DEPARTMENT OF HEALTH & HUMAN SERVICES
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Round 4 Medicaid and CHIP Eligibility Review Pilot FAQs-Updated

Q1 - Round 4 Pilot Guidance specifies that states are not required to sample cases from each month of the review period (April 2015 through March 2016) and may choose to sample a smaller timeframe. My state plans to sample cases from April 2015 to December 2015. Does this timeframe meet the Round 4 requirement?
A1 -Yes, this timeframe meets the Round 4 requirement. However, if a state has implemented any eligibility determination policy, process, or system changes during the review period, CMS encourages states to review determinations made after the change. This would give the state the opportunity to receive feedback on the effectiveness of such changes and prevent errors moving forward. The goal of the pilots is to reduce or eliminate eligibility errors that may have the potential to be identified in future PERM reviews.

Q2 - Our state would like to expand the payment reviews beyond the minimum requirement for this round. Can our state review claims for services received in more than the first month of eligibility and paid up through more than the following two months and/or past April 30, 2016?
A2 - Round 4 Pilot guidance specifies that states are required to conduct payment reviews on active cases where the decision about overall eligibility was incorrect. At a minimum, states are required to collect payments for services received in the first month of eligibility and paid in the first two months of eligibility or by April 30, 2016 (whichever comes first). States have the option to expand the payment reviews including the timeframe as long as the state still meets the reporting due dates. In order to standardize reporting, states should report payment review findings in accordance with the minimum payment review reporting requirements specified in the guidance.

Q3 - Would it be considered a Round 4 Pilot finding if a copy was used as verification for citizenship instead of an original?
A3 - Yes. Under 42 CFR §435.407(i), states can only use originals or certified copies as documentary evidence for citizenship. Using an approved third party data source, such as SSA data, to verify citizenship is also acceptable as long as the system shows that a match occurred and verified citizenship. If documentation was used as evidence for citizenship, the case file should show that an original or certified copy was used (e.g., a caseworker comment). If it does not, the state should report the case as a deficiency.

Q4 - Do states need to review the transfer between the system and the caseworker?
A4 - The states should review the information provided by the applicant and the third party data sources as it moves through the determination and redetermination process from beginning to end. Therefore, the state should ensure that the caseworker uses the information from the system correctly as they do their work to make a determination or redetermination. For example, if a

system generates an alert to a caseworker, such as “new hire” (indicating the client has new income), the state should review that the caseworker followed-up on the alert appropriately.

Q5 - How should the state review Title IV-E cases determined by an outside agency?
A5 - Some children are eligible for Medicaid based on eligibility for another program. Such cases include Title IV-E cases. If a client was determined eligible for Medicaid based on eligibility for Title IV-E foster care, the state should check that the client was enrolled in Title IV-E at the time of the Medicaid determination. For instance, states could contact the department that maintains Title IV-E enrollment to verify enrollment.

Q6 - Should ex parte or “passive” renewal cases be included in the universe? If so, how should they be reviewed?
A6 **–** Cases that are renewed based on information from the case file and third party data sources (also referred to as ex parte or “passive” renewals) should be included in the Round 4 universes. The recommended approach to reviewing these renewals is listed below:

1) Review the renewal to confirm that all required data matches were conducted, including confirmation that reasonable compatibility for income was met (as needed).

2) If the all matches could be conducted and the beneficiary remains eligible, review the notice and confirm that the notice was sent to the client.

    a) Review any responses that may have been submitted by the client to indicate changes. If the client did not respond with any changes, the review is complete. If the client did provide changes, review to ensure that those changes were appropriately reflected in the redetermination process.

3) If the required matches could not be conducted or discrepant information is identified, review the pre-populated renewal notice sent to the client requesting additional information.

    a) Review information provided by the client to ensure it supported the eligibility determination.

    b) If the client did not provide the requested information within the state-specified timeframe (at least 30 days), review to ensure that the state followed the appropriate procedures to terminate the case.

Q7 - How should cases determined eligible for Medicaid or CHIP using targeted enrollment strategies be reviewed for the Round 4 pilot?
A7 - States should review the cases to ensure that they were processed according to the guidelines outlined in State Health Official (SHO) letters #13-003 and 15-001 (available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-15-001.pdf), which describe state plan and waiver options for states to use targeted enrollment strategies. If the state has any questions about how to review cases enrolled using targeted enrollment strategies, please contact CMS at FY2014-2016EligibilityPilots@cms.hhs.gov for further clarification.

Q8 - My state has a question about assigning the GE – Group Error finding code. If the review indicates the person is approved for the correct program and enrolled in the correct

broad category (e.g., Home and Community-Based Services) but the individual was enrolled in the wrong state-specific subcategory (e.g., Older Adult Waiver), should the case be assigned the GE – Group Error finding code?

Q8 - Yes, states are required to review cases to the most specific category that applies to your state (including at the subcategory level) to verify that the individual was enrolled in the appropriate group/category. The Round 4 spreadsheet, when available, will provide a dropdown list of general Medicaid and CHIP group/categories for states to choose from (these general categories are for national-level analysis) and states will also be required to report the state-specific group/category/subcategory case information in a separate column. If this state-specific group/category/subcategory information is incorrect on a case, the case should be reported as a GE – Group Error even if the general category was correct.

Q9- My state sampled a case that is enrolled in a category that is not available on the dropdown list for "General Eligibility Group/Category" (column J). How should our state identify this information?

A9- The majority of cases should fit into one of the group/categories listed. CMS reminds states to report the group/category that the individual is enrolled in and not attempt to specify the "type" of case on the dropdown list of the spreadsheet. For example, a type of case may be a hospital presumptive eligibility (PE) case. This is not the group/category. The group/category for this PE case may be MAGI Medicaid Children Under 19. If the case does not fit into any category/group from the dropdown, states should contact their CMS PERM Eligibility liaison prior to selecting "Other."

Q10- What is the difference between the "*MAGI Medicaid Adult*" and "*MAGI Medicaid Expansion Adult*" choices for General Eligibility Group/Category?

A10- CMS has recently updated the spreadsheet to clarify these options. The *MAGI Medicaid Adults - not newly eligible (*previously, *MAGI Medicaid Adult*) dropdown should be selected for cases where the individual is enrolled in the new adult group but did not meet the requirements of "newly eligible" and is not receiving the enhanced FMAP as "newly eligible". The state should select *MAGI Medicaid Expansion Adults - newly eligible* (previously, *MAGI Medicaid Expansion Adult*) for cases where the state has enrolled the individual in the new adult group as "newly eligible" and the state is receiving the enhanced FMAP rate.

Q11- My state reviewed a case where there was missing information for the reviewer for both citizenship and income. My state was successful in obtaining the necessary documentation to verify citizenship in order to complete the review, but was unsuccessful in obtaining the income verification that was missing in the record. Is our state required to report both of these issues?

A11- Yes, states should report all issues identified in the pilot reviews. Since income verification was not obtained to complete the review, the finding on the case would be reported as "Undetermined". Four qualifiers should be reported for this example:

- For all cases identified as "Undetermined" states should report the primary qualifier as *#20- Documentation missing in the records or no evidence in system that state conducted verification and state was unsuccessful in obtaining missing documentation/information.*

- A secondary qualifier is required to identify the source of missing information. In this case, the qualifier selected would be *#09- Income requirements not appropriately applied*.
- The state should also report the initial issue with missing information for verification of citizenship even though it was resolved. In this case, the third qualifier would be #18- *Citizenship/Immigration status not verified in accordance with state and federal policies.*
- A fourth qualifier reported would be *#21- Documentation missing in records or no evidence in system that state conducted verification but state successfully obtained document/information to complete review*.

Q12- My state has multiple Medicaid categories/groups. The caseworker made a data entry error which caused the client to be eligible for an incorrect Medicaid subgroup, however the client was still eligible for overall Medicaid. Is a Group Error reported only when the General Eligibility Category/Group (column J of the spreadsheet) is determined to be incorrect?

A12- No, this case would be considered a "Group Error". Per the Round 4 Medicaid and CHIP Eligibility Review Pilot Guidance, the client was "enrolled in the correct program (Medicaid), but in the wrong category/group within Medicaid". States should report findings as Group Errors if the individual is enrolled in the incorrect General Eligibility Category/Group or the incorrect State-Specific Eligibility Category/Group or subcategory/subgroup.

Q13- Are states required to review eligibility for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI)?

A13- States should review cases for all categories and all eligibility groups in which the sampled individual is enrolled. If a state reviews a case and finds that the individual is eligible for QMB but not the Aged, Blind and Disabled category, the error would be a reported as a group error. The finding on a case would be reported as an eligibility error only if both categories were incorrect and the individual was not eligible for any other Medicaid category.