Medicaid and CHIP Eligibility Review Pilots

Round 5 Reporting and Corrective Action Plan Guidance – Cycle 1 and 2 States

MAY 2, 2017

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Background

State Health Official (SHO) 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 fifth round of pilots.

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.

This guidance specifies the reporting and corrective action requirements for the Round 5 pilots due June 30, 2017. Guidance for submitting the Round 5 pilot proposal was issued in November 2016. The Round 5 reporting spreadsheet guidance was released in March 2017 and is also included in this CAP narrative guidance.

Round 5 Reporting and Corrective Action Overview – Cycle 1 and 2 States

Similar to Round 4, states will submit Round 5 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 then complete the corrective action plan by inputting narrative into fields in PETT. States will provide discussion/analysis of the overall findings, root cause descriptions, and corrective action information. States will also provide updates to ongoing corrective actions. This includes states that participated in either FY14-16 pilots or ESC pilots.

REMINDER!
There are significant changes to both the spreadsheet and narrative/corrective action reporting requirements since Round 4.

Round 5 changes to the spreadsheet include:

- States are reviewing samples selected from the Fee-for-Service (FFS) and Managed Care (MC) PERM claims sample. For these states, The SC has **pre-populated** the first nine columns **(Columns A through H)** of the spreadsheet based on the sampled claim. A partially populated spreadsheet was sent to each state for completion.[1]

[1] States using an alternative sample for Round 5 will have received a blank reporting template and are required to complete Columns A through H in accordance with the reporting guidelines.

- States were previously asked to report **General** eligibility category/group in Round 4. In Round 5, states are asked to do the same but general eligibility category/group is now labeled **Federal** eligibility category/group. States are also asked to report state-specific eligibility categories/groups for all cases reviewed which is similar to Round 4.
- Previously, in Round 4, cases were coded with a "**Finding Code**" of Correct, Deficiency, Group Error, Eligibility Error or Undetermined. In Round 5, this is called a "**Review Result**" and the options are **Correct, Payment Error, Deficiency Only, or Payment Error & Deficiency.**
- States are asked to report **Eligibility Review (ER) Error Codes** which is a significant change from previous rounds of the pilots. ER codes identify the error or deficiency and states must also choose a **Qualifier** that describes the error.
- States have the option to report **up to six (6) Error Codes and/or Technical Deficiencies (TDs)** on the spreadsheet. States have the option to report one (1) qualifier for each error code and may **use an error code more than once if there are different qualifiers associated with each error code.**
- For all cases reviewed, states are required to report the assigned **FMAP** rate.
- For cases cited with either an **ER5 or ER6** (placed in the wrong eligibility category or group), states are required to report the appropriate Federal eligibility category/group and the appropriate detailed state-specific eligibility category/group that the individual should have been enrolled in. Additionally, the state is required to report the correct FMAP rate that should have been assigned and the total claims with the incorrect FMAP (if applicable).

Round 5 changes to the Reporting and Corrective Action Guidance include:

- The Round 5 Reporting and Corrective Action Plan (CAP) has a new look! In an effort to realign with the PERM cycle and in preparation for the resumption of PERM, the corrective action plan is now in a similar format to the one that is used on the Medical Review and Data Processing side of PERM.
- Findings are bucketed into sections based on the revised error codes and qualifiers.
- Case IDs associated with the qualifiers are prepopulated in Sections 3-15 and are called PERM IDs in Round 5.

Due Dates & Submission

Round 5 pilot findings spreadsheet, along with corrective action information, are due to CMS on June 30, 2017. It is essential that all findings (both the spreadsheet and the corrective action template) are submitted to CMS **no later than** June 30, 2017.

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 pre-populate case information (e.g. total number of eligibility errors) into the corrective action report on PETT. **States must submit their findings spreadsheets before they begin entering information into the corrective action report.** States will enter their description of the issue and corrective action information directly into the findings narrative section of the PETT website.

REMINDER!
CMS encourages states to submit their findings spreadsheet as soon as it is completed, although they may not be finished with the CAP. Both must be submitted by June 30, 2017.

CMS recommends that states submit their findings spreadsheet as soon as it is completed even while the state continues to work on the CAP. This will allow CMS time to review the findings spreadsheet for inconsistencies and provide feedback prior to states finalizing their corrective action plan. If a state has to make revisions to the findings spreadsheet, the state will have to re-upload the document onto PETT. **Note:** The PETT submission is a final report to CMS and is not intended to collect information as reviews are being completed. States should not submit their Round 5 findings spreadsheet to PETT until all reviews are complete.

REMINDER!
Any revisions to the findings spreadsheet will require the state to re-upload the spreadsheet in PETT.

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. Once the corrective action report has been reviewed and approved by CMS, the status of both the findings spreadsheet and CAP will be changed to "approved." **Note**: If the state is required to make revisions to their Round 5 pilot findings spreadsheet and re-upload it to PETT, text already entered into the corrective action report will not be affected. Rather, this will simply update the prepopulated numbers.

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 responsibility for 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.

REMINDER!
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.

Webinar trainings and instructions for uploading Round 5 pilot reporting findings spreadsheet and submitting narrative information will be offered prior to the pilot reporting due date.

CMS Review and Approval

CMS comments and approval of the Round 5 pilot reporting 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 5 Findings Spreadsheet Instructions

This section outlines the instructions for completing each section and column of the Round 5 pilot findings spreadsheet. States will be able to modify all columns highlighted in yellow. Columns in gray contain information pre-populated by the Statistical Contractor (SC) or will be automatically calculated using built in formulas.

NOTE: Please <u>DO NOT</u> use the copy and paste function in your spreadsheet. This may result in error when uploading your spreadsheet onto the PETT 2.0 site and could impact your state's information. Please manually enter all data or use the dropdown menus provided.

In this guidance, *Cases* refer to persons eligible to receive the service that was sampled for this review. *Claims* refer to the payments made for these services.

A. Pilot Round: Round 5 (Pre-populated)

B. Claims Date of Payment Timeframe:

<u>Pre-populated</u> based on Quarter data provided by SC or review period selected by states using alternative sample

C. Total Cases Reviewed

This section is **<u>pre-populated</u>** based on the total number of cases sampled for review. 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

This section is **<u>pre-populated</u>** based on the number of total Medicaid cases sampled for review.

E. Total CHIP Cases Reviewed

This section is **<u>pre-populated</u>** based on the number of total CHIP cases sampled for review.

<u>Column A: Pre-populated Row Numbers</u>

States are required to report on all cases reviewed for the Round 5 pilot including correct cases. For any dropped cases, as discussed in more detail below, states will still be required to report the background information on the case. States should enter the results for the review of each case on a separate row of the spreadsheet. The total number of cases specified in Section C of the general information section should match the number of rows of cases reported in the spreadsheet. The spreadsheet provides 265 rows for reporting on cases. States are to review no more than 250 cases per the Round 5 pilot proposal guidance. The 15 additional rows account for a possible oversample due to dropping of FFM-D or ELE cases, if applicable.

Column B: PERM ID

The PERM ID is **pre-populated** for those states using the claims sample provided by the SC, which was previously sent via the Lewin's FTP site. States that are not using the claims sample will need to assign a PERM ID to each case using the Alternative Sample Guidance for FY14-17 Round 5 Eligibility Pilots regarding assigning case IDs in the Medicaid and CHIP Eligibility Review Round 5 Pilot Guidance. 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 "AN" and "AO") to track this information.

PLEASE NOTE
If your state is not using the claims sample, please refer to the Alternative Sample Guidance for FY14-17 Round 5 Eligibility Pilots document, which was sent directly to your state by the SC.

Column C: Fee-for-Service/Managed Care (FFS/MC)

This column is **pre-populated** for states based on the selected claims sample that was previously provided by the SC via the Lewin sFTP site. "N/A" should be selected by states using alternative samples.

Column D: Program

This column is **pre-populated** for states based on the selected claims sample that was previously provided by the SC via the Lewin sFTP site. States using an alternative sample will need to identify whether the case under review is Medicaid or CHIP.

Column E: Date of Service From (MM/DD/YYYY)

This field represents the date on which the services associated with the sampled claim began. This column is **pre-populated** based on the selected claims sample that was previously provided by the SC via the Lewin sFTP site.

The field should be left blank for states using an alternative sample that is not claims based.

Column F: Date of Service To (MM/DD/YYYY)

This field represents the date on which the service associated with the sample claim ended. This may be the same date as that in Column E. This column is **pre-populated** based on the selected claims sample that was previously provided by the SC via the Lewin sFTP site.

The field should be left blank for states using an alternative sample that is not claims based.

Column G: Date of Payment (MM/DD/YYYY)

This field represents the date that the claim was paid to the provider. This column is **pre-populated** based on the selected claims sample that was previously provided by the SC via the Lewin sFTP site.

The field should be left blank for states using an alternative sample that is not claims based.

Column H: Total Claim Payment

This field represents the total claims associated with the sampled claim. This column is **pre-populated** based on the selected claims sample that was previously provided by the SC via the Lewin's FTP site.

For states using an alternative sample, the claim paid amount should be entered in Column H. For states using an alternative sample, Column H should reflect the sum of dollars for the case based on the payment review period. See Alternative Sample Guidance for FY14-17 Round 5 Eligibility Pilot Cycle 1 and 2 States for more information.

Column I: Active/Negative

States will identify each sampled claim as "Active" or "Negative" using the drop down box provided.

Column J: 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
- Unknown*
- Other*

These choices are general options for national analysis and states should select the most applicable point of application. The points of application selected should be consistent with the applicable points of application identified in 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 AN and AO) 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.
- **NOTE**: If a state selects "Redetermination" 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 options, but the state is aware of the point of application.

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

Column K: Type of Application

For each claim, states should identify the Type of Application as one of the following options from the drop-down provided:

- Single-streamlined
- Multibenefit
- Redetermination
- Qualified Entity Presumptive Eligibility
- Targeted enrollment
- Unknown*
- Other*

These choices are general options for national analysis and states should select the most applicable type of application.

- **NOTE**: If a state selects "Redetermination" 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 options, but the state is aware of the type of application.

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

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

Column L: Channel of Application

For each claim, 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
- Unknown*
- Other*

These choices are general options for national analysis and states should select the most applicable

channel of application. The channels of application selected should be consistent with the applicable channels of application identified in the state's pilot proposal.

- **NOTE**: If a state selects "Redetermination" 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 options, but the state is aware of the channel of application.

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

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

Column M: MAGI/ Non-MAGI

States are required to identify the selected claims as either "MAGI" or "Non-MAGI" by selecting from the drop-down list provided.

Column N: Federal Eligibility Category/Group

States should identify the Federal eligibility category/group that the individual was enrolled in. For each case, states will choose from one of the eligibility categories in the drop-down list, which are listed below.

- Aged, Blind, & Disabled - Categorically Needy
- Aged, Blind, & Disabled - Medically Needy
- Elderly Waivers
- Emergency Services (Including for Non-Citizens)
- Home and Community-Based Services
- Individuals with Breast or Cervical Cancer
- Katie Beckett
- LTC/Nursing Home
- MAGI CHIP Children under Age 19
- MAGI CHIP Medicaid Expansion Kids
- MAGI CHIP Unborn Child
- MAGI Family Planning
- MAGI Former Foster Care
- MAGI Medicaid Adult - Newly Eligible
- MAGI Medicaid Adult - Not Newly Eligible

- MAGI Medicaid Parent Caretaker
- MAGI Medicaid Children under Age 19
- MAGI Deemed Newborn
- MAGI Pregnant Woman
- Other
- Other Full Benefit Dual Eligible (FBDE)
- QMB
- Qualified Disabled and Working Individuals
- Qualified Individuals
- SSI Recipients
- SLMB

These choices are general options for national analysis and states should select the most applicable Federal eligibility category.

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

Column O: State Eligibility Category/Group/Subcategory/Subgroup

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. This column provides the opportunity for states to identify more specific categories/groups applicable to their state for each case.

States should identify all state specific eligibility categories/groups that the individual is enrolled in. The state-specific category/group and/or subcategory/subgroup identified in Column O should align with the category/group identified in Column N. If the individual is eligible for more than one state specific category/group and/or subcategory/subgroup, then this information should be included in one of the "Optional Field" (Columns AN and AO) columns.

Column P: Dropped Claim

Cycle 1 and 2 States will not be required to review Federally-Facilitated Marketplace-Determination (FFM-D) or Express Lane Eligibility (ELE) cases during Round 5. (Please note that FFM-D states should include determinations where the state resolved inconsistencies and made the final eligibility determination.) As such, if these claims are included in the sample, states will be required to drop them from review and report in Column P whether the dropped cases was a "FFM-D" or "ELE" case. If states encounter a claim that must be dropped, please notify your CMS PERM eligibility liaison.

Column Q: Date of Last Action (MM/DD/YYYY)

States will be required to identify and report the date of last action related to the case under review.

Column R: Type of Last Action

States are required to identify the type of last action under review as either "Initial Determination," "Redetermination," "Change in Circumstance," or "Other" by selecting from the drop-down list provided.

Column S: Review Results

States should assign each reviewed claim one of the review results as shown in **Table 1** below.

Table 1. Definition of Review Results

Name	Definition	Notes
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 error codes or qualifiers should be identified on these cases.
Payment Error	There was at least one payment error cited on the case, but no technical deficiencies were identified.	At least one error code and qualifier (Columns T and U) will be reported, though the state has the ability to report up to six different error codes and associated qualifiers. Any error code (ER1 through ER12) may be reported.
Deficiency Only	There was at least one technical deficiency cited on the case, but this did not result in a payment error.	At least one error code and qualifier (Columns T and U) will be reported, though the state has the ability to report up to six different error codes and associated qualifiers. The error code reported will be an ER-TD.
Payment Error and Deficiency	At least one payment error and one technical deficiency was cited on the case	At least two error codes and associated qualifiers (Columns T through W) must be reported, though the state has the ability to report up to six different error codes and qualifiers. Any error code (ER1 through ER 12) and ER-TD may be reported.

Columns T, V, X, Z, AB, and AD: Error Codes 1-6

Similar to the PERM Medical Review and Data Processing claims error code reporting, the eligibility pilots will be using ER Error Codes to identify the type of error cited on each case. The full version of the Error Codes and Qualifiers was included in the Round 5 Pilot Proposal Guidance as Appendix G.. The following is a list of error codes that will be used on cases cited as either a "Payment Error," Deficiency Only," or "Payment Error and Deficiency" in Column S ("Review Result"):

- **ER1** – Not eligible for enrolled program; financial issue
- **ER2** – Not eligible for enrolled program; non-financial issue
- **ER3** – Should have been enrolled in a different program (i.e., Medicaid or CHIP); financial issue
- **ER4** – Should have been enrolled in a different program (i.e., Medicaid or CHIP); non-financial issue
- **ER5** – Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; financial issue
- **ER6** – Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; non-financial issue
- **ER7** – Ineligible for service; not eligible for enrolled eligibility category; financial issue
- **ER8** – Ineligible for service; not eligible for enrolled eligibility category; non-financial issue
- **ER9** – State non-compliance with federal regulation
- **ER10** – Cannot confirm eligibility; insufficient documentation
- **ER11** – Cannot confirm Medicaid or CHIP eligibility determined by another agency or qualified entity
- **ER12** – Other errors
- **ER-TD** – Technical deficiencies

Correct cases should have no error codes or qualifiers reported because there should be no issues identified if the case is reported as correct. The ER-12 error code should ONLY be used if there are no other applicable error codes. States should utilize one of the "Optional Field" columns (Columns AN and AO) to provide information on any errors cited with an ER12.

Columns U, W, Y, AA, AC, and AE: Qualifiers 1-6

States are required to assign qualifiers that are applicable to the error code cited on the case. States are required to use the CMS specified qualifiers listed below in **Appendix B**. Only one qualifier can be cited for each error code assigned.

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

For any ER-TD code reported, states may use any of the qualifiers listed in the table as being associated with a technical deficiency. However, the qualifiers marked with an asterisk (*) can *only* be classified as a technical deficiency and not as a payment error.

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" under any given error code should only be used for findings related to an element or process reviewed that is not listed in the chart. States should utilize one of the "Optional Field" columns (Columns AN and AO) to provide information on any errors cited with a qualifier of "Other."

Column AF: Assigned FMAP Rates

For all cases reviewed, states are required to report the FMAP rate associated with the assigned Federal Eligibility Category/Group.

Note: For additional information on FMAP, please refer to the Round 5 Pilot Proposal Guidance, Appendix F.

Column AG: Total Claim Payment in Error

For all cases reviewed that were cited with an ER error code except ER5, ER6, or ER-TD, the state will be required to report the **total claim amount**.

Column AH: Federal Payment Share in Error

Based on the information entered into Column AF (Assigned FMAP Rate) and AG (Total Claim Payment in Error), Column AH will automatically update. **NOTE**: There is a formula built into this column and the cells have been locked so that the formula cannot be edited. This value will be unchanged for any cases that were cited as "Correct," "Technical Deficiency Only," ER5, or ER6.

Column AI: Correct FMAP Rate

This column is only required if one of the two error codes, listed below, was cited.

- **ER5 –** Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; financial issue
- **ER6** – Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; non-financial issue

For cases in which the individual was assigned to the incorrect eligibility category, the state will be required to report the FMAP rate associated with the correct category for the individual.

Column AJ: Correct Federal Eligibility Category/Group

States identified the Federal eligibility category/group in Column N that the individual was enrolled in. If an error was made in the Federal eligibility category/group (ER5 or ER6), then states must identify the correct Federal eligibility category/group in Column AJ. The state will identify the correct Federal eligibility category/group from the drop-down box by selecting one of the categories from the list provided below:

- Aged, Blind, & Disabled - Categorically Needy
- Aged, Blind, & Disabled - Medically Needy
- Elderly Waivers
- Emergency Services (Including for Non-Citizens)
- Home and Community-Based Services
- Individuals with Breast or Cervical Cancer
- Katie Beckett
- LTC/Nursing Home
- MAGI CHIP Children under Age 19
- MAGI CHIP Medicaid Expansion Kids

- MAGI CHIP Unborn Child
- MAGI Family Planning
- MAGI Former Foster Care
- MAGI Medicaid Adult - Newly Eligible
- MAGI Medicaid Adult - Not Newly Eligible
- MAGI Medicaid Parent Caretaker
- MAGI Medicaid Children under Age 19
- MAGI Deemed Newborn
- MAGI Pregnant Woman
- Other
- Other Full Benefit Dual Eligible (FBDE)
- QMB
- Qualified Disabled and Working Individuals
- Qualified Individuals
- SSI Recipients
- SLMB

***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 one of the "Optional Field" (Columns AN and AO) columns.

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

Column AK: Correct State Eligibility Category/Group/Subcategory/Subgroup

Similar to Column AJ, states will need to identify the correct state eligibility category/group/subcategory/subgroup that the client should have been enrolled in. This only applies to those cases that had either an ER5or ER6 cited. States may have reported the state-specific category/group and/or subcategory/subgroup the client was enrolled in, and will document the client's correct state-specific category/group and/or subcategory/subgroup in this free text field.

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 AJ should align with the category/group identified in Column AK. If they are eligible for more than one state specific category/group and/or subcategory/subgroup then this information should be included in one of the "Optional Field" (Columns AN and AO).

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

Column AL: **Total Claim with Incorrect FMAP**

For all cases on which an ER5 or ER6 was cited, the state will be required to report the total claim with the incorrect FMAP.

Column AM: Federal Payment Share due to Incorrect FMAP

Based on information populated in other columns of the spreadsheet ("AF – Assigned FMAP Rate," "AI – Correct FMAP Rate," and "AL – "Total Claim with Incorrect FMAP"), the Federal Payment Share due to Incorrect FMAP will be updated. The amount will not change for states that did not have one of the two error codes (ER5 orER6) reported, as discussed above. **NOTE**: There is a formula built into this column and the cells have been locked so that the formula cannot be edited.

Columns AN and AO: Optional Fields 1 and 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 columns to track additional state information and NOT as an alternate to selecting drop-down boxes from the required columns. **NOTE**: These columns are each limited to 300 characters. States should be aware that the limit is 300 characters and no more. If more than 300 characters are typed the narrative will get cutoff when uploading into PETT occurs.

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

Round 5 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 5 pilot findings.

Section 1: General Information

Fields 1 through 8 (pre-populated):

1. State Name
2. Pilot Round (Round 5)
3. Determination Review Period
4. Date of Submission
5. Reporting Period (June 2017)
6. a) State Contact Name a b) State Contact Name b
7. a) State Contact E-mail Address a b) State Contact E-mail Address b
8. a) State Contact Phone Number a b) State Contact Phone Number b

The contact information will be used by CMS for any questions regarding Round 5 reporting. Although information in Section 1 is pre-populated, states can make changes if necessary.

Section 2: Background Information

State will provide responses to the following:

1. **Has anything changed about the pilot since approval of the Round 5 pilot proposal? If yes, please describe**. The state should include information about any changes that have been made since the 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 5 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 5 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 that could have either resolved issues in Round 5 or caused further errors in reporting. States should be sure to include the effective date of system update.
3. **Please include any other information that may help with interpretation of the pilot results**. Please include details of how this has an impact on the review period and 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.

Sections 3 (ER1) through Section 15 (ER-TD): Root Causes and Corrective Actions for Related Findings

In sections 3 through 15, states will provide the root cause of findings and corrective action details. Each section represents one Eligibility Review (ER) Error Code (ER1-ER12 and ERTD) with its own associated qualifiers. In Round 5, states will be required to report the root cause of the findings by qualifier, and corrective actions by Error Code, which is a significant change from Round 4. Sections 3-15 of the CAP will each have the following components.

Data Analysis Results

- Number of errors, dollars in error, federal dollars in error, and state dollars in error for each qualifier used within the error category will be pre-populated based on the data from the state's spreadsheet uploaded onto the PETT site. States are not required to provide additional information for data analysis.
- Space is provided for states to enter additional optional data analysis if they choose to add more information about the nature of the error. The data analysis section should enable the state to gain a more thorough understanding of the root cause of the errors, when the errors occurred, and who or what caused the error.
    - *Example*: This error accounted for 20% of the total errors (10 errors) identified during the eligibility Round 5 pilot review. It resulted in a total overpayment of $100. The error occurred because a large number of caseworkers at a specific agency were not properly trained on what verifications were needed.

Program Analysis

Under the program analysis section, states must review the findings of the data analysis to determine the specific causes of the errors. For each qualifier listed in the state's CAP, the state should describe why a particular program/operational procedure caused the error and identify the root causes of errors. The following sections are included under program analysis:

- **Qualifier table:** These tables are pre-populated from the state's results spreadsheet and will display the breakdown of qualifiers cited within the associated error code section (e.g. Household composition or tax filer unit incorrect - caseworker). This breakdown includes PERM IDs that were cited with that qualifier, as well as the total federal and state dollars in error for each PERM ID.
- **Identification of Root Cause:** For each qualifier cited within the error category, states must describe why a particular program/operational procedure caused the specific error and identify the root causes of errors (e.g., system did not calculate income correctly; eligibility staff needs training on application of earned income; etc.). States should be as specific as possible in identifying the root causes of the errors that led to the qualifier being cited.
    - *Example*: If caseworker income calculation errors seem to be caused by inadequate training, then the state should take actions to strengthen its training programs. This could be accomplished by worker interviews, questionnaires, policy reviews, and conferences with local managers, etc.

Corrective Action

The state will describe the corrective action initiatives to be implemented for the ***error category***. Corrective actions should address each root cause of error.

- *Example 1*: The state had numerous ER1 Errors (Not Eligible for Enrolled Program; Financial Issue). The state would determine whether the errors are due to a system issue where the allowable income was not calculated correctly or if the caseworker incorrectly applied an exclusion. Once the root cause is identified, the state would determine a corrective action and explain how the corrective action will reduce or eliminate that error category.

Implementation and Monitoring

States must complete the implementation and monitoring chart for each corrective action. Each corrective action should be entered on its own row and the state should add rows to the table as needed. The following information is required in the Implementation and Monitoring table.

- **Corrective Action:** Place the corrective action the state has identified in this section.
- **Is this an ongoing corrective action from previous rounds?** Please select "yes" if this corrective action is ongoing from prior pilot/ESC rounds. Please select "no" if this corrective action is new to Round 5.
- **Status:** Has the corrective action been implemented, not implemented or pending implementation?
- **Implementation date:** The date the corrective action was/will be implemented.
- **Responsible Party:** Agency, program, or personnel responsible for the implementation and supervision of the corrective action.
- **How State Plans to Monitor the Effectiveness:** Describe how your state plans to assess the progress of the implemented corrective action. The purpose of monitoring is to determine whether the implemented CAP is in the process of yielding intended results and meeting identified goals for reducing errors. Monitoring activities are ongoing, operational activities the state undertakes while CAP activities are being implemented.

Example of Implementation and Monitoring Table

Corrective Action	***Is this an ongoing corrective action from previous rounds?***	***Status***	***Scheduled Implementation Date***	***Responsible Party***	***How State plans to monitor the effectiveness?***
Implementing a system patch to correct the income calculations	*No*	*Implemented*	*8/10/16*	*ABC programming Contractor, Tom Jones*	The state will perform independent system testing prior to release, and quarterly audits will be completed to determine if the system is calculating income correctly.

Evaluation

States should describe how they plan to evaluate if the implemented corrective actions are accomplishing the desired results. This section should evaluate the current corrective actions or describe how the state will evaluate the corrective actions when they are implemented. It should be clear from the evaluation that the state will be able to determine if the corrective actions are achieving the expected results.

- *Example*: The state will conduct reviews of 15 eligibility determinations every month to confirm that the eligibility system is applying income exclusions correctly.

Section 16 - State Analysis of Findings

In this section, states will provide discussion/analysis of the cases identified as MAGI Medicaid, Non-MAGI Medicaid, and CHIP errors. PETT will prepopulate the number of payment errors and deficiencies reported in your state's findings spreadsheet. States will be required to provide an analysis of the payment errors and deficiencies as described below.

- **What were the main contributors to MAGI errors? What were the main contributors to non-MAGI errors?**
  - For this question, states should identify the main causes of MAGI and non-MAGI errors that were identified in the Round 5 pilot and consider the following questions.
    - Did state report more errors related to caseworker issues or system issues?
    - Are these errors related to ongoing issues that were identified in previous rounds or new issues?
- **Please provide an analysis and generally describe your state's MAGI vs. non-MAGI findings.**
  - For this question state should discuss any trends identified with MAGI vs. non-MAGI findings and consider the following questions.
    - Were there any issues only identified for MAGI or for non-MAGI cases?
    - Did state see any trends in the errors for MAGI vs. non-MAGI?
    - States should provide any additional analysis that may be useful to the state.
- **Please provide an analysis and generally describe your state's Medicaid vs. CHIP findings.**
  - For this question state should discuss any trends identified with Medicaid vs. CHIP findings and consider the following questions.
    - Were there any issues only identified for Medicaid or for CHIP cases?
    - Did state see any trends in the errors for Medicaid vs. CHIP?
    - States should provide any additional analysis that may be useful to the state.

Section 17: Resolved Corrective Actions from Previous Rounds of Pilots

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 prior rounds. 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 previous 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 earlier rounds of 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/Impact on Round 5 (if any):** 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. Describe the impact the action had on the Round 5 results.

Section 18 - 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.

- **How did Round 5 findings compare to the findings identified in your state's previous pilots?**
  - 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 error codes and qualifiers identified in Round 5 pilot compare with issues identified in previous rounds?

- **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.

  - *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 developing corrective action to address ongoing issues?**

- Please consider including any information that your state provided in Section 17 – Resolved Corrective Actions from Previous Rounds of Pilots.

- **Optional Additional State Analysis or General Comments**
  - 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 questions to the CMS Eligibility Pilots mailbox at FY2014-2016EligibilityPilots@cms.hhs.gov