by the following:

- Point of application (e.g., state agency/delegated entity, transferred from FFM, renewals)
- Type of application (e.g., single streamlined application, multi-benefit application)
- Channel (e.g., in person, telephone, online, mail, transferred from marketplace)

Point of application analysis must include discussion of applications received at state agencies/delegated entities (cannot just focus on transfers) and channel analysis must include discussion of in person and online.

States must report analysis on **all** points below:

- Was the decision about program eligibility correct?
- Was the decision about eligibility group correct?
- What improper payments were incurred due to associated case errors?
- If the decision has been finalized and eligibility denied, was the case transferred to the FFM appropriately?
- If the decision has been finalized and eligibility denied, have appropriate final notices been sent?
- In assessment states, if the application was transferred from a FFM, were appropriate steps taken to ensure reuse of application and verification information?
- Did the state conduct verifications in accordance with its verification plan?
- Based on the information supplied, attested and verified, was the household composition for the applicant properly established?
- Based on the information supplied, attested and verified, was the income level for the applicant properly established?
- Based on the information supplied, attested and verified, was the citizenship or immigration status for the applicant properly established?

### **Corrective Actions**

For errors and deficiencies identified through the pilots, states are required to discuss corrective actions to avoid such errors/deficiencies in the future. States should describe the corrective actions that the state will implement and how these actions will reduce or eliminate errors/deficiencies. For each corrective action, the state should discuss with as much detail as possible (at a minimum):

- What state key personnel and components will be responsible for implementing the corrective action?
- Identify how the root cause of the error will be addressed with the corrective action
- Details on the action to be taken, providing a step-by-step process, where applicable. States should identify the specific actions that will be taken (e.g., systems changes, new and/or updated trainings, policy clarifications)
- The corrective action implementation dates and the expected due dates for resolving problems
- Expected results of the corrective action and how the state plans to monitor the effectiveness of the corrective action
- Any other corrective action information CMS should know

While states must discuss corrective actions for errors, it remains the state's decision on which corrective actions to implement to decrease or eliminate errors/deficiencies. States are encouraged to use the most cost effective corrective actions that can be implemented to best correct and address the root causes of the errors/deficiencies. If the state determines that the cost of implementing a corrective action outweighs the benefits, then the final decision of

implementing the corrective action is the state's decision. In cases where the state chooses not to implement an action, the cost benefit analysis and the final decision should be included as part of the corrective action discussion.

Along with the Round 2 results and corrective actions, states are also required to provide an update on the Round 1 corrective actions, including an evaluation of the effectiveness of the corrective actions.

**ALERT! Change from Round 1**

States will need to report on and develop corrective actions for both errors and deficiencies.

## **Recoveries**

States are not required to refund the FFP for errors identified through these eligibility pilots. For errors identified through another audit or through other means outside of these pilots, states are subject to disallowances under the Medicaid recoveries regulation.

## **Staffing and Administrative Matching**

States can utilize state staff (including existing MEQC/PERM review staff) or contractors to fulfill pilot requirements. If states use state staff for review, the state agency responsible for conducting the pilot reviews must be independent of the state agency that makes eligibility determinations (similar to the current PERM/MEQC independence requirements). The agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews must be functionally and physically separate from the agency and personnel that are conducting the eligibility review pilots. The staff responsible for eligibility policy and making eligibility determinations must not report to the same direct supervisor as the staff conducting the eligibility pilots. States are required to describe how the agencies maintain independence in the pilot proposal.

Administrative matching should be claimed under PERM for Medicaid and CHIP according to the sample size from each program. States should claim as they normally would for the PERM program. As specified in the Affordable Care Act: State Resource FAQ at <http://www.medicare.gov/state-resource-center/FAQ-medicare-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicare.pdf>, the enhanced funding for Medicaid eligibility systems operation and maintenance does not apply to PERM activities which are considered program integrity activities and eligible for the 50 percent FFP for Medicaid and 90 percent FFP for CHIP.

## Questions

Please submit all questions to [FY2014-2016EligibilityPilots@cms.hhs.gov](mailto:FY2014-2016EligibilityPilots@cms.hhs.gov).