Medicaid and CHIP Eligibility Pilots Spreadsheet Guidance

Round 5 Pilot - Cycle 1 and 2 States

****REVISED****

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicaid and CHIP Eligibility Review Pilots

Round 5 Findings Spreadsheet Instructions

March 28, 2017

Similar to Rounds 3 and 4 of the FY14-17 eligibility pilots, states will be required to report individual case review findings using the Round 5 pilot findings 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 5 pilot. **This document provides instruction for completing the Round 5 pilot findings spreadsheet.** Additional details regarding final reporting of results will be included in the Medicaid and CHIP Eligibility Review Pilots Round 5 Reporting and Corrective Action Guidance, which will be released at a later date.

PLEASE NOTE: If your state is not using the claims sample provided by the Statistical Contractor for the Round 5 eligibility pilots, then some elements of this guidance may not apply. Please refer to the alternative sample guidance that was sent on January 31, 2017. The alternative sample guidance will continue to be updated throughout the Round 5 review and reporting process. If you have any questions, please contact your CMS liaison.

States are required to submit a findings spreadsheet that lists each PERM ID along with the results of the review. States are required to report results on all cases that were reviewed through the Round 5 pilot. Additional information for uploading the spreadsheet in PETT 2.0 will be available at a later date.

CMS has made important changes to the spreadsheet since Round 4. In Round 5, the key changes to the spreadsheet include the following:

- The majority of states will now review eligibility for a sample selected from the Fee-for-Service (FFS) and Managed Care PERM claims sample. For these states, The Lewin Group (Lewin) will **pre-populate** the first nine columns **(Columns A through H)** of the spreadsheet based on the sampled claim. The partially populated spreadsheet will then be shared with the state for completion.
- States were previously asked to report **General** eligibility category/group in Round 4. In Round 5, states will be 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 will be called a "**Review Result**" and the options are **Correct, Payment Error, Deficiency Only, or Payment Error & Deficiency.**
- States will be 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 will have the option to report one (1) qualifier for each error code.
- For all cases reviewed, states will be required to report the assigned **FMAP** rate.
- For cases cited with either an **ER5 and 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 will be required to report the correct FMAP rate that should have been assigned and the total claims with the incorrect FMAP (if applicable).

Due Dates & Submission

The Round 5 pilot findings spreadsheet, along with corrective action information, is 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 numbers (e.g. total number of eligibility errors) into the corrective action report on PETT.

CMS recommends that states submit their findings spreadsheet as soon as it is completed and when the PETT 2.0 website becomes available, 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 pre-populated numbers in the corrective action template.

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 SC or will be automatically calculated using built in formulas.

NOTE: Please DO NOT 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 states 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:

Pre-populated based on Quarter data provided by Statistical Contractor (SC) or review period selected by states using alternative sample

C. Total Cases Reviewed

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

E. Total CHIP Cases Reviewed

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

Column A: Pre-populated Row Numbers

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 sFTP 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."**


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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 ER12) 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, but is also included again below in **Table 1**. 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.

Please 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 in error**.

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.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.

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 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.

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

Appendix A. Business Rules

The FY 14-17 Round 5 Pilot Findings spreadsheet has several business rules built into it. When the spreadsheet is uploaded onto the PETT 2.0 website, the system will check to ensure that all rules have been followed. The following section provides more information about these business rules embedded into the template to ensure states complete their spreadsheet appropriately. The list of business rules are as follows:

1. **If "OT - Other" is selected for "Point of Application," "Type of Application," and/or "Channel of Application," at least one of the optional fields must be populated.**

The state must fill out Optional Field(s) 1 and/or 2 (Columns AN and AO respectively) if the state chooses “OT - Other" for columns J, K, or L.

2. **If Column P is selected (the claim was dropped), then none of the other columns following are required.**

If the state indicates the claim was dropped in Column P, then the state will not need to fill out Columns Q through AO.

3. **If "Correct" is selected for "Review Result," (Column S), Column T through Column AE are not required.**

The state will not need to fill in the Error Code and Qualifier columns (Column S through Column AE) if the state chooses “Correct” for Column S.

4. **If "Payment Error," "Deficiency Only," or "Payment Error and Deficiency" is selected for "Review Result" (Column S), Column T and Column U must be completed.**

The state must fill in at least one Error Code and Qualifier (Columns T and U respectively) if anything other than “Correct” is chose in Column S.

5. **Columns V through Column AE are not required for any cases.**

While the state may report up to 6 Error Codes and Qualifiers for each case reviewed that is cited as a "Payment Error," "Deficiency Only," or "Payment Error and Deficiency" in Column S, the state is only required to fill in one of each (see Business Rule 4).

6. **Limit "Optional Field 1" and "Optional Field 2" to 300 characters.**

Optional Fields 1 and 2 (Columns AN and AO respectively) are limited to 300 characters of text.

7. **If "Redetermination" is selected for "Point of Application," "Redetermination" also needs to be selected for "Channel of Application" and vice versa.**

If the state selects “Redetermination” for Column J (Point of Application), the state must also select “Redetermination” for Columns K and L.

8. **Column AF is assigned for all cases**

States must fill out the “Assigned FMAP Rate” Column for all cases (Column AF).

9. **Column AG is required for all cases except if the "Review Result" (Column S) is "Correct" or if the "Error Code" selected is an ER5, ER6, or TD**

States must fill out the “Total Claim Payment in Error” column (Column AG) except if the case is correct or if the following error codes are selected: ER5, ER6 or TD.

10. **Columns AI through AL are required for cases in which one of the Error Codes (Columns T, V, X, Z, AB, and AD) is ER5 or ER6.**

States must fill out columns AJ through AL if they use ER5 or ER6 in Columns T, V, X, Z, AB, or AD.

11. **If "Error Code 1" (Column T) is selected, then "Qualifier 1" (Column U) has to be selected. The same applies to all other error codes and qualifier columns (V and W; X and Y; Z and AA; AB and AC; AD and AE).**

The state must select qualifiers associated with corresponding error codes listed under the dropdown menus provided in the spreadsheet.

Appendix B. Error Codes and Qualifiers (Revised March 28, 2017)

Error Code	Description	Qualifiers
ER1 – Not eligible for enrolled program; financial issue	Case should not have been granted eligibility for medical assistance (i.e., both Medicaid and CHIP) due to a financial issue.	1. Household composition or tax filer unit incorrect - caseworker 2. Household composition or tax filer unit incorrect - system 3. Tax filer status incorrect - caseworker 4. Tax filer status incorrect - system 5. Deduction incorrectly included/excluded - caseworker 6. Deduction incorrectly included/excluded - system 7. 5% MAGI disregard incorrectly included/excluded - caseworker 8. 5% MAGI disregard incorrectly included/excluded - system 9. Exempt income incorrectly included - caseworker 10. Exempt income incorrectly included - system 11. Countable income incorrectly excluded - caseworker 12. Countable income incorrectly excluded - system 13. Income conversion factor incorrect - caseworker 14. Income conversion factor incorrect - system 15. Resources calculated incorrectly - caseworker 16. Resources calculated incorrectly - system 17. Data entry error - caseworker 18. Resources incorrectly included/excluded - caseworker 19. Reported resources not included in calculations - caseworker 20. Reported resources not included in calculations - system 21. Income exceeds income limit, but was calculated correctly - caseworker 22. Income exceeds income limit, but was calculated correctly - system 23. Financial information provided, not acted on - caseworker 24. Income incorrectly calculated - caseworker (other) 25. Income incorrectly calculated - system (other)
ER2 – Not eligible for enrolled program; non-financial issue	Case should not have been granted eligibility for medical assistance (i.e., both Medicaid or CHIP) due to a non-financial issue	1. Residency requirement not met - caseworker 2. Residency requirement not met - system 3. Citizenship requirement not met - caseworker 4. Citizenship requirement not met - system 5. Social security number requirement not met - caseworker 6. Social security number requirement not met - system 7. Individual had other insurance (CHIP only) - caseworker 8. Individual had other insurance (CHIP only) – system 9. Age requirement not met – caseworker 10. Age requirement not met - system 11. Blindness/disability determination not correct at time of last action - caseworker 12. Identity requirement not met - caseworker 13. Identity requirement not met - system 14. Non-financial information provided, not acted on - caseworker 15. Other non-financial error – caseworker 16. Other non-financial error - system
ER3 – Should have been enrolled in a different program (i.e., Medicaid or	Case should not have been granted eligibility in enrolled program (i.e., Medicaid or CHIP), but should have been enrolled	1. Household composition or tax filer unit incorrect - caseworker 2. Household composition or tax filer unit incorrect - system 3. Tax filer status incorrect - caseworker 4. Tax filer status incorrect - system 5. Deduction incorrectly included/excluded - caseworker 6. Deduction incorrectly included/excluded - system 7. 5% MAGI disregard incorrectly included/excluded - caseworker

Error Code	Description	Qualifiers
CHIP); financial issue	in a different program due to a financial issue	8. 5% MAGI disregard incorrectly included/excluded - system 9. Exempt income incorrectly included - caseworker 10. Exempt income incorrectly included - system 11. Countable income incorrectly excluded - caseworker 12. Countable income incorrectly excluded - system 13. Income conversion factor incorrect - caseworker 14. Income conversion factor incorrect - system 15. Resources calculated incorrectly - caseworker 16. Resources calculated incorrectly - system 17. Data entry error - caseworker 18. Resources incorrectly included/excluded - caseworker 19. Reported resources not included in calculations - caseworker 20. Reported resources not included in calculations - system 21. Income exceeds income limit, but was calculated correctly - caseworker 22. Income exceeds income limit, but was calculated correctly - system 23. Income incorrectly calculated - caseworker (other) 24. Income incorrectly calculated - system (other)
ER4 – Should have been enrolled in a different program (i.e., Medicaid or CHIP); non-financial issue	Case should not have been granted eligibility in enrolled program (i.e., Medicaid or CHIP), but should have been enrolled in a different program due to a non-financial issue	1. Age requirement not met – caseworker 2. Age requirement not met – system 3. Blindness/disability determination not correct at time of last action - caseworker 4. Blindness/disability determination not correct at time of last action - system 5. Other non-financial error - caseworker 6. Other non-financial error - system
ER5 –Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; financial issue	Case was enrolled in the incorrect eligibility category due to a financial issue, which resulted in an FMAP error	1. Household composition or tax filer unit incorrect - caseworker 2. Household composition or tax filer unit incorrect - system 3. Tax filer status incorrect - caseworker 4. Tax filer status incorrect - system 5. Deduction incorrectly included/excluded - caseworker 6. Deduction incorrectly included/excluded - system 7. 5% MAGI disregard incorrectly included/excluded - caseworker 8. 5% MAGI disregard incorrectly included/excluded - system 9. Exempt income incorrectly included - caseworker 10. Exempt income incorrectly included - system 11. Countable income incorrectly excluded - caseworker 12. Countable income incorrectly excluded - system 13. Income conversion factor incorrect - caseworker 14. Income conversion factor incorrect - system 15. Resources calculated incorrectly - caseworker 16. Resources calculated incorrectly - system 17. Data entry error - caseworker 18. Resources incorrectly included/excluded - caseworker 19. Reported resources not included in calculations - caseworker 20. Reported resources not included in calculations - system 21. Income exceeds income limit, but was calculated correctly - caseworker 22. Income exceeds income limit, but was calculated correctly - system 23. Income incorrectly calculated - caseworker (other)

Error Code	Description	Qualifiers
		24. Income incorrectly calculated - system (other)
ER6 –Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; non-financial issue	Case was enrolled in the incorrect eligibility category due to a non-financial issue, which resulted in an FMAP error	1. Age requirement not met – caseworker 2. Age requirement not met - system 3. Blindness/disability determination not correct at time of last action – caseworker 4. Blindness/disability determination not correct at time of last action - system 5. Other non-financial error – caseworker 6. Other non-financial error - system
ER7 – Ineligible for service; not eligible for enrolled eligibility category; financial issue	Case was enrolled in the incorrect eligibility category due to a financial issue, which resulted in an individual receiving a service for which he or she shouldn't have been eligible	1. Household composition or tax filer unit incorrect - caseworker 2. Household composition or tax filer unit incorrect - system 3. Tax filer status incorrect - caseworker 4. Tax filer status incorrect - system 5. Deduction incorrectly included/excluded - caseworker 6. Deduction incorrectly included/excluded - system 7. 5% MAGI disregard incorrectly included/excluded - caseworker 8. 5% MAGI disregard incorrectly included/excluded - system 9. Exempt income incorrectly included - caseworker 10. Exempt income incorrectly included - system 11. Countable income incorrectly excluded - caseworker 12. Countable income incorrectly excluded - system 13. Income conversion factor incorrect - caseworker 14. Income conversion factor incorrect - system 15. Resources calculated incorrectly - caseworker 16. Resources calculated incorrectly - system 17. Data entry error - caseworker 18. Resources incorrectly included/excluded - caseworker 19. Reported resources not included in calculations - caseworker 20. Reported resources not included in calculations - system 21. Income exceeds income limit, but was calculated correctly - caseworker 22. Income exceeds income limit, but was calculated correctly - system 23. Income incorrectly calculated - caseworker (other) 24. Income incorrectly calculated - system (other)
ER8 – Ineligible for service; not eligible for enrolled eligibility category; non-financial issue	Case was enrolled in the incorrect eligibility category due to a non-financial issue, which resulted in an individual receiving a service for which he or she shouldn't have been eligible	1. Age requirement not met - caseworker 2. Age requirement not met - system 3. Citizenship requirement not met - caseworker 4. Citizenship requirement not met - system 5. Blindness/disability determination not correct at time of last action - caseworker 6. Blindness/disability determination not correct at time of last action - system 7. Other non-financial error – caseworker 8. Other non-financial error - system
ER9 – State non-compliance	The state did not conduct eligibility determination or	1. Citizenship not verified - caseworker 2. Citizenship not verified - system 3. Citizenship not verified correctly - caseworker 4. Citizenship not verified correctly - system

Error Code	Description	Qualifiers
with federal regulation	redetermination in accordance with federal regulations	5. Reasonable opportunity period ended - citizenship - caseworker 6. Reasonable opportunity period ended - citizenship - system 7. Immigration status not verified - caseworker 8. Immigration status not verified - system 9. Immigration status not verified correctly - caseworker 10. Immigration status not verified correctly - system 11. Reasonable opportunity period ended - immigration status - caseworker 12. Reasonable opportunity period ended - immigration status - system 13. Social Security Number not verified - caseworker 14. Social Security Number not verified - system 15. Social Security Number not verified correctly - caseworker 16. Social Security Number not verified correctly - system 17. Residency not verified - caseworker 18. Residency not verified - system 19. Post-eligibility period ended - Residency not verified - caseworker 20. Post-eligibility period ended - Residency not verified - system 21. Income not verified - caseworker 22. Income not verified - system 23. Post-eligibility period ended - Income not verified - caseworker 24. Post-eligibility period ended - Income not verified - system 25. Resources/assets not verified - caseworker 26. Resources/assets not verified - system 27. Post-eligibility period ended - age not verified - caseworker 28. Post-eligibility period ended - age not verified - system 29. Post-eligibility period ended - household composition not verified - caseworker 30. Post-eligibility period ended - household composition not verified - system 31. Redetermination not conducted timely (i.e., within 12 months or the federally required timeframe) - caseworker 32. Redetermination not conducted timely (i.e., within 12 months or the federally required timeframe) - system 33. Presumptive eligibility period ended - full eligibility determination not completed timely - caseworker 34. Presumptive eligibility period ended - full eligibility determination not completed timely - system 35. Application form not signed - caseworker 36. Application form not signed - system 37. Renewal form not signed - caseworker 38. Renewal form not signed - system 39. State did not do required disability/blindness determination at time of last action –caseworker 40. State did not do required disability/blindness determination at time of last action - system 41. State did not seek to clarify discrepant information that does not meet reasonable compatibility standard – caseworker 42. State did not seek to clarify discrepant information that does not meet reasonable compatibility standard - system
ER10 – Cannot confirm eligibility; insufficient documentation	Client under review may be financially and categorically eligible, but the state cannot provide	1. Application or review form not on file (unable to verify self-attestation) 2. Citizenship verification not on file 3. Social security number verification not on file 4. Income verification not on file/incomplete 5. Resource verification not on file/incomplete

Error Code	Description	Qualifiers
	required documentation to support the eligibility determination This code will be used for cases where the state correctly obtained the verification, but did not maintain documentation appropriately.	6. Residency verification not on file/incomplete 7. Electronic data source verification not on file 8. Inconsistent/incomplete information not resolved 9. Case file not provided 10. Post eligibility verification not on file 11. Tax filer status not on file 12. Electronic data source not accessed - caseworker 13. Electronic data source not accessed - system 14. State does not have medical record for blindness/disability determination (only needed if determination done as part of last action) 15. State does not have sufficient documentation for blindness/disability determination 16. Other verification not on file/incomplete 17. The record was lost or destroyed due to an unforeseeable and uncontrollable event such as fire, flood, or earthquake
ER11 – Cannot confirm Medicaid or CHIP eligibility determined by another agency or qualified entity	Client not enrolled in the underlying program on which eligibility for Medicaid or CHIP is based. The eligibility review pilots do not review the eligibility determination or redetermination made by the other agency (e.g., the SNAP determination would not be reviewed).	1. SSI - enrollment not established or verified 2. Title IV-E eligibility not established or verified 3. Targeted Enrollment - eligibility for underlying program (e.g. SNAP) not established or verified 4. Hospital presumptive eligibility (PE) - state did not follow appropriate process for enrolling individual 5. Other enrollment cannot be confirmed
ER12 – Other errors	Other errors that do not fall under other codes.	1. Individual was incorrectly denied/terminated resulting in an underpayment 2. Contribution to care calculated incorrectly - caseworker 3. Contribution to care calculated incorrectly - system
ER-TD – Technical deficiencies	The state did not determine or redetermine the case correctly, but the issue did not result in a payment error	1. Household composition or tax filer unit incorrect - caseworker 2. Household composition or tax filer unit incorrect - system 3. Tax filer status incorrect - caseworker 4. Tax filer status incorrect - system 5. Deduction incorrectly included/excluded - caseworker 6. Deduction incorrectly included/excluded - system 7. 5% MAGI disregard incorrectly included/excluded - caseworker 8. 5% MAGI disregard incorrectly included/excluded - system 9. Exempt income incorrectly included - caseworker 10. Exempt income incorrectly included - system 11. Countable income incorrectly excluded - caseworker

Error Code	Description	Qualifiers
		12. Countable income incorrectly excluded - system 13. Income conversion factor incorrect - caseworker 14. Income conversion factor incorrect - system 15. Resources calculated incorrectly - caseworker 16. Resources calculated incorrectly - system 17. Data entry error - caseworker 18. Resources incorrectly included/excluded - caseworker 19. Reported resources not included in calculations - caseworker 20. Reported resources not included in calculations - system 21. Income exceeds income limit, but was calculated correctly - caseworker 22. Income exceeds income limit, but was calculated correctly - system 23. Financial information provided, not acted on - caseworker 24. Income incorrectly calculated - caseworker (other) 25. Income incorrectly calculated - system (other) 26. Residency requirement not met - caseworker 27. Residency requirement not met - system 28. Citizenship requirement not met - caseworker 29. Citizenship requirement not met - system 30. Social security number requirement not met - caseworker 31. Social security number requirement not met - system 32. Individual had other insurance (CHIP only) - caseworker 33. Individual had other insurance (CHIP only) - system 34. Age requirement not met - caseworker 35. Age requirement not met - system 36. Blindness/disability determination not correct at time of last action - caseworker 37. Identity requirement not met - caseworker 38. Identity requirement not met - system 39. Non-financial information provided, not acted on - caseworker 40. Other non-financial error - caseworker 41. Other non-financial error - system 42. Blindness/disability determination not correct at time of last action - system 43. Citizenship not verified - caseworker 44. Citizenship not verified - system 45. Citizenship not verified correctly - caseworker 46. Citizenship not verified correctly - system 47. Reasonable opportunity period ended - citizenship - caseworker 48. Reasonable opportunity period ended - citizenship - system 49. Immigration status not verified - caseworker 50. Immigration status not verified - system 51. Immigration status not verified correctly - caseworker 52. Immigration status not verified correctly - system 53. Reasonable opportunity period ended - immigration status - caseworker 54. Reasonable opportunity period ended - immigration status - system 55. Social Security Number not verified - caseworker

Error Code	Description	Qualifiers
		56. Social Security Number not verified - system 57. Social Security Number not verified correctly - caseworker 58. Social Security Number not verified correctly - system 59. Residency not verified - caseworker 60. Residency not verified - system 61. Post-eligibility period ended - Residency not verified - caseworker 62. Post-eligibility period ended - Residency not verified - system 63. Income not verified - caseworker 64. Income not verified - system 65. Post-eligibility period ended - Income not verified - caseworker 66. Post-eligibility period ended - Income not verified - system 67. Resources/assets not verified - caseworker 68. Resources/assets not verified - system 69. Post-eligibility period ended - age not verified - caseworker 70. Post-eligibility period ended - age not verified - system 71. Post-eligibility period ended - household composition not verified - caseworker 72. Post-eligibility period ended - household composition not verified - system 73. Redetermination not conducted timely (i.e., within 12 months or the federally required timeframe) - caseworker 74. Redetermination not conducted timely (i.e., within 12 months or the federally required timeframe) - system 75. Presumptive eligibility period ended - full eligibility determination not completed timely - caseworker 76. Presumptive eligibility period ended - full eligibility determination not completed timely - system 77. Application form not signed - caseworker 78. Application form not signed - system 79. Renewal form not signed - caseworker 80. Renewal form not signed - system 81. State did not do required disability/blindness determination at time of last action - caseworker 82. State did not do required disability/blindness determination at time of last action - system 83. State did not seek to clarify discrepant information that does not meet reasonable compatibility standard - caseworker 84. State did not seek to clarify discrepant information that does not meet reasonable compatibility standard - system 85. Application or review form not on file (unable to verify self-attestation) 86. Citizenship verification not on file 87. Social security number verification not on file 88. Income verification not on file/incomplete 89. Resource verification not on file/incomplete 90. Residency verification not on file/incomplete 91. Electronic data source verification not on file 92. Inconsistent/incomplete information not resolved

Error Code	Description	Qualifiers
		93. Case file not provided 94. Post eligibility verification not on file 95. Tax filer status not on file 96. Electronic data source not accessed - caseworker 97. Electronic data source not accessed - system 98. State does not have medical record for blindness/disability determination (only needed if determination done as part of last action) 99. State does not have sufficient documentation for blindness/disability determination 100. Other verification not on file/incomplete 101. The record was lost or destroyed due to an unforeseeable and uncontrollable event such as fire, flood, or earthquake 102. SSI - enrollment not established or verified 103. Title IV-E eligibility not established or verified 104. Targeted Enrollment - eligibility for underlying program (e.g. SNAP) not established or verified 105. Hospital presumptive eligibility (PE) - state did not follow appropriate process for enrolling individual 106. Other enrollment cannot be confirmed 107. Individual was incorrectly denied/terminated resulting in an underpayment 108. Contribution to care calculated incorrectly - caseworker 109. Contribution to care calculated incorrectly - system 110. Residency requirement not met 111. Citizenship requirement not met 112. Social security number requirement not met 113. Individual had other insurance (CHIP only) 114. Age requirement not met 115. Blindness/disability determination not correct at time of last action 116. System or caseworker processed case incorrectly due to applicant entry error 117. Other non-financial error 118. Blindness/disability not determined 119. Approval notice information inconsistent***** 120. Approval notice not on file***** 121. Approval notice not sent***** 122. Beneficiary premiums/spend down/cost of care incorrect calculations***** 123. PARIS match not conducted at most recent redetermination***** 124. PARIS match information not acted on***** 125. Application not processed timely***** 126. State did not provide the recipient with a pre-populated renewal form (for MAGI non-passive renewals) ***** 127. Wrong data sources accessed for verification - caseworker***** 128. Wrong data sources accessed for verification - system***** 129. Appropriate verification documentation not requested/collected - caseworker***** 130. Appropriate verification documentation not requested/collected - system***** 131. Verified information incorrectly - caseworker*****

Error Code	Description	Qualifiers
		132. Verified information incorrectly - system*****
		133. TPL requested information not provided - caseworker*****
		134. Required forms not on file/incomplete*****
		135. Client not moved from pregnant women category to new category 60 days postpartum*****
		136. Other state-specific eligibility processes not followed - caseworker*****
		137. Other state-specific eligibility processes not followed - system*****

***Note: Cases should only be reported as a technical deficiency and not as a payment error.**