Medicaid and CHIP Eligibility Review Pilot Guidance

Pilot: 3rd Round
Issued: January 2015- Updated

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 third round of pilots. Guidance for subsequent pilots will be released at a later date.

Similar to Round 2, the Medicaid and CHIP Eligibility Review Pilots consist of two independent components, the case review component and the test case component. States are required to:

1. Case Review Component: 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 'case review')
2. Test Case Component: Run test cases (provided by CMS) through the UAT section of the state's eligibility determination system.

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 3 pilot proposals for the case review of state eligibility determinations follows below.

Round 3 Overview

CMS made significant changes to the guidance from previous rounds. States should not continue pilot processes from Rounds 1 and 2. Specific differences in Round 3 requirements include:

- Review of determinations (initial and redeterminations) made October 2014 through March 2015;
- Inclusion of non-MAGI determinations in addition to MAGI determinations for review;
- Minimum sample sizes for certain types of determinations. States must review at least 20 non-MAGI Medicaid active determinations, 65 MAGI Medicaid active determinations, 85 CHIP active determinations, and 30 total Medicaid and CHIP negative determinations;
- Assignment of a case ID number to each reviewed determination using CMS-defined logic;
- CMS-defined error codes and findings codes;
- Detailed direction for elements to review instead of general review questions;
- Requirement to review notices for active cases in addition to negative cases; and
- Reporting findings for each individual case reviewed.

Eligibility Support Contractor (ESC) Pilots

States participating in the ESC pilots will not need to submit a Round 3 pilot proposal as the ESC pilots will serve as the Round 3 case review pilots. However, ESC pilot states are still required to:

- Run and report on test cases for Round 3 (Guidance to follow separately); and
- Provide updates to Round 2 case review corrective actions.

Due Dates

Pilot proposals for Round 3 are due to CMS no later than February 28, 2015. States will use the PERM Eligibility Tracking Tool (PETT) website to submit Round 3 pilot proposals using the same process as Round 2. In general this process entails:

- Word versions of the pilot proposal can be used for draft versions but CMS will not accept pilot proposals via email and a PETT upload function will not be available.
- Once pilot proposals are submitted, 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.

Per the SHO letter, pilot findings are due to CMS no later than June 30, 2015. However, due to the timing of the release of this guidance and the number of changes made from Round 2, CMS will allow states to submit pilot findings as late as August 31, 2015. Detailed reporting guidance will be issued at a later date.

Overall Requirements

To evaluate the accuracy of the eligibility determinations, states will pull a random sample of cases for review. States should follow the sampling and review requirements provided below.

In the pilot proposals, states should provide information about 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 that meet the below requirements. The sampling frames should include Medicaid and CHIP determinations (including MAGI, non-MAGI, active, negative, redeterminations, and initial determinations) made October 2014 through March 2015.

ALERT! Change from Round 2

Non-MAGI determinations are included in Round 3

Sampling Unit
The sampling unit is an individual determination. There is no option to sample at the household level in Round 3.

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

- Active vs. Negative Determinations
  - Active determination – determination that approved a new applicant enrollment in Medicaid or CHIP or continued a beneficiary's Medicaid or CHIP enrollment.
  - Negative determination - determination that denied a new applicant enrollment in Medicaid or CHIP or terminated a beneficiary from Medicaid or CHIP
- Initial vs. Redeterminations
  - Initial determination – evaluation of eligibility based on an initial application. This includes determinations made for applicants that left the program and later reapplied.
  - Redetermination –evaluation of continued eligibility for a beneficiary or termination 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.
- MAGI vs. Non-MAGI Determinations
  - MAGI determination – determination of eligibility based on modified adjusted gross income and other ACA-related assessment and verification rules apply when determining eligibility.
  - Non-MAGI determination – determination for all other eligibility categories for which modified adjusted gross income is not the standard for determining eligibility. These are the aged, blind, and disabled eligibility groups.

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

ALERT! Change from Round 2

States are required to sample at the individual level. There is no option to sample at the household level.

Sampling Frame Construction
The following determination types must be included in state sampling frames for Medicaid and CHIP:

- Initial determinations
- Redeterminations
- MAGI determinations
- Non-MAGI determinations
- Active determinations
- Negative determinations

States must include initial determinations from all types of applications, points of application, and channels applicable to the state.

States have flexibility to determine how many sampling frames to build as long as all required determinations types are included and the state reviews the minimum number of non-MAGI Medicaid active determinations, MAGI Medicaid active determinations, CHIP active determinations, and Medicaid and CHIP negative determinations as described in the sampling section below. The state can determine what sampling frame and sampling strategy (e.g. stratification) is used to meet these minimum requirements.

Sampling frames should only include determinations that were made by the state Medicaid or CHIP agency (or contracted vendor for CHIP). As such, the inclusion/exclusion of some initial MAGI determinations may differ depending on the state's marketplace model (and delegation authority). Marketplace model, however, will not have an impact on the inclusion of redeterminations or non-MAGI determinations.

- Federally Facilitated Marketplace (FFM) determination States: Because the state has delegated the authority to make MAGI-based eligibility determinations to the FFM, for individuals who apply via the FFM, the sample should NOT include determinations made by the FFM where the determination was finalized by the FFM and transferred to the state for enrollment. The sample MAY include applications that were referred to the states by the FFM for final determination because the applicant had an inconsistency between attested information and verification information available to the FFM. For these applicants, the state will make the final eligibility determination after it resolves the inconsistencies.
- FFM assessment and State-Based Marketplace (SBM) States: States should include all initial eligibility determinations made by the state regardless of the 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.

Reminder!
Presumptive eligibility cases should be included at the point when the state makes a full eligibility determination

States will be required to define each determination type and include how each determination type will be identified (e.g. specific codes; not identified until sampled category, etc.). States must list their sampling frames and explain what determination type will be in each. States must list the data sources used, who will pull the data and how data will be pulled (e.g., SQL query):

ALERT! Change from Round 2

FFM-D states may include applications that were referred to the states by the FFM for final determination after the state resolves any inconsistencies and state makes the final eligibility determination of the application.

Timeframe

Reminder! States must sample determinations made within the review timeframe

States must sample from eligibility determinations made between October 2014 and March 2015. States may choose to sample from smaller timeframes within this six month review period.

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.

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! Change from Round 2

Round 3 review timeframe = October 2014 – March 2015

Exclusions

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

- Administrative transfers;
- Cases not matched with Title XIX or Title XXI federal funds including state-only cases;
- Express lane eligibility cases;
- Determinations made (and finalized) by the FFM;
- Cases in a presumptive eligibility period (before state has made a full eligibility determination);
- SSI Cases (only for states with SSA agreement under section1634 Social Security Act)
- Title IV-E (Foster Care and subsidized adoption).

A description of how the state will identify exclusions for removal prior to sampling must be included in the pilot proposal.

Alert! Change from Round 2

States must exclude
SSI cases (in 1634 states only) and Title IV- E (Foster Care and subsidized adoption) cases

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.

Quality Control Procedures
States are expected to perform quality control checks on the sampling frame to ensure completeness and accuracy. States should include a description of sampling frame quality control procedures in their pilot proposal. 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 the 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.

Sampling

Sample Size
States must sample a minimum of 200 total determinations for review. Additionally, states must sample a minimum number of the following types of determinations for review:

Determination Type	Minimum # Reviewed
Medicaid Active	**85**
Non-MAGI	*20*
MAGI	*65*
CHIP Active	**85**
Negative *(includes both Medicaid and CHIP)*	**30**
Total	**200**

States must review at least 85 Medicaid active determinations (determinations include both initial and redeterminations). At least 20 of those Medicaid active determinations must be non-MAGI and at least 65 must be MAGI. States must review at least 85 CHIP active determinations (including both initial and redeterminations) and at least 30 negative determinations (Medicaid and CHIP combined). **The 30 negative determinations cover CHIP denials and terminations, and Medicaid MAGI and non- MAGI denials and terminations.**

States can choose to and are encouraged to sample more than the minimum amount of determinations. States will be required to confirm that they will review the minimum number of each determination type. Proposals should include an explanation of the state's approach for meeting the minimum requirements for each determination type. If a state is unable to meet any of the above sampling size requirements, the state is required to provide a detailed explanation in the pilot proposal.

ALERT! Change from Round 2

Minimum sample sizes are required for non-MAGI Medicaid active, MAGI Medicaid active, CHIP active and negative determinations

Sampling Methodology

States must utilize a random sampling methodology. Oversampling is not required but states choosing to sample the minimum number of determinations may need to oversample to meet the minimum sample size requirements for each determination type if a case is dropped after the sample is pulled.

Reviews

Case Review Overview

The purpose of the case review is to evaluate the accuracy of the eligibility determination and identify errors and deficiencies in the eligibility determination process. The case review process should assess whether caseworkers and all automated and manual processes followed state procedures (i.e. state verification plan), state policies, and federal policies while making the eligibility determinations. Case reviews should identify errors and deficiencies related to case worker and automated system processes that are utilized for making the eligibility determinations. The focus should be on whether a determination was made appropriately, according to state and federal policies, and to ensure that appropriate processes were followed.

Eligibility determinations should be reviewed in accordance with the state's CMS-approved State Plan, state regulations, state eligibility manuals, agency policy and procedural manuals, verification plans, approved waivers, other state documents or directives that reflect current policy and procedure, and Federal guidance (e.g., federal laws and regulations, State Health Official and Medicaid Director Letters).

To assist the pilot case review staff in conducting thorough reviews, a variety of other key staff should participate, including:

- **Eligibility Policy staff** who are familiar with how the state interprets both federal and state policy and are aware of what policy was in place when the determinations under review were made
- **Eligibility/Caseworker staff** who are familiar with the caseworker processes and workflow, as well as how information is maintained (e.g., accessing case records)
- **Systems staff** who are familiar with how the system processes cases and interacts with other systems (e.g., third party data sources)

While the pilot case review staff should be independent of the staff responsible for making eligibility determinations, the expertise of this staff will be critical in assisting the state pilot review staff in reviewing determinations in accordance with state processes and policies.

Preliminary Review/Information Collection

The pilot case review staff should first collect necessary background information on each case sampled for review. The review should:

1) Identify whether the case is active or negative.

2) Identify whether the case is Medicaid (Title XIX funds) or CHIP (Title XXI funds) (or would have been Medicaid or CHIP). For negative cases, if unable to specify whether Medicaid or CHIP, states should assign all negative cases to one program and specify how negatives are identified in pilot proposal.
3) Identify the eligibility category for the case, including whether it is a MAGI or non-MAGI case (or what the case would have been if eligibility had been granted or extended).
4) Identify if the case is an initial or redetermination.
5) Identify the point of application (e.g. state agency/delegated entity, transferred from FFM, renewals)
6) Identify the type of application (e.g., single streamlined application, multi-benefit application)
7) Identify the channel (e.g., in person, telephone, online, mail, transferred from marketplace)

Assignment of Case ID

After collecting the necessary background information on the sampled case, the reviewer should use the information to assign a Case ID. States are required to assign a unique Case ID number to all cases reviewed. Although states may have created their own state-specific Case ID numbers, states will be required to assign Case ID numbers using the format specified below for reporting. States will be required to report results on all cases reviewed in Round 3; not only the cases identified with error findings as in the previous rounds. Case ID's should be assigned using the following logic:

The Case ID number should be 9 digits and assigned using the following logic:

1	2	3	4	5	6	7	8	9
State Abbreviation		Budgeting Methodology	Program	Active vs. Negative Determination	Initial vs. Redetermination	Sequence Number		
Standard postal 2 character state abbreviation		M=MAGI N= Non-MAGI	M = Medicaid C = CHIP	A = Active N = Negative	I = Initial Determination R = Redetermination	3 digit sequence number assigned by the state to ensure each case has a unique case ID		

*Example: **ALMMAI003** decodes to:*

State: AL = Alabama
Budgeting Methodology: M= MAGI
Program: M = Medicaid
Active vs. Negative: A = Active
Initial vs. Redetermination: I = Initial
Sequence number = 003

ALERT! Change from Round 2

States are required to assign a unique Case ID number to all cases reviewed.

Case Review Requirements

After collecting the necessary background information on the sampled case, the pilot review staff should begin conducting eligibility reviews considering state and federal policy to identify the accuracy of the eligibility determinations as well as internal and external processes that, while not resulting in eligibility determination errors may result in deficiencies, need to be addressed through corrective actions.

The eligibility case review should focus on whether the caseworker made the correct decision based on information available to the caseworker at the time of the decision. This pilot should also review whether the caseworker took appropriate actions to guide the case through the system and the system appropriately processed case information. Further, the review should include an evaluation of whether the case decision was made appropriately by system edits and whether the appropriate information was verified through the applicable data sources.

To address these considerations, the reviewer should take the following actions:

1) Review each case for all required eligibility criteria to confirm that the state made the appropriate determination of eligibility given information available on the application, through trusted third party data sources, and via hard copy documentation, as applicable. States should review criteria against state and federal policies.
    a. For system actions where calculations (e.g., income, household composition) were conducted as part of the determination, independently review the information used by the system and determine that calculations were done correctly. The reviewer should manually calculate income and household composition to evaluate whether the calculation performed by a caseworker or system was correct.
    b. For systems actions where third party data was used to verify self-attested information that was included on application, review system actions/interactions to determine if the appropriate data source were utilized according to the state's verification plan and other state and federal policies.
2) Determine whether the eligibility determination for program coverage (Medicaid or CHIP) was correct or incorrect.
    a. If active and correct, determine whether the individual was placed into the correct eligibility category.
    b. If negative and correct, determine whether the individual was appropriately transferred to the SBM or FFM.
3) For systems actions where information was received from an outside entity, review systems actions to determine if the information entered the system appropriately and timely.
4) When processing was transferred between the system and a caseworker, review whether that transfer happened timely and appropriately. State should report findings if transfer between caseworker and system should have occurred but did not.
5) Determine whether the eligibility determination was made within the allowable timeframes.
6) There are situations where the information in the case file and/or system does not provide enough information to complete the active or negative case review. States should first

attempt to build case record using other electronic sources. If the attempt to rebuild case is not successful, and information that is still missing from the case file and/or not available through other data sources/system, it may be appropriate to contact the client, as a last resort, to obtain the needed information.

Below are some examples of situations where it may be appropriate for reviewer to contact client for needed information:

- Applications or redetermination forms submitted to the state agency were not present in the case file. Therefore, what the client self-attested at the time of application or redetermination is not available for the pilot review.
- The electronic data matching did not meet compatibility thresholds (income) or did not pass criteria standards (citizenship/immigration status) and documentation was not in the case file to verify the element. Similarly, the household self-attested income and the electronic data source did not meet the reasonable compatibility standard, and the worker did not take any action to resolve the discrepancy.
- Information was identified as received (such as in case comments) but the documentation was not present in the case files.
- For non-MAGI cases, information was requested to verify assets (funeral accounts, investments) and income (pensions) that were either identified in the application or where sources such as SOLQ inquiries where it indicates payment is made to an asset account but no documentation, per state and federal policy, is present in the case file.

If reviewer is unsuccessful in obtaining requested information, the state should report the case as undetermined. States will be required to report the specific root cause of the undetermined findings (i.e. why the documentation was not present in the case file) and provide appropriate corrective action.

Below is an example of situation where states should **not** contact the client for information:

- If the information is not missing but unavailable to the reviewer (e.g., information was accessed through a third party data source but state does not require the exact information to be documented in the eligibility system) the state reviewer should not contact the client for information.

Reviews should include all elements necessary to evaluate correctness of overall program eligibility as well as eligibility category. The state's case review should be a comprehensive review that includes all of the elements described below and any additional elements that the state uses to determine the appropriate program eligibility and eligibility group and a review of the eligibility determination process. At a minimum, the eligibility criteria in Table A below should be considered when reviewing cases for the accuracy of eligibility determinations. States should also include information for any additional review elements that are not included in the chart below.

For each of the eligibility criteria listed, states are required to provide the following information in the pilot proposal:

- What information from the case record will be reviewed?
- What information from eligibility screen will be reviewed to verify appropriate eligibility determination process was followed?
- How will compliance with verification plan be reviewed?
- Any other review process for eligibility criteria not listed.

States should be clear in the proposal that the criteria review information submitted will thoroughly address all aspects of the eligibility determination process. States can provide lists of general information that will be reviewed for each eligibility criteria (element). States should not provide a detailed list of every possible source of information.

Please note that all elements may have different implications for Medicaid vs. CHIP or MAGI vs. non-MAGI cases. Similarly, not all required review elements apply to both active and negative cases or to both initial determinations and redeterminations.

Table A: Review of Eligibility Criteria (Elements)

Eligibility Criteria (elements)	Considerations
Income	Was the state's reasonable compatibility standard, as specified in the verification plan, followed?
	Were income calculations correctly made based on MAGI vs. non-MAGI status?
	Was the individual placed in the appropriate eligibility group based on income?
Residency	Was residency verified in accordance with state policies, including the state verification plan?
Age (Date of Birth)	Was age verified in accordance with state policies, including the state verification plan?
	Was the individual placed in the appropriate eligibility group based on age?
	Was the individual placed in managed care or managed care plan based on age?
Gender	Was the individual placed in the appropriate eligibility group based on gender?
Social Security Number/Identity	Were state and federal policies followed in verifying the applicant's identity?
Citizenship and Immigration Status	Was citizenship/immigration status verified in accordance with state and federal policies?

	If applicable, did the state appropriately apply the reasonable opportunity period policy?
Household Composition	Was the household composition constructed properly?
	Were all appropriate individuals included and excluded in the household?
Pregnancy Status	Was the individual placed in the appropriate eligibility group based on pregnancy status?
Caretaker Relative	Was the individual placed in the appropriate eligibility group based on caretaker relative status?
Medicare	Was Medicare status determined appropriately?
	Was the individual placed in the appropriate eligibility group based on Medicare status?
Application for Other Benefits	Was individual eligible to apply for other benefits?
Other Coverage	If the state has a waiting period, was the requirement met?
Assets	Were appropriate assets included/excluded from the state's calculation?
	Was the individual eligible based on asset criteria?
	Were assets calculated properly?
Transfer of resources and expenses	Did the state ask for appropriate documentation related to resource transfers?
	Was the individual eligible based on resource transfer criteria?
Medical eligibility requirements	Did the state ask for appropriate medical eligibility documentation?
	Was the individual eligible based on medical eligibility requirements?
Expenses and Deductions	Did the state ask for appropriate documentation for expenses and deductions?
	Was the individual eligible based on expenses and deductions eligibility criteria?
Long-Term Care Specific Information (e.g., look back period assessment, spousal share, Miller Trust, etc.)	Did the state ask for appropriate documentation?
	Was the individual eligible based on long-term care criteria?

In addition to reviewing individual elements as described above, states are also required to review the overall case for correct processing as described in Table B below (at a minimum). The chart below provides a list of review criteria related to the overall process in making eligibility determinations. For each of the eligibility process area listed, states are required to provide information about how state is reviewing to assure correct processes have been followed. States should provide general information in this section. States are not required to provide detailed lists of information.

For each of the processes listed below, the following information should be included in pilot proposal:

- What information from the case record will be reviewed?
- What information from eligibility screen will be reviewed to verify appropriate eligibility determination process was followed?
- How will compliance with Verification Plan be reviewed?
- Any other review process for eligibility criteria not listed.

Table B: Review of Eligibility Process

Process Findings	Considerations
Notices Active and Negative Cases	Were appropriate notices sent for both active and negative cases that included all required and accurate information?
	Were notices sent in a timely manner?
Denial and Terminations Transfers	States utilizing FFM: Were denied cases transferred to the FFM appropriately?
	States utilizing SBM: • For SBM states that do not have shared eligibility system, was denied case sent to SBM for enrollment in a qualified health plan and determination of Advance Premium Tax Credit? • For SBM states with shared eligibility system, was there confirmation that an APTC determination was made?
Transfers from FFM	If the application was transferred from the FFM, was information reused appropriately in accordance with verification plan?
Caseworker/system Transfers	If both system edits and caseworker actions were part of the eligibility determination process, did the caseworker transfer processing back to the system appropriately?
	For system actions where information was received manually from an outside entity, was the information entered into the system appropriately and timely?
Applicant information Requests	If information was requested from the applicant, was such information properly requested based on attestations and verifications, or existing data, and utilized properly in the eligibility determination?
Timeliness	Was case processed within the required state and federal timeframe?

Alert! Change from Round 2

States are required to review notices for timeliness and appropriateness for both active and negative cases.
States are required to review cases for timeliness of case processing within the required state and federal timeframe.

Error Code and Finding Code Overview

States will be required to use CMS specified error codes and finding codes defined in this guidance. For each case reviewed, states must assign an error code as well as any applicable finding codes.

The error code will specify if the sampled case had an incorrect eligibility determination, had a deficiency but the overall eligibility determination was correct, or was a correct case with no issues identified. The finding codes will specify all issues that were found when reviewing the case (e.g. caseworker inappropriately contacted applicant, household composition incorrect) which may or may not have led to an eligibility error.

Only one error code can be assigned to a case but a case can have multiple finding codes. Correct cases should have no finding codes. Errors, deficiencies, and undetermined cases should have at least one finding code.

Reminder!
Only one error code can be assigned to a case but a case can have multiple finding codes. Correct cases should have no finding codes.

Error Codes

States should assign each reviewed case one of the error codes specified below:

Code	Name	Definition	Notes
C	**Correct**	The overall eligibility determination was correct and no issues or problems were identified during the review of the case (i.e. everything was perfect).	No findings codes should be identified on these cases.
D	**Deficiency**	The overall eligibility determination was correct but an issue was identified during the review of the cases that did not impact overall eligibility.	At least one findings code should be identified on these cases.
E	**Error**	The decision about overall program	Includes cases:

		eligibility was incorrect.	• determined to be ineligible for Medicaid or CHIP program coverage • 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 At least one findings code should be identified on these cases.
U	**Undetermined**	Insufficient information available for review to determine if the overall eligibility decision was correct or incorrect.	A case should be cited as "undetermined" only if the agency cannot verify eligibility or ineligibility using the case record documentation or other sources available at the time of review. A missing case record does not automatically make a case "undetermined." At least one findings code should be identified on these cases.

Finding Codes

For each reviewed case states should assign all findings codes that are applicable to the case.

Code	Finding
01	Case not appropriately transferred to the FFM/SBM. Negatives only.

02	Notice not sent upon denial or termination. Negatives only.
03	Notice sent but was not timely or did not contain correct information. Negatives only.
04	Notice of eligibility not sent. Actives only.
05	Notice of eligibility sent but not timely or did not contain correct information. Actives only.
06	Case placed in incorrect eligibility category/group
07	Incorrect household composition established
08	Incorrect income level calculated
09	Assets not calculated correctly (non-MAGI only)
10	Case did not meet medical eligibility requirements (non- MAGI only)
11	Third party data source not utilized as specified in verification plan
12	Applicant contacted before state exhausted all other efforts to verify information
13	State verified element for which self-attestation accepted
14	State did not verify element in accordance with verification plan and other state/federal policies
15	Case not processed within required state and federal timeframes
16	No action taken when reasonable compatibility standard not met
17	Citizenship/Immigration status not verified in accordance with state and federal policies
18	State did not appropriately apply reasonable opportunity period
19	Unable to complete case review due to missing records. Undetermined only.
20	No documentation available in state records/system to confirm third party data sources were verified due to caseworker issue.
21	No documentation available in system to confirm third party data sources verified.
22	Case over income limit
23	Residency not verified in accordance with state/federal policies
24	Age not verified in accordance with state/federal policies
25	Identity not verified in accordance with state/federal policies
26	Medicare/other coverage status not appropriately determined/considered
27	State did not ask for appropriate documentation related to resource transfers. Non-MAGI only.
28	State did not ask for appropriate documentation for expenses and deductions. Non-MAGI only.
29	Case did not meet expenses and deductions eligibility criteria. Non-MAGI only.
30	State did not ask for long-term care specific information appropriately. Non-MAGI only.
31	Case did not meet long-term care eligibility criteria. Non-MAGI only.
32	Case transferred from marketplace and information was not appropriately reused
33	Case processing transfers between caseworker and system did not occur appropriately
34	Information not manually entered into system appropriately/timely
35	Self-attested pregnancy information not appropriately utilized
36	Case was denied/terminated without incorporating information that was provided before the submission timeframe
37	Agency failed to follow-up on inconsistent or incomplete information
38	Agency failed to follow-up on impending changes
99	Other

Alert! Change from Round 2

States are required to assign one CMS-defined error code to each reviewed case. States are also required to assign as many CMS-defined finding codes as applicable to each reviewed case.

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 that the recipient was placed in the correct eligibility group/category, states are not required to verify that the correct federal match was claimed. 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).

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

Originally, pilot results were due to CMS no later than June 30, 2015. However, due to the timing of the release of this guidance and the number of changes made from Round 2, CMS will

allow states to submit pilot findings no later than August 31, 2015. CMS will issue more detailed reporting and corrective action guidance including a reporting template at a later date. States will submit individual case review finding as required in past PERM cycles and will submit final findings and corrective actions to CMS. States will be required to report results for each case reviewed using the uniquely assigned case ID number. 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.

ALERT! Change from Round 2

For Round 3, states will be required to report on all cases reviewed and submit findings spreadsheet in PETT listing results for each reviewed case.

Case-Specific Results

States are required to report results on all cases that were reviewed (not just the minimum number) through the Round 3 Pilot. States will be required to submit a findings spreadsheet (format to be released at a later date) that lists each case ID reviewed along with the results of the review of each case. States will be required to enter one error code for each case and all applicable findings codes for each case. States will also report other case specific information (i.e. channel of application).

Results Narrative and Corrective Actions

States will also be required to submit a narrative with a discussion/analysis of the overall findings as well as a description of corrective actions. This narrative will be based on findings reported in Round 3 pilot. Corrective actions are required for each error and deficiency identified through the Round 3 pilot reviews.

Along with the Round 3 results and corrective actions, states are also required to provide an update on the Round 2 corrective actions, including an evaluation of the effectiveness of the corrective actions.

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.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.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.