Medicaid and CHIP Eligibility Review Pilots

Round 5 - Cycle 1 and 2 States Frequently Asked Questions Version 2

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Medicaid and CHIP Eligibility Pilot Round 5 Guidance FAQs

This document provides a summary of Frequently Asked Questions (FAQs) regarding the FY14-17 Round 5 pilot. CMS will update this document periodically throughout the course of the pilot study. Please note that some questions and corresponding responses were provided in Version 1 of the FAQs which was shared with the states on January 24, 2017. Additional Version 2 questions are marked with "*NEW*" throughout the FAQ.

Please note: FAQs only apply to the Cycle 1 and Cycle 2 states who are conducting their own pilot reviews and may not be applicable to Cycle 3 states working with the Eligibility Review Contractor (ERC) for Round 5.

I. ROUND 5 PILOT REVIEW FEE-FOR-SERVICE AND MANAGED CARE SAMPLING

A. Methodology

QA1: What was the methodology used to determine the Fee-For-Service (FFS) and Managed Care (MC) claims sample sent to each Cycle 1 and 2 state?
AA1: Each state's FFS/MC claims sample for the eligibility review pilots will be submitted to the Cycle 1 and 2 PERM states in mid-January 2017 by the PERM Statistical Contractor (SC) via an electronic secure file transfer protocol (eSFTP). Sample sizes vary by state. State specific quarter sample sizes are based on the state's most recently completed PERM quarterly sample, the state's proportion of Medicaid and CHIP FFS/MC spending, the available claims sample for the state's most recent PERM quarter, and a slight oversample from CHIP. Please note that, as in previous pilots, there is no error rate being calculated in Round 5, and therefore, the sample should not be considered statistically valid.

B. Inclusions/Exclusions

QB1: Will the FFS/MC claims sample include any negative cases?
AB1: Yes, but this is not typical. A negative case could be sampled if there is a denied claim following an individual's termination from Medicaid or CHIP. All cases randomly sampled, except those indicated in the guidance as cases allowed to be dropped, should be reviewed. Negative cases cannot be dropped from the review if sampled. Please contact your CMS PERM Eligibility Liaison if this situation comes up.

QB2: Express Lane Eligibility (ELE) cases are to be dropped from the reviews. How will states report dropped ELE cases?
AB2: The Round 5 reporting spreadsheet will include a field where the state can indicate dropped ELE cases. CMS issued guidance to states on how to complete the Round 5 reporting spreadsheet on March 28, 2017.

QB3: FFM-D cases identified in FFM-D states are to be dropped from the review sample. How will states report dropped FFM-D cases?
AB3: The Round 5 reporting spreadsheet will include a field where the state can indicate dropped FFM-D cases. (Note: If states worked on an FFM-D case to resolve inconsistencies and make a final eligibility determination, then states are to include such cases in the eligibility reviews).Only FFM-D cases in Cycle 1 and 2 states are excluded from the Round 5 eligibility review pilots; Cycle 3 states will not be excluding FFM-D cases, as the Eligibility Review Contractor (ERC) will be conducting the FFM-D case reviews.

QB4: My state received a sample with two claims for the same recipient. How should the state review and report on these claims?*NEW*
AB4: The state should maintain both claims in the sample. The state should determine whether each claim is associated with a different determination or redetermination based on the date of service (i.e., did the same or different action cause the person to be eligible for Medicaid/CHIP as of each date of service).

- If the action was the same, the state should conduct the case review once and report the same finding for both claims.
- If the action was different, the state should review each action to determine whether the action taken was appropriate and report a separate finding for each claim.

QB5: My state has a Medicaid expansion eligibility category, which is paid for with Title XXI funds. Should cases for clients enrolled in this category be included in the Medicaid or CHIP sample?*NEW*
AB5: The samples for PERM are based on funding stream. Therefore, these Medicaid expansion cases should be included in the CHIP sample since they are funded through Title XXI.

C. Utilizing Claims Sample Fields to Conduct Eligibility Reviews

QC1: Some of the sampled FFS/MC claims submitted to the state have an Invoice Control Number (ICN)/ Transaction Control Number (TCN) but no Recipient ID. The state tried to identify the client based on ICN/TCN, but it does not appear to match the state's claim. How should the state identify the client?*NEW*
AC1: The PERM claims Medicaid sample includes Medicare premium payments which are submitted directly from CMS to the PERM Statistical Contractor. The ICN/TCN assigned to

Medicare premium payments will not match claims in the state's MMIS. The state should use the recipient's name and date of birth to identify the client in the state's eligibility system.

QC2: The state found that the "Total Claim Payment" column (Column H) on the selected review sample prepopulated spreadsheet submitted to the state for reviews has an incorrect claim amount listed. How should the state address this issue? **NEW**
AC2: Because the selected PERM FFS/MC claims samples only includes original paid claims, there may be instances in which a claim was adjusted and the updated paid amount is not reflected in the sample file sent to the state. States should notify CMS and provide the PERM ID, incorrect amount, and correct amount prior to making any adjustments to the PETT 2.0 reporting spreadsheet.

II. ROUND 5 PILOT REVIEW TOOLS AND TEMPLATES

D. Timeline and Requirements

QD1: If states choose to utilize review tools provided by CMS, will states be required to submit them once reviews are completed?
AD1: As indicated in page 18 of the Round 5 guidance, review tools were provided to Cycle 1 and 2 states as resources only. States may use their own tools to conduct their reviews. However, the tools used by states may be subject to CMS review. Further, CMS may request the documentation tracker during the course of the Round 5 reviews in order to better understand issues related to the maintenance of eligibility documentation. A discussion of these tools may also be added to the agenda for the monthly pilot call with your state.

E. Documentation Tracker

QE1: When should states use the documentation tracker?
AE1: States should use the documentation tracker to document any information that can be requested from another agency, third party data sources, or externally from the client including missing, outdated, or discrepant information. During the Round 5 Pilots, states are not permitted to submit additional documentation when reviewers cite a federal non-compliance error (i.e., ER9). Please refer to page 11 of the Round 5 Pilot Guidance. However, states will be allowed to submit documentation under the following non-federal error circumstances:

- Reviewer determines an appropriate action was taken at the time of the determination/redetermination but the documentation to support that action is missing
- Reviewer determines an appropriate action was not taken at the time of the determination/redetermination but the state can verify the eligibility element through a third party data source

QE2: Is the documentation tracker only to track client contact conducted in Round 5? ***NEW***

AE2: No. All requests made to obtain information that was not in the original case file are to be added to the tracker. Specifically, states should be tracking all of the following types of requests:

- Requests to another agency when documentation needed is not in the original case file;
- Requests to third party data sources for verification requests, such as data matches; and
- Requests to the client to obtain needed documentation, as a last resort.

III. CONDUCTING CASE REVIEWS

F. Payment Errors v. Deficiencies

QF1: In Round 5, states have the option to report a finding as "Correct", "Payment Error", "Deficiency Only", or "Payment Error and Deficiency". What is the difference and how should it be reported? ***NEW***

AF2: Error codes help distinguish a payment error from a deficiency, while the corresponding qualifier provides additional detail identifying the reason for the selected error. All ER1-12 error codes are considered payment errors. By definition, payment errors are review errors resulting in an overpayment or underpayment of claims. This includes eligibility errors as well as errors cited due to insufficient documentation issues or Federal non-compliance. Cases cited with any of these error codes are considered payment errors, including cases that are cited as both a "payment error and deficiency." Technical deficiencies, ER-TDs, are those in which the error did not result in dollars in error or incorrect determination of eligibility.

QF2: My state has a sampled claim where the paid amount is $0. If an error is found when conducting the eligibility review, should we cite a payment error or a technical deficiency? ***NEW***

AF2: If the sampled claim has a paid amount of $0, any eligibility error found would not meet the definition of a payment error, as provided in QF1. Therefore, the state should cite a technical deficiency, using the appropriate qualifier from one of the ER codes. If your state has a question about this FAQ, please contact your CMS PERM Eligibility Liaison.

G. Denied Claims

QG1: How should states review a negative case that is randomly sampled in the FFS/MC claims?

AG1: Negative cases, and the action to deny/terminate, should be reviewed in accordance with the ***Round 4*** negative case review guidance. If the state identifies that the case was incorrectly denied/terminated, it should be cited with error code ER12.

H. Post-Eligibility Verification

QH1: A state acted on self-attested income, but not within the required post-eligibility verification period. How should the state cite this case?
AH1: If the agency fails to complete the post-eligibility verification within the required period specified in the state's Verification Plan, the case should be cited as an ER9. In instances when the state's Verification Plan does not outline a specific post-eligibility verification period, states should cite an ER9 if the post-eligibility verification is not conducted within 90 days or by the date of payment of the claim (whichever is later). If the verification is completed past the period stated in the State's Verification Plan or within 90 days but before the date of payment, it should be cited as a Technical Deficiency (ER-TD).

QH2: The date of service (DOS) and date of payment both fall within the 90 day post-eligibility verification window. How should the state cite this case?
AH2: This case is correct.

I. Federal Non-Compliance Errors

QI1: How should a case be cited if the action under review is a federal requirement but the state is unable to determine if it was compliant due to insufficient documentation?
AI1: If the reviewer is unable to find documentation to assess if the state met federal regulation requirements (i.e., all those listed as qualifiers under ER9), then the case should be cited with an insufficient documentation error (ER10). States ***will not be allowed*** to request documentation from third party data sources or the client to obtain information needed to complete the review.

QI2: What if the state was compliant with federal regulation requirements but there was no documentation to prove it?
AI2: If the reviewer is unable to find documentation but there is evidence in the case file or system that the state met federal regulation requirement/s, then the state ***will be allowed*** to request documentation from third party sources or the client to obtain information needed to complete the review. The case should be cited with an insufficient documentation error (ER10) if no documentation is obtained.

For example, a state's system indicates that pay stubs were used to verify income at the time of the last determination. However, the state cannot locate the paystubs relevant or applicable to the last determination date in the case file during the PERM review. In this example, the state would be allowed to request documentation because there is evidence that the required verification occurred. The state would be allowed to access a third party data source to support the income used at the time of the last determination or, as a last resort, conduct client contact.

QI3: The state did not comply with a federal regulation requirement, such as verification of income/residency/citizenship/immigration/SSN, renewals, application signatures, etc. The Round 5 guidance indicates that non-compliance should be cited as a federal regulation error (ER9) and the reviewer should not obtain third party verification or reach out to the client to obtain missing information. Does that mean that the reviewer should stop the review of the case?

AI3: No. Reviewers should complete the case review for all other eligibility review components not impacted by Federal non-compliance errors in accordance with the state's case review checklist. The reviewer should not attempt to obtain verification or missing information for specific review components cited with an ER9. For example, if income was not verified at the time of the determination, the state should not request income verification for the purpose of completing the pilot case review.

One exception to this type of case is discussed in question AI4 below, which indicates that redeterminations not conducted timely would prompt the state to stop the review.

QI4: My state found that a case was not renewed within 12 months, as required by Federal Regulation. As clarified in QI3, reviewers should complete the review of all eligibility elements not impacted by Federal non-compliance errors. What does that mean for renewals not conducted timely? **NEW**

AI4: If the reviewer identifies that the state was non-compliant with Federal Regulation due to the "redetermination not conducted timely (i.e., within 12 months as of the date of service)", the state should cite these errors and consider the review complete. This is because reviewers cannot use outdated information to complete a case, and the state is not allowed to request new information for non-compliance errors.

J. Insufficient Documentation Errors

QJ1: Would the state cite a case as ER10 if the reviewer was able to obtain the verification from third party data sources or client contact?

AJ1: No. For cases where the state is allowed to provide additional documentation to complete a review, the state would cite Technical Deficiency (ER-TD) if the state was able to obtain the verification and verify that eligibility was appropriately determined. The state may use any applicable qualifier listed in other error codes, including those under ER10.

For example, if it was determined that the state did verify citizenship per an indicator in the state's system or through the review of caseworker notes but did not have the documentation on file that was used at the time of the last determination under review (e.g., birth certificate), the state would be allowed to verify citizenship for PERM through a trusted third party data source or through client contact. If the state was able to obtain this verification for PERM, the state

should cite an ER-TD if eligibility was not impacted with qualifier "citizenship verification not on file" (listed under ER10).

QJ2: My state reviewed a case where there was missing information for both citizenship and income, but the case file indicated that the verification had been done at the time of the determination. The state was successful in obtaining the necessary documentation to verify citizenship in order to complete the review, but was unsuccessful in obtaining income verification. Is our state required to report both of these issues?
AJ2: Yes, both issues should be reported. If it is verified that citizenship was determined correctly, the state should cite the citizenship issue as a Technical Deficiency (ER-TD), with qualifier "citizenship verification not on file." As for the income issue, if the state could not produce income verification via third party data sources or from the client, an insufficient documentation error (ER10) should be cited.

K. Documentation Request Process

QK1: Case file information indicates that income was verified with pay stubs at the time of the determination, but the state is unable to locate pay stubs in the state's document imaging system. Is the state permitted to contact a county office to request the physical check stubs? **NEW**
AK1: Yes. Because the case file indicates that income was verified, the state is permitted to obtain documentation from internal sources, such as county offices or sister agencies, to obtain verification.

L. FMAP and Group/Category Errors

QL1: Why is Round 5 incorporating a review of FMAP Application into eligibility reviews?
AL1: Under the requirements of the proposed PERM rule, CMS is moving away from identifying federal improper payments at the aggregate level and beginning to identify federal improper and correct payments at the sample level to enhance federal reporting. This approach is included in the Round 5 eligibility pilots and will require application of the FMAP rate to each sampled claim. Previously, improper payments were only cited if the total computable amount - the federal share plus the state share - was incorrect. However, this regulatory update will allow CMS to cite improper payments when a claim's FMAP is incorrect so that CMS can achieve an accurate reporting of federal dollars in error.

QL2: If the state is reviewing cases based on claims from the 4th quarter of 2015, what FMAP rates will the state need to identify and apply to the case?
AL2: The FMAP rates should reflect those allowable rates effective on the date of service. Generally, FMAP rates based on the eligibility category will be effective for the entire Federal Fiscal Year and will update the first day of the following fiscal year. These include 1) regular FMAP rates and 2) enhanced FMAP rates for newly eligible individuals (which begin reducing from 100% each year, beginning with FY17). The other areas with increased FMAP – Breast and Cervical Cancer and Qualified Individuals – are always 100%. Please contact your CMS PERM Eligibility Liaison if you have additional questions.

QL3: How would the state reviewer code the case if the individual was placed in the wrong eligibility category but the FMAP rate was the same as the eligibility category the individual should have been enrolled in?
AL3: It should not be cited as an error. In the instance of an incorrect category placement where the FMAP is not affected, the case should be cited as a Technical Deficiency (ER-TD). Note: This is a change from Round 4.

QL4: How would the state reviewer code the case if the individual was placed in the wrong eligibility category that had a different FMAP rate than the eligibility category in which the individual should have been enrolled in?
AL4: It should be cited as an error (ER5 or ER6). Please refer to Appendix F in the Round 5 Guidance for information on how to capture dollars in error.

QL5: My state has multiple Medicaid categories/groups. The caseworker made a data entry error which caused the client to be enrolled in an incorrect Medicaid subgroup. However, the client was still eligible for overall Medicaid. How should the state cite this case?
AL5: This case should only be cited as an error if the correct subgroup has a different FMAP rate (ER5 or ER6), or the correct subgroup has a different benefit package and the sampled claim was for services that the individual should not have received (ER7 or ER8). Otherwise, a Technical Deficiency (ER-TD) should be cited.

QL6: How should a state report a payment error for a sampled managed care capitation payment where the case was placed in the wrong eligibility category? **NEW**

AL6: As part of the eligibility review, states are required to determine if an individual is in the correct eligibility category. Additionally, the eligibility review will also verify that all information about the case used to make the determination was accurate per case documentation. If the state identifies any information that was not correct at the time of the determination (e.g., the individual's address) or if the individual was placed in the wrong eligibility category, it is possible that the capitation amount for the individual could be incorrect due to this eligibility determination error. The payment error would be the difference between the managed care capitation rate that was paid on behalf of the individual and what the capitation amount should have been.

The state should cite an ER7 or an ER8, along with the appropriate qualifier, if the client was placed in the wrong eligibility category and a different capitation payment should have been made. If there are no issues identified with the determination under review, the state is not required to further review the accuracy of the capitation payment.

QL7: The sampled claim is for a benefit that was not covered for the Medicaid/CHIP group the individual is enrolled in. How should the state review and cite this case? **NEW**

AL7: If, based on the state's review of a case, it is determined that the claim sampled was for a service that should not have been covered, an ER7 or ER8 may be cited. This issue may come up with limited category programs (e.g. emergency services) or eligibility categories that are associated with different managed care capitation payments (see AK5). For example, the client was enrolled in the parent/caretaker category, but should have been enrolled in the emergency services only category due to citizenship status. If the sampled claim was not for an emergency service, the state should cite an ER8 error. If the sampled claim was for an emergency service, the state should cite an ER-TD, since the service would have still been covered if the client had been enrolled in the correct category.

QL8: The client was enrolled in Pregnancy Medicaid (as of the DOS), but the state found that the individual should have been enrolled in Parent Caretaker. How should the state cite this case? **NEW**

AL8: The state will need to determine if the service paid for by the claim would have been covered under the Parent Caretaker group. If the individual enrolled in the Pregnancy Medicaid group is eligible for different services than those in the Parent Caretaker group ***and*** the claim was sampled for a benefit that would not have been covered by the Parent Caretaker group, then the state should cite this case as an ER8. However, if not, the state should cite this as an ER-TD. ER8 should only be used if the sampled claim was for a service that should not have been covered, and therefore, there were improper federal payments made.

QL9: Does the state need to complete the "Correct FMAP Rate" column if an ER3 or ER4 is cited? **NEW**

AL9: The “Correct FMAP Rate” column does not need to be filled out on the spreadsheet, as enrollment in the wrong program means the total claim paid is improper. In column AG, please input the total claim paid (sum of federal and state share).

M. Title IV-E

QM1: My state’s Round 5 case review sample includes a number of Title IV-E cases. My state’s QC staff does not have access to the third party agency (i.e., Child Protective Services) systems or files to verify Title IV-E benefits. How should the state review these cases? **NEW**

AM1: The state does not need to provide support for the underlying Title IV-E eligibility. However, QC staff will need to see electronic or hard copy documentation showing that the individual was enrolled in Title IV-E benefits at the time of the date of service of the sampled claim for the purpose of Round 5 eligibility reviews. Thus, if QC does not have access to this documentation, a request to obtain the information from the applicable agency should be made. This request should be tracked in the documentation request tracker.

N. Renewals and Changes of Circumstance

QN1: The state found that the redetermination under review was incorrect. However, the client provided information a change of circumstance prior to the DOS. The state processed the change correctly, and as of the DOS, the client was eligible for Medicaid. How should the state cite this case? **NEW**

AN1: A Technical Deficiency (ER-TD) should be cited for the incorrect redetermination; the state should use a qualifier that describes why the full redetermination was incorrect. This case is not a payment error because it was correctly eligible as of the date of service, and therefore, the sample claim is not a federal improper payment.

QN2: My state’s eligibility system conducted a passive renewal that re-enrolled a client prior to the DOS. Post renewal, the client reported multiple changes of circumstance (e.g., income change, change in employment, etc.) also prior to the DOS. How should the state review this case? **NEW**

AN2: The state should review the accuracy of the full determination as of the DOS and review that the state took appropriate steps to follow-up on reported changes.

O. PARIS

QO1: How should states conduct a review of PARIS for Round 5? **NEW**

AO1: In accordance with the Round 5 guidance, states are required to review the following elements related to PARIS.

- Did the state submit the sampled recipient's ID to PARIS?
- Did the state review the report returned from PARIS to see if a match occurred?
- Was appropriate action taken if there was a match?

States are only required to follow the steps above for cases where the last action is a renewal. This does not mean that CMS requires a PARIS match at renewal. Rather, because there is no specific timeframe within which states have to conduct a PARIS check and because many states submit regular (often quarterly) reports to PARIS for all enrolled recipients, CMS assumes that by the time a renewal occurs, a case is likely to have been included on the most recent submission of cases to PARIS. Reviewing new applications for PARIS matching isn't possible because completing the PARIS match as of the new determination isn't required and is rarely done before coverage begins.

If a state identifies any issues with PARIS matching, a Technical Deficiency (ER-TD) should be cited along with the appropriate qualifier.

IV. REPORTING OF FINDINGS

P. Citing Multiple Errors

QP1: The state has identified multiple errors on one case that fall under one ER code, some of which have the same qualifier and some of which have a different qualifier. How should the state report these errors? **NEW**

AP1: All error codes identified during a case review should be reported. For errors identified that fall under one ER code, the state should report on the case as follows:

- Report each error code/qualifier combination separately. For example, the state found that the tax filer status was incorrectly determined, which also led to the caseworker incorrectly excluding countable income from the income calculation. These two financial issues made the person ineligible for Medicaid. Thus, the state should identify these errors by citing ER1 twice, one with the "Tax filer status incorrect- caseworker" qualifier and one with "Countable income incorrectly excluded- caseworker" qualifier.
- Report an error code/qualifier combination once if the errors have the same qualifier. For example, if more than one type of countable income was excluded from the income calculation, resulting in the person not being eligible for Medicaid, the state would only cite ER1 with the qualifier "Countable income incorrectly excluded- caseworker" once in the applicable case. The details of the errors can be explained more fully in the CAP.

QP2: What date should states use to populate the *Date of Last Action* column (Column Q)? **NEW**

AP2: The *Date of Last Action* should be the date of the action that made the client eligible for services on the date of service of the claim. It is the last determination, redetermination, or change in circumstance prior to the date of service of the claim.

QP3: For SSI cases, how should the state report the *Date of Last Action*, *Point of Application*, and *Type of Application* in the spreadsheet? **NEW**

AP3: For SSI cases, the field for date of last action is not required and can be left blank in the spreadsheet, as PERM eligibility is not reviewing the action taken by the SSA. "Other" may be selected as the Point of Application, Type of Application, Channel of Application, and Type of Last Action.