Medicaid and CHIP Eligibility Review Pilots

Round 4 Reporting and Corrective Action Guidance

Issued: March 2016

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Background

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. An additional SHO letter, 15-004 was issued on October 7, 2015 to extend the pilot measurement through FY 2017, requiring States to conduct five streamlined pilot measurements over the four year period. The pilot measurement results should be reported to CMS by the last day of June 2014, December 2014, June 2015, June 2016, and June 2017. This guidance is intended for the fourth round of pilots. Guidance for the fifth pilot will be released at a later date.

Guidance for conducting the Round 4 pilot reviews was issued in November 2015. This guidance specifies the reporting and corrective action requirements for the Round 4 pilots due June 30, 2016.

The Medicaid and CHIP Eligibility Pilot reviews consist of two independent components; the case review component and the test case component. This reporting and corrective action guidance is for the case review component only. Guidance for the test case reporting is issued separately.

Round 4 Reporting Overview

Similar to Round 3, states will submit Round 4 pilot results in two parts:

1. States will upload a findings spreadsheet to the PERM Eligibility Tracking Tool (PETT) website – this spreadsheet will provide the results of each individual case reviewed.
2. States will input narrative into fields in PETT – the narrative will provide discussion/analysis of the overall findings, root cause descriptions, and corrective action information. Corrective action information will include updates on corrective actions from previous pilot rounds for ongoing issues as well as resolved Round 3 issues.

PLEASE NOTE: CMS has made important changes to both the spreadsheet and narrative/corrective action reporting requirements since Round 3.

Round 4 changes to the spreadsheet include:

- Updates to the **point of application, type of application and channel** drop down lists in the spreadsheet based on new requirements for Round 4 reviews which include hospital presumptive eligibility and targeted enrollments cases. For more information on these types of cases, please refer to page 9 of Round 4 Pilot Review Guidance.
- States are required to report a **general eligibility group/category** as well as a more detailed **state specific eligibility group/category** for all active cases reviewed.
- An additional "**Finding Code**" was added, and the codes are now Correct, Deficiency, Group Error, Eligibility Error, or Undetermined.

- "**Qualifiers**" are used to describe the issues identified. For deficiencies, group errors, eligibility errors, and undetermined, states are required to report a primary qualifier (i.e., the main cause of a problem). This primary qualifier should be reported in the first qualifier column.
- States have the option to report **up to 4 qualifiers** on the spreadsheet.
- For cases identified as a **Group Error (GE),** states are required to report the appropriate general eligibility group/category and the appropriate detailed state-specific eligibility group/category that the individual **should have** been enrolled in.

Round 4 changes to the Reporting and Corrective Action Guidance include:

- Findings are bucketed into sections based on the revised qualifiers
- Case IDs associated with the qualifiers are prepopulated in Sections 3-10
- The number of cases reported in the previous round for each qualifier will be prepopulated in Sections 3-10 for ease of comparing Round 3 vs. Round 4 findings
- A section for states to provide updates on Round 3 Ongoing Corrective Actions is included below each appropriate Section instead of in one area at the end of the reporting document

Due Dates & Submission

Round 4 pilot findings spreadsheet, along with corrective action information, are due to CMS on June 30, 2016. It is essential that all findings (both the spreadsheet and the corrective action template) are submitted to CMS **no later than** June 30, 2016.

States will use the PETT website to upload the Medicaid and CHIP Eligibility Review pilot findings spreadsheet. PETT will use the individual case information from the findings spreadsheet to prepopulate numbers (e.g. total number of eligibility errors) into the corrective action report on PETT. States will enter their description of the issue and corrective action information directly into the findings narrative section of the PETT website.

CMS recommends that states submit their findings spreadsheet as soon as it is completed, though the corrective action template may not be complete. This will allow CMS time to review the findings spreadsheet for inconsistencies and provide feedback prior to states finalizing their corrective action information based on these findings. If a state has to make corrections on the findings spreadsheet, the state will have to re-upload it into PETT in order to update the prepopulated numbers in the corrective action template.

Note: The PETT submission is a final report to CMS and is not intended to collect information as reviews are being completed. Therefore, states should not submit their Round 4 findings spreadsheet to PETT until all reviews are complete.

States will receive a 'pending approval' status notification on their findings spreadsheet once it has been reviewed by CMS and there are no further comments. However, states do not need to wait until their findings spreadsheet is pending approval before submitting their corrective action information. Once the corrective action report has been reviewed and approved by CMS, the status of the findings spreadsheet will also be changed to 'approved.'

Note: If the the state is required to make edits to their Round 4 pilot findings spreadsheet and re-upload it to PETT, this will not affect the text already entered into the corrective action report. Rather, this will simply update the prepopulated numbers.

States are required to certify results submitted in PETT. States should specify the name of the state official (State Medicaid/CHIP Director or designee) that is attesting to the accuracy of the findings.

States should plan to complete their pilot reviews well in advance of the reporting due date so that they are able to analyze the results, develop corrective actions that will effectively reduce or eliminate errors and deficiencies, and report those corrective actions to CMS. Oftentimes, the state staff responsible for conducting and reporting on these pilots is not the same staff that has control over implementing necessary corrective actions. Therefore, state pilot staff should plan to work with other components (e.g., systems and eligibility policy staff) within their state as necessary to plan and report on corrective actions.

Webinar trainings and instructions for uploading Round 4 pilot findings spreadsheet and submitting narrative information will be offered prior to the findings due date.

CMS Review and Approval

CMS comments and approval will also be handled through the PETT website. If the spreadsheet and narrative are submitted together, CMS will review and provide comments or approval within two (2) weeks. Similarly, if the spreadsheet or narrative is submitted separately, CMS will review the component of submission and provide comments within two (2) weeks. States will have one (1) week to revise the reporting template based on CMS comments.

Any comments that CMS has on the reporting spreadsheet may have an impact on the state's narrative and vice versa. If a state submits the spreadsheet prior to the narrative, the spreadsheet cannot be approved until CMS reviews the findings narrative along with the spreadsheet. Spreadsheets will get a 'pending approval' status until the review of the corrective action analysis report has been approved.

Round 4 Findings Spreadsheet Instructions
Revised March 2016

Similar to the Round 3 pilots, states will be required to report individual case review findings using a spreadsheet and provide a narrative with a discussion/analysis of the overall findings as well as a description of corrective actions. The narrative will be based on findings reported in the Round 4 pilot. This document provides instruction for completing the Round 4 Pilot findings spreadsheet.

States are required to submit a findings spreadsheet that lists each case ID along with the results of the review. States are required to report results on all cases that were reviewed (not just the minimum number) through the Round 4 Pilot.

Round 4 Findings Spreadsheet Instructions:

General Information

A. Pilot Round: Round 4 (Prepopulated)

B. Determination Review Period: April 2015-March 2016 (Prepopulated)
States will provide the following information:

C. Total Cases Reviewed

States should enter the total number of cases reviewed. This number should match the total number of cases individually reported in the rows of this spreadsheet. This number should also match the sum of the total Medicaid and total CHIP cases reviewed, as reported below.

D. Total Medicaid Cases Reviewed

States should enter the total number of Medicaid cases reviewed.

E. Total CHIP Cases Reviewed

States should enter the total number of CHIP cases reviewed.

Column A – Prepopulated Row Numbers

States are required to report on all cases reviewed for the Round 4 pilot including correct cases. States should enter the results for the review of each case on a separate row of the spreadsheet. Results of the review should include reporting issues identified on that case. The total number of cases reviewed that are specified above in the general information section should match the number of rows of cases reported in the spreadsheet. The spreadsheet provides 1,050 rows for reporting on cases.

Column B - Case ID

States are required to identify all cases reviewed using the case ID logic (9 digits) specified below. Column B should only include information using the 9 digit case ID logic.

Case ID’s should be assigned using the following 9 digit logic:

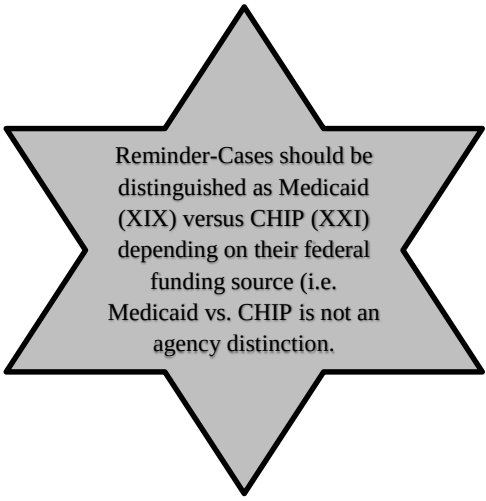
1	2	3	4	5	6	7	8	9
State Abbreviation		Budgeting Methodology	Program	Active vs. Negative Determination	Initial vs. Redetermination	Sequence Number		
Standard postal 2 character state abbreviation		M=MAGI N= Non-MAGI	M = Medicaid C = CHIP	A = Active N = Negative	I = Initial Determination R = Redetermination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

Additional information about assigning case ID logic is available in the Medicaid and CHIP Eligibility Review Round 4 Pilot Guidance. If states are unable to specify whether negative cases are Medicaid or CHIP, states should assign all negative cases to one program and specify how negatives are identified in this pilot. States will provide information in one of the "optional fields" and specify "all negative Medicaid" or "all negative CHIP."

If states have additional state specific logic that is used to identify cases, states have the option of using one of the "Optional Fields" (Columns "X" and "Y") to track this information.

Column C - Program

State will identify each case as "Medicaid" (Title XIX funds) or "CHIP" (Title XXI funds) (or, for negative cases, what they would have been) using the drop-down box provided. 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 this pilot.



Column D - Active or Negative

State will identify each case as "Active" or "Negative" using the drop-down box provided.

Column E - Point of Application

For each case, states should identify the point of application as one of the following options from the drop-down box provided:

- State agency/delegated entity
- Local office/county office
- Transferred from FFM/SBM
- Redetermination
- Hospital presumptive eligibility
- Targeted enrollment
- Unknown
- Other*

These choices are general buckets for national analysis and states should select the most applicable general bucket. This information should be consistent with the state's pilot proposal.
If the point of application is a "sister" agency, the state would select the "state agency/delegated entity" option. States may be working with "sister" agencies and want to track the type or name of the sister agency or other more state-specific points of application for internal use. States may use the "optional fields" (column "X" and "Y") to capture more specific information in this section. CMS encourages states to track any state-specific information needed to be able to develop effective corrective actions.
If a state selects either "Redetermination," "Hospital presumptive eligibility," or "Targeted enrollment" the same selection should also apply to both the type and channel of application.

"Unknown" should only be chosen when a state is unable to capture the point of application information. Similarly, the "Other" option should only be used in instances where cases do not fall into one of the other buckets, but the state is aware of the point of application.

***Please contact your state's CMS PERM eligibility liaison prior to choosing "Other."**

Column F - Type of Application

For each case, states should identify the type of application as one of the following options from the drop-down provided:

- Single-streamlined
- Multibenefit
- Redetermination
- Hospital presumptive eligibility
- Targeted enrollment
- Unknown
- Other*

These choices are general buckets for national analysis and states should select the most applicable general bucket. This information should be consistent with the state's pilot proposal.
If a state selects either "Redetermination," "Hospital presumptive eligibility," or "Targeted enrollment" the same selection should also apply to both the point and channel of application.

"Unknown" should only be chosen when a state is unable to capture the type of application information. Similarly, the "Other" option should only be used in instances where cases do not fall into one of the other buckets, but the state is aware of the type of application.

***Please contact your state's CMS PERM eligibility liaison prior to choosing "Other."**

States may have more specific information about the type of application beyond the drop-down choices available. CMS encourages states to continue capturing whatever state-specific information needed to be able to develop effective corrective actions. States may want to use the "Optional fields" (column "X" and "Y") to capture more specific information in this section.

Column G – Channel of Application

For each case, states should identify the appropriate channel of application as one of the following options from the drop-down provided:

- In-person
- Online
- Mail
- Telephone
- Transferred from FFM/SBM
- Fax
- Redetermination
- Hospital presumptive eligibility
- Targeted enrollment
- Unknown
- Other*

These choices are general buckets for national analysis and states should select the most applicable general bucket. This information should be consistent with the state's pilot proposal.

If a state selects either "Redetermination," "Hospital presumptive eligibility," or "Targeted enrollment" the same selection should also apply to both the point and type of application.

"Unknown" should only be chosen when a state is unable to capture the channel of application information. Similarly, the "Other" option should only be used in instances where cases do not fall into one of the other buckets, but the state is aware of the channel of application.

***Please contact your state's CMS PERM eligibility liaison prior to choosing "Other."**

States may have more specific information about the channel of application beyond the drop-down choices available. CMS encourages states to continue capturing whatever state-specific information needed to be able to develop effective corrective actions. States may want to use the "Optional fields" (column "X" and "Y") to capture more specific information in this section.

Column H – MAGI vs. non-MAGI

States are required to identify cases as "MAGI" or "non-MAGI" by selecting from the drop-down box provided.

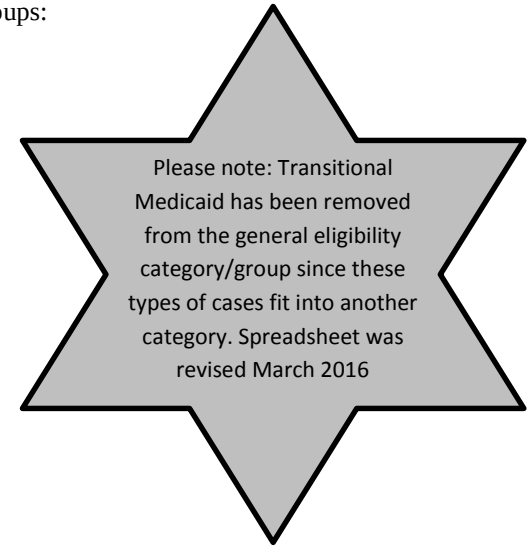
Column I – Case Action

States are required to identify cases as "Initial Determination" or "Redetermination" by selecting from the drop-down box provided.

Column J- General Eligibility Category/Group

This is a **new requirement** in Round 4. States should identify the general eligibility category/group that the individual is enrolled in. This new requirement is only for **active cases.** For each active case, states will identify from the drop-down box one of the following general eligibility categories/groups:

- Aged, Blind, & Disabled
- Home And Community-Based Services
- Long Term Care/Nursing Home
- MAGI CHIP Pregnant Women
- MAGI CHIP Unborn
- MAGI CHIP Targeted Low-Income Children
- MAGI Medicaid Adults-not newly eligible
- MAGI Medicaid Children Under Age 19
- MAGI Medicaid Expansion Adult- newly eligible
- MAGI Medicaid Newborn
- MAGI Medicaid Parent/Caretaker
- MAGI Medicaid Pregnant Women
- QMB
- SLMB
- Other



These choices are general buckets for national analysis and states should select the most applicable general bucket.

***Please note:** If a case is enrolled in more than one general eligibility category/group, states should review to determine that the individual was enrolled appropriately in each of the general eligibility categories/groups. States are required to report the review results for all general eligibility categories/groups. Please select one specific general eligibility category/group from the drop-down box. For the additional general eligibility categories/groups that are identified, please provide the information for those general eligibility categories/groups in the "Optional fields" (Columns "X" and "Y") sections.

Column K- State Eligibility Category/Subcategory/Group

For **active cases only**, states will be required to identify their state specific eligibility category/group, and/or subcategory/subgroup that the individual was enrolled in. States will provide the requested information in the free text field in the spreadsheet. Because the state must select general categories for national analysis in Column J – General Eligibility Category/Group, Column K provides the opportunity for states to identify more specific categories/groups applicable to their state for each active case.

States should identify all state specific eligibility categories/groups that the individual is enrolled in including if they are eligible for more than one eligibility category/group. The state-specific category/group and/or subcategory/subgroup identified in Column K should align with the category/group identified in Column J. If they are eligible for more than one state specific category/group and/or subcategory/subgroup then this information should be included in the "Optional fields" (Columns "X" and "Y") sections.

Column L – Finding Codes

In Round 4, states will report results as "Finding Codes" instead of "Error Codes". States are required to assign one finding code to each case reviewed. States should identify the finding code as "Correct," "Deficiency," "Group Error," "Eligibility Error," or "Undetermined" by selecting from the drop-down box provided. Only one finding code is assigned per case. States should report issues that were identified during the review through separate codes called "Qualifiers." States have the option of reporting up to 4 qualifiers. The instructions for reporting multiple qualifiers are included in the qualifiers section.

Examples:

- A state reviewed a case where the decision about overall program eligibility was incorrect because the case was over the income limit. This case was also not processed within required timeframes. The state would report 'EE-Eligibility Error' as the "Finding Code" since the decision about overall program eligibility was incorrect. The state would report **two qualifiers** on this case and select qualifier 09 - "Income requirements not appropriately applied" as well as qualifier 16 - "Case not processed within required state and federal timeframes, including redeterminations." The state reports both qualifiers because states are required to report findings associated with the case even if the additional findings did not cause the eligibility determination error. The primary cause of the eligibility error would be that the case was over income limits and should be reported as the primary qualifier #1 in Column M.
- A state reviewed a Medicaid active case where the incorrect household composition was established, causing the case to be placed in the wrong eligibility category/group, however, the individual was still Medicaid eligible. The states should report 'GE- Group Error' as the "Finding Code" and report the cause of error (household composition) as the qualifier. The state would report qualifier 06 – "Incorrect household composition established."

States should assign each reviewed case one of the finding 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 qualifier should be identified on these cases.
D	**Deficiency**	The overall eligibility determination and group/category assignment was correct but an issue was identified during the review of the cases that did not	**At least one qualifier** should be identified on these cases. Includes cases:

		impact overall eligibility or the group/category enrollment.	• Overall eligibility determination and group/category assignment correct but issues were identified. • The information is unavailable to reviewer to complete reviews, even when the missing documentation or information is obtained through other sources. **Requires two qualifiers**
GE	**Group Error**	The decision about overall Medicaid or CHIP program eligibility was correct, but the case was assigned to the incorrect group/category.	Includes cases: • Enrolled in correct program (CHIP), but in the wrong category/group within CHIP • Enrolled in the correct program (Medicaid), but in the wrong category/group within Medicaid • This should not be used for cases that are determined eligible for Medicaid but should have been eligible for CHIP or vice versa • This should not be used for cases where decision about overall program eligibility was incorrect **The primary cause of the error should be listed first. At least one qualifier should be identified on these cases.**
AEE	**Eligibility Error**	The decision about overall program eligibility was incorrect.	Includes cases: • 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 but should have been eligible for Medicaid • Determined not eligible for CHIP but should have been eligible for CHIP **One qualifier must be identified on these cases. The primary cause of error should be listed first.**
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." **Two qualifiers should be identified on these cases at a minimum.**

Columns M, O, Q, and S – Qualifiers

States are required to assign qualifiers that are applicable to the erroneously coded case. States are required to use the CMS specified qualifiers listed below. Only one finding code can be assigned to a case but a case can have multiple qualifiers. The spreadsheet will accommodate up to four (4) qualifiers per case (one primary qualifier and 3 additional qualifiers). Cases identified as "Eligibility Errors," "Group Errors," and "Deficiency" should have at least one (1) qualifier identified, and "Undetermined" cases should have at least two (2) qualifiers reported. Please note: For undetermined cases, the first qualifier codes the case as undetermined (Qualifier #20) and the second qualifier explains additional details regarding what information is missing.

Correct cases should have no qualifiers reported because there should be no issues identified if the case is reported as correct.

There may be situations where the findings do not clearly match the available codes listed below. States should assign a qualifier that best fits based on the elements or process reviewed. The qualifier of "other" should only be used for findings related to an element or process reviewed that is not listed in the chart. **The state will be required to provide an explanation in PETT for any findings reported as code 99 – "Other."**

States should report the primary qualifier (main cause of error or deficiency) in Column M (Primary Qualifier 1) using the drop-down list. In the next column, Column N, the state will specify the cause (owner) of the finding. (See next section for additional instructions for Column N). If the state is reporting more than one (1) issue on a case, the additional qualifier should be reported in Column O – Qualifier 2 and report the cause (owner) for as required in next column. States will have the option to report up to four (4) qualifiers and causes (owner) in the additional columns.

Examples:

- State assigned a case as finding code "D-deficiency" since the overall eligibility determination was correct but an issue was identified during the review of the cases that did not impact overall eligibility. One finding was due to assets not calculated correctly for the non- MAGI case but the miscalculation did not result in an incorrect eligibility determination. State should select qualifier 08 –"Assets not calculated correctly (non-MAGI only)." The review also identified another issue that a notice of eligibility was sent but not in a timely manner. State should select additional qualifier 05 - "Notice of eligibility sent but not timely or did not contain correct information. Actives only." States should report both of the issues even though they did not result in an eligibility determination error. States should use their discretion in determining what the primary cause/qualifier is for the Deficiency.

For cases reported as "Eligibility Error," "Group Error," "Deficiency," or "Undetermined" states should assign qualifiers that are applicable to the case as listed below:

Code	Qualifiers
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	Incorrect household composition established
07	Incorrect income level calculated

08	Assets not calculated correctly (non-MAGI only)
09	Income requirements not appropriately applied
10	Spend down policy not applied correctly (non-MAGI only)
11	Case did not meet medical eligibility requirements (non- MAGI only)
12	Third party data source not utilized as specified in verification plan
13	Applicant contacted before state exhausted all other efforts to verify information
14	Self –attested information was not used appropriately by the state.
15	State did not follow the process to verify element in accordance with verification plan and other state/federal policies and issue not identified by other qualifier
16	Case not processed within required state and federal timeframes including redeterminations
17	No action taken when reasonable compatibility standard not met
18	Citizenship/Immigration status not verified in accordance with state and federal policies
19	State did not appropriately apply reasonable opportunity period
20	Documentation missing in records or no evidence in system that state conducted verification and state was UNSUCCESSFUL in obtaining missing documentation/information. Undetermined only.
21	Documentation missing in records or no evidence in system that state conducted verification but state successfully obtained document/information to complete review. Deficiency only.
22	Residency not verified in accordance with state/federal policies
23	Age not verified in accordance with state/federal policies
24	Identity not verified in accordance with state/federal policies
25	Medicare/other coverage status not appropriately determined/considered
26	State did not request for appropriate documentation related to resource transfers, expenses and deductions.(non-MAGI only)
27	State did not request for long-term care specific information appropriately. (non-MAGI only)
28	Case did not meet long-term care eligibility criteria. (non-MAGI only)
29	Case transferred from marketplace and information was not appropriately reused
30	System transfer did not occur appropriately including transfer of information to MMIS
31	Information not manually entered into system appropriately/timely
32	Case was denied/terminated without incorporating information that was provided before the submission timeframe
33	Case denied before allowing the appropriate timeframe for requests for information

34	State failed to follow-up on inconsistent or incomplete information
35	State failed to follow-up when there was a change of circumstance
99	Other

Examples:

- A state assigned a case as finding code "D-Deficiency" for missing documentation and/or missing evidence in the system to verify citizenship. The state did not verify citizenship according to their verification plan. The state requested the missing documentation and was successful in obtaining it. Since the state received the requested documentation to prove citizenship the finding code was deficiency. The primary qualifier that applies is qualifier 18 - "Citizenship/Immigration status not verified in accordance with state and federal policies." The state should also report qualifier 21 – "Documentation missing in records or no evidence in system that state conducted verification, but state successfully obtained document/information to complete review."

Please note: For reporting deficient cases where additional information has been obtained, the primary qualifier should identify the cause of the missing documentation. In the above example, the primary qualifier is #18. States should also identify Qualifier #21 as a supplementary qualifier, which indicates that missing documentation was obtained successfully.

- A state assigned a case as finding code "U-Undetermined" because the state did not verify citizenship documentation of a beneficiary and was unable to obtain documentation to verify citizenship. State

Please note: For cases where "Undetermined" was selected, Qualifier #20 must be selected as the primary qualifier in addition to a second qualifier further explaining the root cause for the undetermined case.

requested proof of citizenship documentation according to the state verification plan during review process and was unsuccessful in acquiring requested documents. The finding code would be "Undetermined" and there are two qualifiers that apply and they are qualifier 20 – "Documentation missing in records or no evidence in system that state conducted verification and state was unsuccessful in obtaining missing documentation/information. Undetermined only." The second qualifier that applies to this situation would be qualifier 18 – "Citizenship/Immigration status not verified in accordance with state and federal policies."

- A state assigned a case as finding code "GE-Group Error" since the beneficiary was correctly determined eligible for Medicaid, but was incorrectly placed in the Home and Community-Based services group, and should have been placed in the Long Term Care/Nursing Home group. This finding was due to the income amount not being calculated correctly as the client was not eligible for Home and Community based services. The client was over the income limits for Home and Community based services. The state should select the qualifier 09 - "Income requirements not appropriately applied."

Column N, P, R, and T - Caseworker or System Findings

States are required to specify if the qualifier reported is an issue related to "Caseworker," "System," "Caseworker and System," or "Other" by selecting from the drop-down boxes provided. In Column N - Caseworker or System – Qualifier 1, the state will specify the cause (owner) of the finding. For each qualifier entered, states will be required to select the root cause owner in the column following. **The state will be required to provide an explanation in PETT for any causes reported as code O – "Other."**

Column U- Group Error Corrected General Eligibility Category/Group

This is a **new requirement** in Round 4. States identified the general eligibility category/group in Column J that the individual was enrolled in. **This new requirement is only for active cases with a GE-Group Error finding code.**

If an error was made in the general eligibility category/group (finding code "GE"), then states must identify the correct general eligibility category/group in Column U. For each of the incorrectly identified cases, states will identify the correct general eligibility category/group from the drop-down box by selecting one of the following categories/groups:

- Aged, Blind, & Disabled
- Home And Community-Based Services
- Long Term Care/Nursing Home
- MAGI CHIP Pregnant Woman
- MAGI CHIP Unborn
- MAGI CHIP Targeted Low-Income Children
- MAGI Medicaid Adults – not newly eligible
- MAGI Medicaid Children Under Age 19
- MAGI Medicaid Expansion Adult – newly eligible
- MAGI Medicaid Newborn
- MAGI Medicaid Parent/Caretaker
- MAGI Medicaid Pregnant Woman
- QMB
- SLMB
- Other

***Please note:** If a case is incorrectly enrolled in more than one category/group then they are required to report the corrected eligibility category/group of all categories/groups. Please select one specific category/group from the drop-down box. For the additional corrected categories/groups that are identified, please provide the information for those categories/groups in the "Optional fields" (Columns "X" and "Y") sections.

Please contact your state's CMS PERM eligibility liaison prior to reporting errors for more than one category/group.

Column V – Group Error Corrected State Eligibility Category/Group

Similar to Column U, states will need to identify the correct state eligibility category/group that the beneficiary should have been enrolled in. In Column K, states will have identified the State specific category/group and/or subcategory/subgroup the beneficiary was enrolled in. Column V only applies to cases for which the case had a Finding Code of "GE – Group Error" in Column L. States will provide the requested information in the free text field in the spreadsheet.

Please note: States should identify **all corrected state specific categories/groups that the individual is enrolled in** including if they are eligible for more than one category/group and/or subcategory/subgroup. The corrected state-specific category/group and/or subcategory/subgroup identified in Column V should align with the category/group identified in Column U. If they are eligible for more than one state specific category/group and/or subcategory/subgroup then this information should be included in the "Optional fields" (Columns "X" and "Y") sections.

As indicated above in Column U, please contact your state's CMS PERM eligibility liaison prior to reporting errors for more than one state category/group.

Column W - Improper Payments Identified

States are required to conduct a payment review to identify improper payments. At a minimum, states are required to report the total dollars incorrect for active cases identified as finding code "EE – Eligibility Error" in Column L where the decision about eligibility determination was incorrect. States should enter the dollar value of improper

payments in Column W. States should only report improper payments identified for active cases coded as Eligibility Errors based on the minimum Round 4 payment review guidance. States will be required to collect payments for services received in the first month of eligibility and paid the first two months of eligibility or by April 30, 2016 (whichever comes first).

Columns X and Y- Optional Fields 1-2

Optional fields are available for states to track any additional state specific information that may be useful in developing corrective action. States should only use these "optional fields" to track additional state information and not use as an alternate to selecting drop-down boxes from required fields.

Please submit questions to the CMS Eligibility Pilots mailbox at FY2014-2016EligibilityPilots@cms.hhs.gov.

Round 4 Narrative and Corrective Action Reporting Instructions

This section provides instructions regarding the information that should be included in the corrective action analysis reporting form on PETT. This is the second component required for the Round 4 pilot findings.

Section 1: General Information

Fields 1 through 5: State Name, Pilot Round (Round 4), Determination Review Period (April 2015 – March 2016), Date of Submission, and Reporting Period (June 2016), will all be prepopulated by the PETT website.

States are required to enter information for fields 6 through 8. Please provide contact information for two state contacts.

- 6. State Contact Names
- 7. State Contact E-mail Addresses
- 8. State Contract Phone Numbers

This contact information will be used by CMS for any questions regarding Round 4 reporting.

Section 2: Background Information

State will provide responses to the following:

1. **Has anything changed about the pilot since approval of the Round 4 proposal? If yes, please describe**. State should include information about any changes that have been made since state's approved proposal will be a part of the reporting review. The approved pilot proposal is CMS' record of how the state chose to conduct the Round 4 pilot. If there is anything in the approved proposal that is no longer accurate or anything missing from the proposal, the state should include a description in this section. If the approved pilot proposal accurately reflects the state's Round 4 pilots, please put "no" for this question.

2. **Please indicate any system updates that impacted these findings (include effective date of system updates).** This should include any updates or changes to the state's eligibility system. States should be sure to include effective date of system update.

3. **Please include any other information that may help interpretation of the pilot results**. Include details of how this has an impact on the review period April 2015- March 2016. Please include any information that may help with the interpretation of the pilot results. The state should include any information that would be beneficial for someone reviewing the state's results to know. Do not include any information that does not relate to the review period of April 2015 to March 2016.

Sections 3 through 10: Root Causes and Corrective Actions for Related Findings

In sections 3 through 10, states will provide the root cause of findings and corrective action details. In order to streamline the reporting process, qualifiers have been "bucketed" into findings sections. Similar to Round 3, states will have the options to report related issues and

corrective action information in one section, limiting the need to duplicate information in various sections as in previous rounds. CMS attempted to group qualifiers together that would likely have similar corrective actions. States will be required to describe the issues identified that led to the qualifiers reported in each section.

Alert! Change from Round 3
Round 4 Sections have been revised based on changes to qualifiers.

In Round 4, the Qualifiers have been grouped into the following sections:

Section 3: Notice Related Findings

- 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

Section 4: Procedure/Process Related Findings

- 16 - Case not processed within required state and federal timeframes including redeterminations
- 17 - No actions taken when reasonable compatibility standard not met
- 19 - State did not properly apply reasonable opportunity period
- 25 - Medicare/other coverage status not appropriately determined/considered
- 31 - Information not manually entered into system appropriately/timely
- 35 - State failed to follow-up when there was a change of circumstance

Section 5: Documentation Related Findings

- 20 - Documentation missing in records or no evidence in system that state conducted verification and state was UNSUCCESSFUL in obtaining missing documentation/information. Undetermined only.
- 21 - Documentation missing in records or no evidence in system that state conducted verification but state successfully obtained document/information to complete review. (Deficiency only)
- 32 - Case was denied/terminated without incorporating information that was provided before the submission timeframe
- 33 - Case denied before allowing the appropriate timeframe for requests for information

- 34 - State failed to follow-up on inconsistent or incomplete information

Section 6: Transfer Related Findings

- 01 - Case not appropriately transferred to the FFM/SBM. Negatives only.
- 29 - Case transferred from marketplace and information was not appropriately reused
- 30 - System transfer did not occur appropriately including transfer of information to MMIS

Section 7: Income and Household Composition Findings

- 06 - Incorrect household composition established
- 07 - Incorrect income level calculated
- 09 - Income requirements not appropriately applied

Section 8: Verification Related Findings

- 12 - Third party data source not utilized as specified in verification plan
- 13 - Applicant contacted before state exhausted all other efforts to verify information
- 14 - Self –attested information was not used appropriately by the state.
- 15 - State did not follow the process to verify element in accordance with verification plan and other state/federal policies and issue not identified by other qualifier
- 18 - Citizenship/Immigration status not verified in accordance with state and federal policies
- 22 - Residency not verified in accordance with state/federal policies
- 23-Age not verified in accordance with state/federal policies
- 24 - Identity not verified in accordance with state/federal policies

Section 9: Non-MAGI Only Findings

- 08 - Assets not calculated correctly (non-MAGI only)
- 10 - Spend down policy not applied correctly (non-MAGI only)
- 11 - Case did not meet medical eligibility requirements (non- MAGI only)
- 26 - State did not request for appropriate documentation related to resource transfers, expenses and deductions.(non-MAGI only)

- 27 - State did not request for long-term care specific information appropriately. (non-MAGI only)
- 28 - Case did not meet long-term care eligibility criteria. (non-MAGI only)

Section 10: Other Findings

- 99 - Other

Alert! Change from Round 3:

Case IDs will be prepopulated for all cases linked to each qualifier.

Prepopulated Numbers

In each section, PETT will populate the number of Round 4 cases associated with each qualifier based on the information submitted in the state's findings spreadsheet. Similarly, the number of cases from the Round 3 pilots will be prepopulated based on the information from the Round 3 pilot findings spreadsheet (this information will not be prepopulated for the states that previously participated in the ESC pilots).

Additionally, the number of cases that were identified as being attributed to the caseworker, system, caseworker & system, or other will be prepopulated based on the information from the findings spreadsheet submitted in PETT.

In Round 4, the report will also be prepopulated with the case IDs associated with each relevant qualifier.

Each section will be prepopulated with the following:

- **Qualifiers** – A list of qualifiers that are included in the section.
- **# of Cases Round 4** – The number of Round 4 cases associated with each qualifier listed.
- **Case IDs** – The case IDs linked to each qualifier.
- **# of Cases Round 3** – The number of cases state reported in Round 3 associated with each qualifier. This will be prepopulated only for states that participated in Round 3 FY14-16 Eligibility Pilots, not the ESC pilots. This will assist state in providing an update on ongoing issues. As not all of the qualifiers in the two pilot rounds line up, some of the lines will have "N/A."
- **Caseworker vs. Systems Findings** – The number of cases that were reported as Caseworker, System, Caseworker & System or other issues. When completing corrective action section, states need to be sure to separate the corrective action for case worker issues vs. systems issues. Case worker issues and system issues should each be identified on a separate line in the corrective action section.

Root Cause & Corrective Action Analysis

In these fields, states will describe the issues that led to the qualifiers cited in that section and provide relevant corrective actions. States should enter a row for separate issue identified and describe the corrective action that will be conducted. States can report similar issues on multiple cases on the same line as long as same corrective action is planned and states include all the case IDs associated with the issues.

Since states are required to identify the case ID associated with each corrective action, states will not be required to specify the number of cases that are associated with the issues identified and corrective action reported. CMS will review to ensure each prepopulated Case ID associated with the qualifier is included in at least one of the corrective action rows. **It is essential that states address all issues and provide corrective actions for all the problems identified in the pilot.**

The information below provides examples for addressing different situations:
In Section 7 (**Income and Household Compositions Related Findings**), analysis shows that qualifier code 06 – *Incorrect Household Composition Established* was cited on 8 cases and qualifier 07 – *Incorrect Income Level Calculated* was cited on 9 cases.

- **Scenario 1**: All findings codes in this section are due to one issue (e.g. caseworker understanding of/misapplication of certain policies). The state would include case IDs for all associated cases in one row, describe that issue, and provide the corrective action information (e.g. additional caseworker training). Thprepe corrective action should include that the training will address income and household composition issues.
- **Scenario 2**: Half of the finding codes are due to the case worker not understanding the policy (from scenario 1) and half are due to a second issue (e.g. the system was programmed incorrectly). The states would include case IDs for associated cases in two rows. The first would be inserted to describe the caseworker issue and the second to describe the systems issue and provide corrective action information for each.

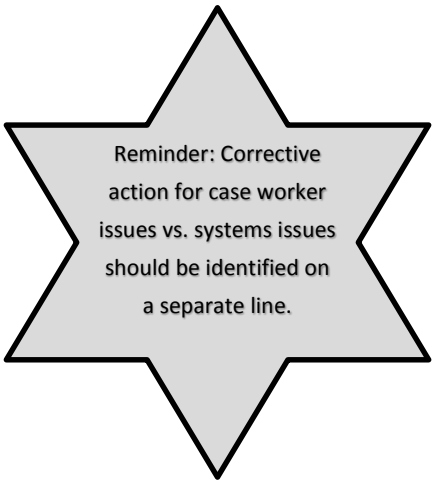
Round 4 Root Cause and Corrective Action Analysis Instructions: States enter a row for each issue and provide the following information:

- **Describe Issue (Root Cause)**
  - Specify the underlying issue.
  - Identify why a particular program/operational procedure caused the issue.

- **Case IDs**
  - States will list all Case IDs that fall under the specified issue.

- **Corrective Action Description**

- Describe action to be taken to prevent the issue from occurring in the future.
- For systems issues, include both a long term fix and interim solution.



- **Component/Staff Responsible for the Corrective Action**
  - Specify the component responsible for implementing the corrective action.
  - States should include the name (if available) and the title/position in the agency or divisions that will oversee the corrective action; and the name (if available) and the title/position of the agency that will implement the corrective action (if different from the agency/division that will provide oversight).

- **Estimated Date of Completion or Implementation**
  - States will provided a target date of when corrective action will be completed or implemented.

- **Expected Results of Corrective Action Plan**
  - States will discuss the expected outcome of corrective actions being implemented.
  - States should include how these corrective actions will impact future error rates when PERM resumes.

- **How Will State Monitor Effectiveness?**
  - State should provide concrete ways to monitor the effectiveness of their corrective actions.

- **Responsible Component/Unit**
  - States should identify who in their state is responsible (may be different that staff responsible for implementing corrective actions) for monitoring effectiveness of corrective actions.

- **Timeframe for Monitoring**
  - States will specify an anticipated timeframe for completion of their corrective actions.

- **Was this an Issue in Rounds 1, 2 or 3?**
  - **Note**: This also includes the Round 1 and Round 2 ESC pilots.
  - Select ‘yes or ‘no” from drop down box to indicate if this issue was also identified through Round 1, 2 or 3 pilots.
  - If yes, states should complete updates in the section titled “Updates on Ongoing Corrective Actions in each of the pertinent sections 3-10
  - If Round 3 issues have been resolved, see section 15.

Updates on Previous Rounds Ongoing Corrective Actions:

Alert! Change from Round 3

States will provide updates on all ongoing issues in Sections 3-10. This will include issues from FY14-16 Eligibility Pilots and the ESC pilots. The number of cases from Round 3 of the FY14-16 pilots will be prepopulated. The results/findings from Round 2 ESC will not be prepopulated.

States must provide an update on previous issues reported and the corrective actions that were implemented as a result (including FY14-16 eligibility pilots and ESC pilots) for issues that continued to be identified in Round 4 or that the state still knows to be a problem.

*Note-The number of cases from Round 3 FY14-16 pilots will be prepopulated based on information submitted in the findings spreadsheet. **For states that participated in the Round 2 ESC pilots, the cases will not be prepopulated. Round 2 ESC states will need to provide this information. Assistance will be provided with this as needed.**

If in sections 3 – 10, the state selected 'Yes' for "Was this an issue in Rounds 1, 2, or 3?" the issue is considered continuing and updates on the previous corrective actions should be included. States should enter a separate row for each for each ongoing issue identified, and must provide the following information.

- **Ongoing Issue from Previous Rounds**
  - Identify the continuing issue and root cause.

- **Root Cause Being Addressed**
  - Provide an explanation for why the issue is still present in Round 4 and why a particular program/operational procedure is continuing to cause the issue.

- **Root Cause Owner**
  - Specify root cause owner-caseworker, system, both or other.

- **Corrective Action Updates**
  - States will provide details of any changes made to the previously implemented corrective action to improve effectiveness and prevent future issues.

- **Targeted Completion Date**
  - Include the corrective action implementation dates and the expected completion dates.
  - If date has passed please explain why targeted date did not come into fruition.

- **Plan for Evaluation**

- Include a plan for evaluation of the expected effectiveness of any updated corrective action.
- Provide any additional information about ongoing issues that may be useful in understanding why issues continued and how issues can be addressed for future PERM Eligibility reviews.

ONGOING ISSUES REMINDER:
States should be preparing to resume the PERM Eligibility reviews. The goal moving forward with each round of the eligibility pilots is to reduce or eliminate eligibility errors that have the potential to be identified in the PERM review process prior to the resumption of PERM eligibility and the calculation of state eligibility error rates. Through these pilots, states should focus on establishing an audit trail, maintaining records, and including a review of all determinations that may be subject to review in future PERM eligibilityreviews.

REMINDER! Changes from Round 3

- PETT will prepopulate the case IDs linked to each qualifier based on information submitted in the findings spreadsheet.
- States are required to include case IDs in the Root Cause & Corrective Action Analysis sections. These case IDs will need to be manually entered by the state.
- The number of cases associated with each qualifier from the previous round will be prepopulated.
- States will be required to provide update to ongoing corrective actions in each section. This includes states that participated in either FY14-16 pilots or ESC pilots.

Section 11 - Eligibility Errors Discussion

In this section, states will provide discussion/analysis of the cases identified as actual eligibility errors with error code **EE- Eligibility Error**. PETT will prepopulate the number of active and negative cases with an error code of **EE – Eligibility Error** based on the state's findings spreadsheet. The number of eligibility errors from Round 3 will also be prepopulated based on the states' Round 3 findings spreadsheet.

States will be required to provide an analysis of the eligibility errors as described below:

- **What were the main contributors to active case eligibility errors?** For this question, states should identify the main causes of active case eligibility errors and consider the following questions:
  - Did state report more errors related to caseworker issues or system issues?

- Are these eligibility errors related to ongoing issues that were identified in previous rounds or new issues?

- **What were the main contributors to negative case eligibility errors?** State should identify the main causes of negative case eligibility errors and consider the following questions:
  - Did state report more errors related to caseworker issue or system issues?
  - Are these eligibility issues related to ongoing issues that were identified from previous rounds or did state identify new issues?

- **Please provide an analysis describing the caseworker vs. system issues.**
  - Here states will describe why issues were either caseworker or system related

- **Please provide an analysis and generally describe your state's active vs. negative findings, including changes from previous rounds.** For this question state should discuss any trends identified with active vs. negative eligibility error (EE) findings and consider the following questions.
  - Were there any issues only identified for active cases or for negative cases?
  - Did state see any trends in the eligibility errors for active vs. negative?
  - States should provide any additional analysis that may be useful to the state.

- **Describe the state's plan for handling actual cases identified where the incorrect eligibility determination was made (i.e. errors).**
  States should describe the steps they will take to correct cases found to be eligibility errors. States should describe the steps taken to review and correct the actual sampled case and identify any other cases where the identified system error or caseworker error would have had a similar impact on eligibility. This is different than corrective action plans discussed in Sections 3 through 8 which are steps to prevent future errors. This discussion focuses on how the state retroactively handled actual cases impacted.

Section 12 - Group Errors Discussion

In this section, states will provide discussion/analysis of the cases identified as GE - Group Errors (i.e., placed in the wrong eligibility group/category).

The number of cases from Round 4 will be prepopulated based on the number of case reported with finding of GE- Group Error.

The number of cases from Round 3 will be prepopulated based number of cases that had a finding code of **06- Case placed in incorrect eligibility group/category** in the Round 3 pilot findings spreadsheet.

States should provide a response to the following questions:

- **What were the main contributors of cases being placed in the wrong eligibility group/category?** When responding, states should consider the following: What

groups/categories were affected? Were there any trends with the identified findings related to findings for incorrect group/category?

- **Please provide an analysis of the typical groups affected and include changes from the previous rounds' findings.**
- **Please provide an analysis describing the caseworker vs. system issues.**

Section 13: Missing Documentation Discussion

In this section, the number of Medicaid and CHIP cases that were identified as Undetermined-qualifier 20 or Deficiency-qualifier 21 will be discussed. These numbers will be prepopulated from the state's findings spreadsheet. States will need to respond to the following:

- **Please provide an analysis on the typical cases affected by missing documentation (e.g., more non-MAGI than MAGI cases).**

- **Please provide common reasons for missing documentation. Were issues related to no evidence in system of verification or missing documentation in records?**

- **What can your state do to improve this improve this issue with missing documentation before PERM resumes?**

Section 14: State Analysis of Findings

In this section, the number of Eligibility Errors, Group Errors, Deficiencies and Undetermined cases reported will be prepopulated in PETT. States should provide high level analysis and address if there were any specific areas that were more prone to problems. If the eligibility review pilots provided any other useful information to your state, please include information in the relevant section. While states should discuss trends, states are not required to provide numbers or cite specific case IDs in this section.

States should generally discuss and describe the state's findings for each of the following classifications:

- Medicaid vs. CHIP
- MAGI vs. Non-MAGI
- Initial vs. Redeterminations
- Point of Application
- Type of Application
- Channel

Section 15: Updates on Round 3 FY14-16/Round 2 ESC Completed Corrective Actions

States will provide updates on their completed corrective actions in this section. States are required to provide an update and an evaluation of corrective actions as a result of the Round 3 findings. It is important for states to provide information on the corrective actions that have

successfully addressed the issue and prevented similar issues from occurring again. States must provide a list of corrective actions in this section for the resolved issues from Round 3 FY14-16 and Round 2 ESC pilots.

Note: None of the information in this section will be prepopulated, and states will be required to complete the section. The number of rows in PETT will expand to accommodate all actions. States will address the following for each of the resolved issues:

- **Corrective Action:** Provide a brief description of the action. This description should summarize the action that was included in Round 3 FY14-16 and Round 2 ESC pilots reporting.
- **Root Cause Being Addressed:** Provide a brief description of the root cause that the action was intended to address.
- **Root Cause Owner:** Specify if root cause was due to 'Caseworker' for issues due to caseworker action, 'Systems' for issues due to systems issues, and 'Other' for any issues that do not fall into one of those two buckets.
- **Completion date:** Enter the date that the state completed the corrective action. States can specify 'ongoing' for any ongoing corrective actions.
- **Evaluation:** Include an evaluation of the effectiveness of the corrective action. Define the methods and procedures used for evaluation purposes. For ongoing actions, evaluate the effectiveness the state has seen so far.
- **Impact on Round 4 (if any):** Describe the impact the action had on the Round 4 results.

Section 16 - Summary and Other Information

This section is intended to capture any additional information that can be gleaned from the pilot results. States are asked to provide information in each of the fields below. If the question/item is not relevant to the state's pilot findings, please specify that in the field.

- **Provide an overall summary of your Round 4 pilot findings.** Provide a summary of your Round 4 pilot findings and corrective actions. This summary should provide a good high-level understanding of the major issues that were identified in the state and how those issues are being addressed. States can also include information about the state's ACA implementation if it is applicable to their findings and compare results to previous rounds.

- **How did Round 4 findings compare to the findings from your state's previous pilot findings? (The findings from Round 1, 2 and 3)**
  For this question state should consider the following:
  - Did state see any trends in issues identified?
  - Were there any expected or unexpected issues identified?
  - How did the errors/deficiencies identified through Round 4 pilot compare with issues identified in Round 3?

- **For findings identified that may have impacted numerous cases, describe how your state handled non-sampled cases that may have been impacted. Did the state follow up on these cases?** States should provide information on how state addressed the issue for non-sampled cases.

  For example: During pilot review, state found that denial notices were not sent for any negative determinations made during a certain timeframe. The corrective action included a plan to send notices for all (not only cases reviewed during pilot) negative determinations made during this period until corrective action was implemented.

- **Is your state willing to share any best practices that may be helpful to other states in resolving ongoing issues?** Please consider including any information that your state provided in Section 15 - Corrective Actions Completed.

- **Optional Additional State Analysis:** In this section, states have the option of reporting any additional state specific analysis. States are not required to complete this section since it is optional.

Questions

Please submit all questions to FY2014-2016EligibilityPilots@cms.hhs.gov