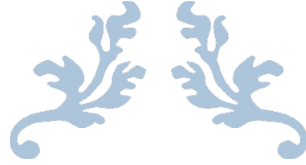
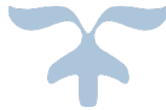


# Medicaid and CHIP Eligibility Pilot Proposal Guidance

# Round 5 Pilot - Cycle 1 and 2 States



NOVEMBER 2016

**Background**
The 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. States will conduct four streamlined pilot measurements over the three-year period. The pilot measurement results should be reported to CMS by the last day of June 2014, December 2014, June 2015, and June 2016. Additionally, SHO Letter 15-004, issued on October 7, 2015, extended the pilot measurement through FY 2017, requiring states to conduct a fifth pilot study with results due to CMS in June 2017. This guidance is intended for the 5th, and final, round of pilots.

The Medicaid and CHIP Eligibility Review Pilots consist of two independent components, the case review component and the test case component. States are required to complete both components, which are explained below:

1. **Case Review Component**: Review actual eligibility determinations made by the state and perform an end to end review from initial application/point of transfer to the final eligibility determination (also referred to as 'case review').
2. **Test Case Component**: Run test cases (provided by CMS) through the UAT section of the state's eligibility determination system.

Guidance for running and reporting on the test cases was issued on November 16, 2016 and will remain on a separate track and timeline. The Round 5 Pilot Proposal Guidance for the review of state eligibility determinations follows below. Note that throughout the guidance, determinations include both new applications (unless otherwise specified) and redeterminations.

**Round 5 Overview**

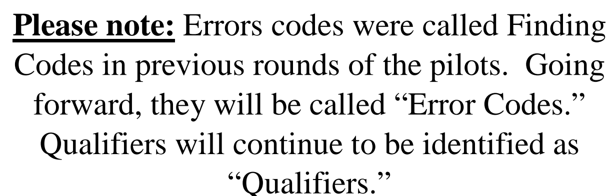
With the completion of four rounds of pilots, states should be preparing to resume the PERM eligibility reviews. The goal moving forward with each round of the eligibility pilots is to reduce or eliminate eligibility errors that have the potential to be identified in the PERM review process prior to the resumption of PERM eligibility and the calculation of state eligibility error rates. **Through this final round of pilots, states should focus on establishing an audit trail, maintaining records, and including a review of all determinations that may be subject to review in future PERM eligibility cycles.** To effectively prepare states for PERM, some determinations that may have been excluded in prior pilot rounds should now be included in reviews for Round 5.

CMS made significant changes to the Round 5 pilot requirements, which are documented below.

- **Sample timeframe:** States will no longer be required to create a separate eligibility universe for cases reviews in Round 5. States will be using the claims sample selected as part of the state's last or current PERM measurement. Cycle 1 states will receive a claims sample from Quarter 4 of Federal fiscal year (FFY) 2015. Cycle 2 states, which are

currently being measured under PERM, will receive samples from the most recent completed quarter as of December 1, 2016. This could be Q1, Q2, Q3, or Q4.

- **Sampling Unit:** The sampling unit for Round 5 will change from the case to the claim. States will be required to review the eligibility determination that made the individual eligible to receive the service as of the claim Date of Service (DOS).
- **Sample Size:** Given the move in Round 5 to official PERM claims quarterly sample, the total sample size will be dependent on the size of the state's most recent PERM quarterly sample but will not exceed 250 claims.
- **Inclusions/Exclusions:** The PERM claims universe includes all originally paid Title XIX and Title XXI claims for services provided to Medicaid and CHIP clients. The only exclusions from the PERM claims universe are adjustments, non-Title XIX and Title XXI claims, and aggregate or administrative payments not tied to services provided to a client (e.g., mass adjustments, grants, staff costs). States will be required to review all cases receiving Title XIX or Title XXI match, with the exception of determinations made by states with a Federally Facilitated Marketplace – Determination (FFM-D) and Express Lane Eligibility (ELE) cases. If sampled, the state will be required to drop these case(s) from review. Additional detail is provided below on Page 5.
- **Error Codes and Qualifiers:** States will be piloting revised error codes and qualifiers and will be required to submit unique error code/qualifier combinations (see below). The new error codes are modeled after the Medical Review (MR) and Data Processing (DP) review error codes used on the PERM claims side. Using these codes in Round 5 will allow for state input into refining the codes and qualifiers, if necessary.



**Please note:** Errors codes were called Finding Codes in previous rounds of the pilots. Going forward, they will be called "Error Codes." Qualifiers will continue to be identified as "Qualifiers."

**Due Dates**

Pilot proposals for Round 5 are due to CMS no later than January 18, 2017. States will be encouraged to use resource tools that will be provided in Round 5 or demonstrate to CMS that they have similar tools in place (see page 18 for additional information).

Once pilot proposals are submitted, CMS will review and provide comments and/or approval within two weeks. If CMS does not approve the proposal, states will have one week to revise the proposal based on CMS comments.

Per the August 15, 2013 SHO letter, pilot findings are due to CMS no later than June 30, 2017. Detailed reporting guidance will be issued at a later date.

NOTE:
PERM proposes to use the claims sample for eligibility to measure official eligibility error rates beginning in 2019.

**Universe Development, Sample Selection, and Sample Size**

In Round 5, states will utilize the Medicaid and CHIP Fee-for-Service (FFS) and Managed Care (MC) quarterly claims samples from their most recent claims review cycle for all PERM Cycle 1 and Cycle 2 states. Universe data from which the samples will be selected have already been submitted by each state.[1]

- For Cycle 1 states, the Q4 sample from the most recent cycle will be used (claims paid between July 1 and September 30, 2015).
- For Cycle 2 states, which are currently being measured under PERM, claims from the most recently completed quarter as of December 1, 2016 will be used. This could be Q1, Q2, Q3, or Q4.

The PERM Statistical Contractor (SC) will be responsible for providing each state with their Round 5 samples. From the state's official quarterly PERM sample, the SC will select a subsample of claims which the state will review in Round 5. The subsample will be selected using a simple random sample methodology. The total sample size will depend on the size of each state's most recent PERM quarterly sample but will not exceed 250.

Once the subsample for Round 5 is selected, the SC will transfer eligibility sample files to the state. The SC will work with each state point of contact to establish access to a secure file transfer (FTP) site, hosted by the SC, where the sample will be submitted to each state.

The eligibility sample files will include the fields listed in Appendices A (FFS) and B (MC). Each claim will have a PERM ID assigned by the SC. The PERM ID submitted to states for the Round 5 pilot will be the same identification number assigned to the claim for the Cycle 1 and Cycle 2 PERM measurement. PERM IDs are created using a logic identifying which State, Cycle, Universe, Quarter, and claim. The table below provides the logic for the claim PERM ID.

[1] Specific details on the PERM claims universe submission and sampling process can be found in the PERM Manual: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/CMSPERMMAnual1.pdf

| Field No. | Field Designation | Field Description |
|---|---|---|
| 1 | State Abbreviation | Standard postal 2 character state abbreviation |
| 2 | | |
| 3 | Medicaid/CHIP Indicator | Medicaid/CHIP Indicator |
| 4 | Cycle Year | 15 or 16 |
| 5 | | |
| 6 | Quarter | Q1, Q2, Q3, Q4 |
| 7 | | |
| 8 | FFS/MC Indicator | F=FFS<br>M=Managed Care |
| 9 | Sequence Number | 3 digit sequence number assigned by the state to ensure each case has a unique case ID |
| 10 | | |
| 11 | | |

As noted above, the PERM claims universe is specified based on the claim date of payment. However, the date of service for each claim is also provided. The state will utilize the claim date of service to identify the determination which will be reviewed. Following are two examples of sampled claims and the appropriate determination to be reviewed.

- Example 1: The claim DOS was 8/15/15 with a payment date of 8/28/15. The application was filed 2/4/15. The caseworker authorized the action on 2/25/15, with an eligibility effective period of 2/1/15 through 1/31/16. No changes were reported by the household and no action was taken on the case between the date the worker authorized the action and the DOS.
    - The state should review the 2/4/15 application and all verification/documentation that was received prior to the date of the eligibility determination (02/25/15) and supports the eligibility determination.
- Example 2: The claim DOS was 8/15/15 with a payment date of 8/28/15. The application was filed on 2/4/15. The caseworker authorized the action on 2/25/15, with an eligibility effective period of 2/1/15 through 1/31/16. On 5/13/15, the client reported a new job and provided information regarding the anticipated hourly rate and hours. The caseworker entered the earnings information from the new job, and authorized a change to the case on 5/23/15.

- The state should review the 2/4/15 application and all verification/documentation that was received prior to the date of the eligibility determination (02/25/15) and supports the eligibility determination authorized on 2/25/15;
- Additionally, the state should review the 5/23/15 action and the verification/documentation that was received pertaining to the new job;
- Because not all elements (i.e., age, relationship, household composition, unearned income) were impacted by the new job, the state should review the information as it existed at the time of the 02/25/15 eligibility determination.

In the event that the state has any questions or encounters any issues with utilizing the claims sample for the Round 5 eligibility reviews, the state should contact CMS and the SC who will work with each state on resolution of questions.

**Inclusions and Exclusions**

In Round 5, CMS is requiring states to review all cases included in the FFS and MC sample, with the exception of FFM-D and ELE cases. The rationale for minimizing exclusions in Round 5 is to better prepare states for the eventual re-start of PERM and the types of cases that will be part of that review. States will be required to confirm and report to CMS if any of the following cases were excluded or dropped from the review:

1. FFM-D – cases made and determined by the FFM in FFM-D states. FFM-D states should include determinations where state resolved inconsistencies and made the final eligibility determination.
2. ELE – Express Lane Eligibility cases.

States will also be required to notify CMS during pilot reporting which FFM-D and/or ELE cases were dropped from the sample. To account for any dropped cases, each state will be provided with a small oversample which will need to be utilized if any cases are dropped due to being an FFM-D or ELE case.

**Mitigations Plans/Waivers**
In the pilot proposals, states should provide information about CMS-approved mitigation plans or strategies, delayed renewal waivers in place, or any other information that impacts the eligibility review process or pilot approach. CMS understands that all states may not be able to comply with all of the requirements below. In those cases, states should clearly identify those requirements and provide an explanation of the states' limitations in meeting them. States will be asked to list their mitigation plans/waivers in relation to reviews and systems requirements in the proposal/pilot planning document.

**Case Record Documentation**
States will be asked where the documentation for their eligibility cases are located. Specifically, states should include information about whether all case files are stored in electronic data systems or whether there are hard copy case files that will need to be requested from county offices or other state offices/entities. States should also note any anticipated challenges around collecting necessary documentation (e.g., can the state access third party data sources to confirm that a case was receiving SSI benefits).

## Reviews

**Case Review Overview**
The purpose of the case review is to evaluate the accuracy of the eligibility determinations and redeterminations, identify errors and deficiencies in the eligibility determination process, and conduct corrective actions based on the issues identified. The case review process should assess whether the caseworkers and systems followed federal policies, state procedures (i.e., state verification plan), and other state policies when making the eligibility determinations.

Eligibility determinations should be reviewed in accordance with the state's CMS-approved State Plan, state regulations, state eligibility manuals, agency policy and procedural manuals, verification plans, approved waivers, other state documents or directives that reflect current policy and procedure, and Federal guidance (e.g., federal laws and regulations, State Health Official and Medicaid Director Letters).

To assist the pilot case review staff in conducting thorough reviews, a variety of other key staff should participate, including:

- **Eligibility Policy staff** who are familiar with how the state interprets both federal and state policy and are aware of what policy was in place when the determinations under review were made;
- **Eligibility/Caseworker staff** who are familiar with the caseworker processes and workflow, as well as how information is maintained (e.g., accessing case records);
- **Financial staff** who are familiar with the application of Federal Medical Assistance Percentage (FMAP); and

- **Systems staff** who are familiar with how the system processes cases and interacts with other systems (e.g., third party data sources).

While the pilot case review staff should be independent of the staff responsible for making eligibility determinations, the expertise of this staff will be critical in assisting the state pilot review staff in reviewing determinations in accordance with state processes and policies.

**Identification of Individual and Last Action Prior to Case Review**

The pilot case review staff should first collect necessary background information on each case sampled for review. The review should include:

1) Identification of last action – States must determine the last action(s) on the case that made the individual eligible to receive services on the sampled claim DOS which serves as the basis for the review period. As noted above, the SC will provide the state with the recipient ID, name, and the claim date of service which can be used by the state to determination the last action under review that made the individual eligible on the DOS. Examples of identification of last action date are located on pages 4-5.

2) Documentation of eligibility category – States should note the eligibility category that the individual was enrolled in as of the last action under review. During the review process, the state will be required to review to determine if the eligibility category assigned at the last determination was accurate.

3) Collect documentation – States should collect all documentation associated with the last action under review. This could include identifying the necessary screenshots or requesting and collecting documentation from county offices.

**Case Review Requirements**

The purpose of the case review is to identify any issues with the eligibility determination process and assist states in their efforts to develop corrective actions to address vulnerabilities in their Medicaid and CHIP programs. The case review focuses on whether a determination, redetermination, or change was processed accurately and appropriately based on applicable state and federal policies. The point in time under review is based on the most recent action in effect as of the DOS of the sampled claim payment. Eligibility determinations will be reviewed in accordance with the following:

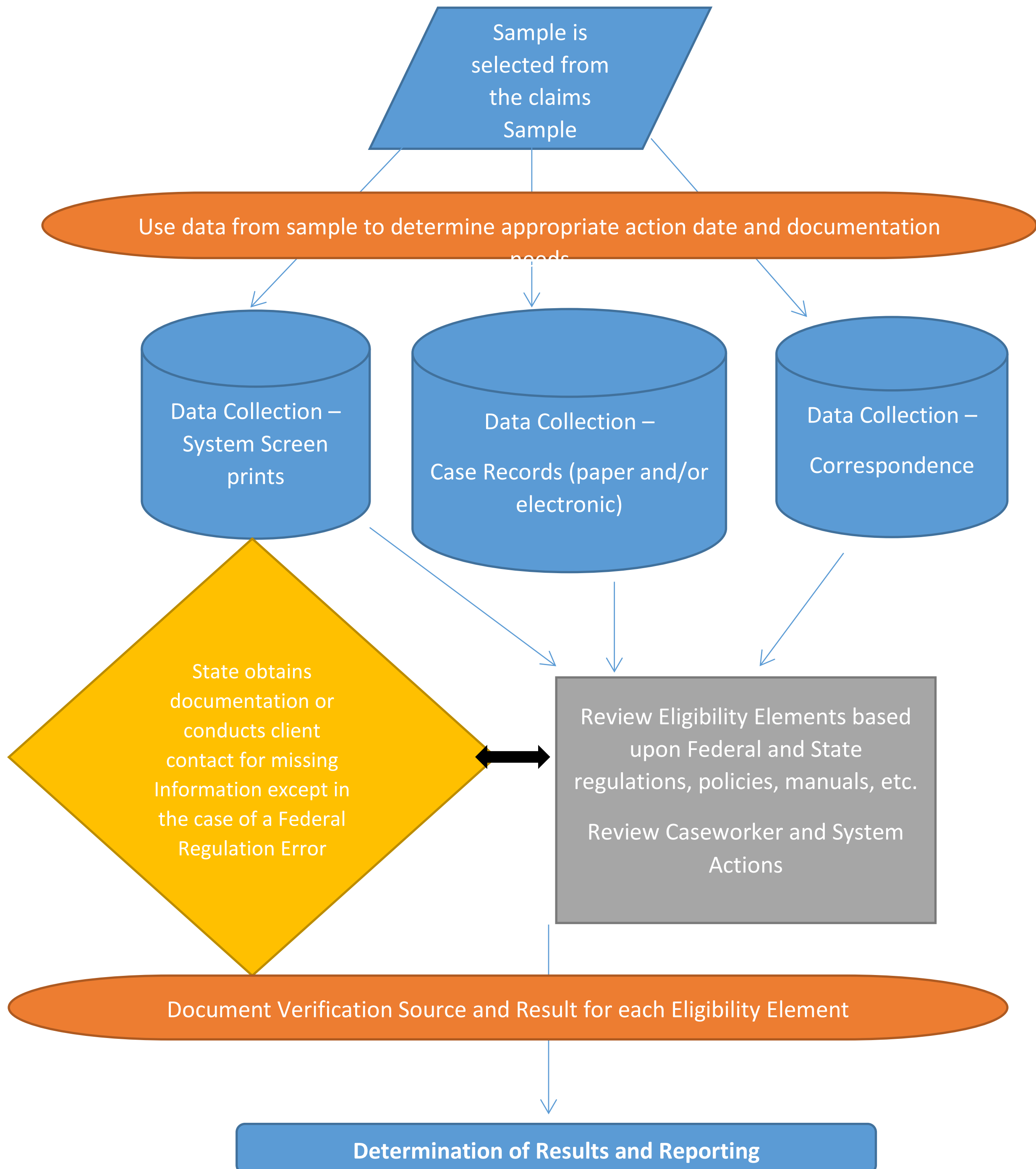
- CMS-approved State Plan
- State and Federal Regulations
- State policy and procedure Manuals
- MAGI-Based Eligibility Verification Plan and amendments
- Approved waivers
- Federal guidance
- Memorandums; and

- Application forms and other standardized forms

**Overview of the Case Review Process**

The case review process consists of multiple steps from the point an eligibility sample is selected by the SC to the culmination of reporting of findings for each sample. The case review process is described by the following flow chart in **Figure 1** below. The details around the process for conducting the eligibility case review are also outlined in the following sections.

**Figure 1. Eligibility Review Pilots Case Review Process**



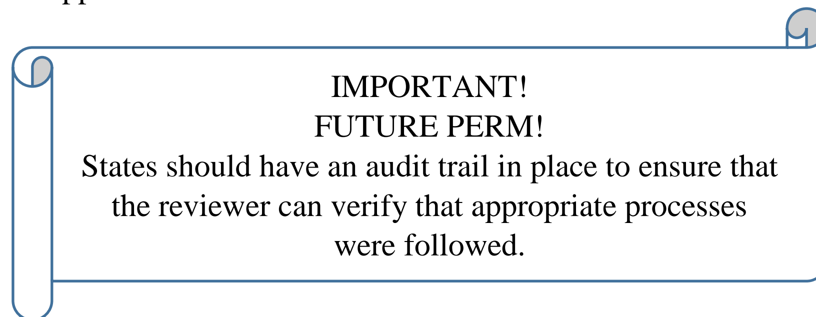
**Case Review Methodology**

After receiving the necessary background information on the sampled case from the SC, the pilot review staff should begin conducting eligibility reviews with the following review considerations:

1. Federal and state policy to identify the accuracy of the eligibility determinations
2. Internal and external processes that may result in findings and therefore need to be addressed through corrective actions.

The eligibility case review includes a caseworker action review and a systems review. Definitions of each type of review are listed below:

- The eligibility case review should focus on whether the caseworker made the correct decision based on information available to the caseworker at the time of the decision.
- This pilot should also review whether the caseworker took appropriate actions to guide the case through the system and the system appropriately processed case information.
- Further, the review should include an evaluation of whether the case decision was made appropriately by system edits and whether the appropriate information was verified through the applicable data sources.




To address these considerations, the reviewer should take the following actions:

1) Review each case for all required eligibility criteria to confirm that the state made the appropriate determination of eligibility given information available on the application, through trusted third party data sources, and via hard copy documentation, as applicable. States should review criteria against state and federal policies.

    a. For system actions where calculations (e.g., income, household composition) were conducted as part of the determination, independently review the information used by the system and determine that calculations were done correctly. The reviewer should manually calculate income and household composition to evaluate whether the calculation performed by a caseworker or system was correct.

b. For systems actions where third party data was used to verify self-attested information that was included on application, review system actions/interactions to determine if the appropriate data sources were utilized according to the state's verification plan and other state and federal policies.

2) Determine whether the eligibility determination for program coverage (Medicaid or CHIP) was correct or incorrect.

3) For systems actions where information was received from an outside entity, review systems actions to determine if the information was entered into the system appropriately and timely.

4) When processing was transferred between the system and a caseworker, review whether that transfer happened timely and appropriately. State should report findings if transfer between caseworker and system should have occurred but did not.

5) Determine whether the eligibility determination was made within the allowable timeframes.

- Below are some examples of situations where additional information is needed:
  - A state used paystubs to verify income which is supported by caseworker notes and/or indicators in the state eligibility system but no documentation is present in the case file.
  - Information was requested to verify assets (e.g., funeral accounts, investments) and income (e.g., pensions) that were either identified in the application or where sources such as SOLQ inquiries where it indicates payment is made to an asset account but no documentation is present in the case file.

Reviews should include all elements necessary to evaluate correctness of overall program eligibility as well as eligibility category. The state's case review should be comprehensive including all of the elements described below and any additional elements that the state uses to determine the appropriate program eligibility, eligibility group, and determination process. At a minimum, the eligibility criteria in Appendix C below should be considered when reviewing cases for the accuracy of eligibility determinations. States should also include information for any additional review elements that are not included in the chart below but are included in the eligibility determination process.

For each of the eligibility criteria listed states are required to conduct reviews to evaluate the accuracy of the eligibility determinations and identify errors and deficiencies in the processes in accordance with: state CMS-approved State Plan, state regulations, state eligibility manuals, agency policy and procedural manuals, verification plans, approved waivers, other state documents or directives that reflect current policy and procedure, and Federal guidance (e.g., federal laws and regulations, State Health Official and Medicaid Director Letters).

States should consider the following when conducting reviews:

- What information from the case record will be reviewed?
- What information from eligibility screen will be reviewed to verify appropriate eligibility determination process was followed?
- How will compliance with verification plan be reviewed?
- Any other review process for eligibility criteria not listed.

Please note that all elements may have different implications for Medicaid vs. CHIP or MAGI vs. non-MAGI cases. Similarly, not all required review elements apply to both active and negative cases or to both initial determinations and redeterminations. The various review elements, as well as the more detail on the review process, are displayed in Appendix C and Appendix D, respectively.

**Case Review – Missing Information/Additional Documentation**
The eligibility case review cannot be used to correct a problem identified with the determination under review when not compliant with federal regulation. States will be required to cite errors with no further client contact or follow-up when found in non-compliance with federal regulation requirements (e.g., if a state does not conduct a required redetermination at the end of the 12-month period, the state will need to cite an error on the case and will no longer review the case as of the sample month).

**Federal non-compliance errors**

In situations where documentation is missing for a case and the absence of the documentation does violate any federal regulations requirements, states will not have the opportunity to utilize third party data sources or conduct client contact to verify the missing information. In situations where documentation is missing for a case and the absence of the documentation does not violate any federal regulations requirements, states will have the opportunity to utilize third party data sources or conduct client contact.

States must exhaust third party data sources prior to conducting client contact. States should note that guidance regarding use of third party data sources or client contact specifically for eligibility reviews are still under CMS review and are subject to change when the official PERM eligibility measurement resumes.

**Documentation Tracker**

States will also be asked to track third party data source and client contact issues. A Documentation Tracker (Appendix E) will be provided for all other instances when the state requires additional documentation to complete case reviews. The tracker must indicate what items were missing and what items were requested and obtained successfully.

Similar to the claims review component, CMS is moving PERM eligibility toward more stringent requirements with the federal regulation and the goal of Round 5 pilots is test the process before the resumption of PERM. This document will be a useful tool for states and CMS to track this process and states are not required to submit this document but may be subject to review by CMS.

**Other Case Review Considerations**
The Round 5 pilot will now include a review of different types of determinations, a couple of which were also included in the Round 4 pilot. Background information on these cases, along with the review methodology has been outlined in the sections below.

**SSI Cases**
Section 1634 (42 U.S.C. 1383c) of the Social Security Act allowed states to enter into an agreement with the Commissioner of Social Security to provide Medicaid coverage to recipients of SSI. In a "1634 state" individuals deemed eligible for SSI by the Social Security Administration are automatically enrolled in Medicaid. The SSI cases will be included in the Round 5 eligibility pilot reviews, if applicable.

Although the state will not need to review the individual's underlying eligible for SSI, the state will be required to review to ensure the case record contains verification that the individual was receiving benefits for SSI as of the claim DOS. Examples of documents that may be used to verify receipt of SSI include the following:

- State On-line Query (SOLQ)
- Bendex
- SSA Benefit Letter

**Post-Eligibility Income Verification**
As part of the eligibility pilot reviews, states are required to ensure that income was verified within 90 days following the determination. If the income was not verified within the 90 days, and the state is unable to verify the income at the time of the Round 5 review, an eligibility error will be cited. Alternatively, if the income was not verified within the required timeframe but was verified prior to the claim date of payment, a technical deficiency would be cited.

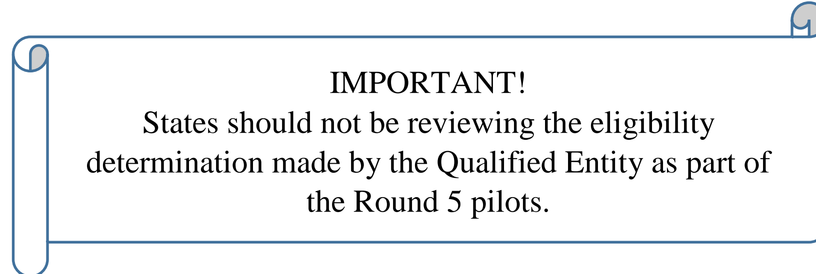
**Presumptive Eligibility**
Presumptive eligibility (PE) is an expedited process of enrolling eligible individuals in the Medicaid program and provides individuals with Medicaid coverage PE allows the State and certain providers, designated as Qualified Entities (QE) and Qualified Hospitals (QH), to make a preliminary Medicaid eligibility determination. The different types of PE are described in more detail below.

- **State determined PE**: Under this form, the State makes the PE decision. The State has the option to determine if they will conduct PE and which programs will allow an individual to be enrolled using PE criteria.

- **Qualified Hospital determined PE:** The ACA established the Hospital PE program, which requires states to allow hospitals to make PE decisions giving temporary Medicaid to children, pregnant women, parents and caretaker relatives, former foster children, and adults covered under the Medicaid expansion.
- **Qualified Entity determined PE**: States have the option to designate clinics, health care centers community-based organizations, and schools as QEs and allow them to make PE decisions.

If the DOS of the sampled claim is during the time period the beneficiary is determined eligible based on PE, the state will:

- Verify that the start and end dates of the PE set forth in the eligibility system were properly established;
- The start date is the date on which the client files the application;
- The end date is the date that a decision has been made on a Medicaid application that was filed after PE began; or
- If a Medicaid application has not been filed, the end date of PE is the last day of the month following the month in which the determination of PE was made.
- If the case is coded as PE, but is outside of the PE period and a full application has not been submitted and Medicaid approved, the case will be cited as a payment error attributed to the State.




**Targeted Enrollment**

For cases enrolled through targeted enrollment strategies (i.e., SNAP applications), states should review and attest that the state followed the appropriate processes and procedures for enrollment in Medicaid or CHIP. States must have a CMS approved waiver to conduct targeted enrollment strategies and this information should be reported by the state in the "Mitigation/Waiver" section of the pilot proposal.

If the review finds that the state did not follow the appropriate targeted enrollment strategy process for enrolling the individual in Medicaid or CHIP, the case would be reported as an eligibility error. For example, if the state finds that there was no indication that the individual was eligible for the underlying program (e.g., SNAP) when the determination was made, an ER12 should be cited on the case as the Medicaid or CHIP eligibility would not have been able to be confirmed. States will also need to review any other eligibility elements that were verified by the Medicaid agency as part of the targeted enrollment strategy (e.g., citizenship).

PLEASE NOTE!
States should not be reviewing the underlying eligibility determination made by another program through targeted enrollment strategies (e.g., income determined by SNAP program should not be reviewed).

**Passive Renewals**
The State must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's record or other more current information available to the agency, including but not limited to, information accessed through any data sources accessed by the State. These automated processes are known as passive renewals or ex parte renewals.

When reviewing a passive renewal, the state will:

- Confirm that all required data matches were conducted in accordance with the state's verification plan.
- Verify the electronic data supported the information provided by the client, including that the income met the reasonable compatibility standard.

If all electronic matches were conducted and supported the original information provided by the client, the state will:

- Confirm that a notice was sent to the client notifying them of the renewal approval and the information used to determine their eligibility. If the client did not respond with any changes, the state will consider the review to be complete (passive renewal).
- If the client did respond with changes, the state will review the case to ensure that those changes were appropriately reflected in the renewal process.

If the required matches were not conducted or discrepant information was identified, the state will take the following actions:

- Review the case to confirm that a notice was sent to the client requesting additional information.
- If the client responded the state will review the information to ensure it supported the eligibility determination.
- Verify a notice of decision was sent to the client.

**PARIS – Redeterminations Only**
States are required to conduct Public Assistance Reporting Information System (PARIS) matches for recipients to determine if they are receiving benefits in another state. States should apply this review process to **redetermination** cases. States will be required to review the quarterly reports

yielded from PARIS matches. The following list includes questions the states should be asking during the review process:

1. Did the review happen?
2. Did the state review the report for matches?
3. Was appropriate action taken if there was a match?

**Federal Medical Assistance Percentage (FMAP) Reporting Federal Dollars in Error**

States will be asked to identify their Medicaid and CHIP FMAP rates specific to the case that is being reviewed. If there is an error associated with the case under review, the federal share of the claim dollar amount will need to be identified. States will be also asked to identify if there are any specific eligibility codes associated with eligibility categories with enhanced FMAP rates (e.g., newly eligible adults vs. other adults in Medicaid expansion states).

For example, the reporting spreadsheet will include the following items:

1. State-assigned FMAP rates
2. Total dollars in error on claim amount
3. State dollars in error on claim amount
4. Federal dollars in error on claim amount

Additional guidance around FMAP and how it will be applied to the eligibility findings is provided in Appendix F below. This guidance includes example cases with the information that should be included in the reporting spreadsheet.

**Definition of an Error**

During the case review, the state reviews each eligibility element to determine if the caseworker and /or system accurately determined or redetermined the individual's eligibility for Medicaid or CHIP based on federal and/or state policies. When the state finds that the caseworker or system processed the case incorrectly, the case will be cited as one of the following:

- **Eligibility Review (ER) error:** An eligibility error is an error resulting in an overpayment or underpayment that is determined from a review of a beneficiary's eligibility determination, in comparison to the documentation used to establish a beneficiary's eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State's improper payments.
- **Technical Deficiency (TD):** A technical deficiency occurs when a finding in processing identified through case review does not meet the definition of an eligibility error.

PLEASE NOTE!
Error codes and qualifiers have significantly changed from previous rounds.

In these instances, the state will assign an error code, which identifies the error at a high-level. Each error code will be assigned a qualifier, which identifies the root cause of the error. Since the error codes and qualifiers are assigned to an element and the state may find issues in more than one element within a case, ***multiple eligibility errors and qualifiers can be cited on the case***. Additionally, a case can be cited with both eligibility errors and technical deficiencies if there are multiple issues with the case.

- **Error code**: Identifies the error at a high-level.
- **Qualifier**: Describes the root cause of an error, thereby permitting the accurate identification of issues and facilitating the development of CAPs.

This following section describes the error codes and qualifiers and how they will be used to report findings to the states.

**Error Code and Qualifiers Overview**
States will be required to use CMS specified error codes to designate the results of the review and assign the appropriate qualifier for each case reported as an error or deficiency as defined in this guidance.

The error code will specify if the sampled case had an incorrect overall eligibility determination, was incorrectly placed in a category/group, had a deficiency but the overall eligibility determination was correct, or was a correct case with no issues identified.

The qualifier will specify all issues that were found when reviewing the case (e.g. caseworker incorrectly calculated income, household composition incorrect) which may or may not have led to an eligibility error. Correct cases should have no qualifiers reported.

**Change from Round 4:**
Since the error codes and qualifiers are assigned to an element and the state may find issues in more than one element within a case, multiple eligibility errors and qualifiers can be cited on a case.

**Error Codes**
**Note: Program** refers to Medicaid and CHIP.

Previously in Round 4, states used “finding codes” such as “Correct,” “Deficiency,” “Eligibility Error,” “Group Error,” and “Undetermined.” In Round 5 of the eligibility pilots, there are changes to codes for reporting results. States should assign each reviewed case one of the following codes to identify eligibility errors and technical deficiencies:

- **ER1 -** The client is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) based on a financial issue

- **ER2 -** The client is not eligible to receive coverage under the enrolled program (i.e., Medicaid or CHIP) based on a non-financial issue.
- **ER3 -** The client is not eligible to receive coverage under their enrolled program (i.e., Medicaid or CHIP), but should have been enrolled in a different program based on a financial issue.
- **ER4 -** The client is not eligible to receive coverage under their enrolled program (i.e., Medicaid or CHIP), but should have been enrolled in a different program based on a non-financial issue.
- **ER5 -** The client is enrolled in the wrong eligibility category, resulting in a federal claiming (i.e., FMAP) error based on a financial issue.
- **ER6 -** The client is enrolled in the wrong eligibility category, resulting in a federal claiming (i.e., FMAP) error based on a non-financial issue.
- **ER7 -** The client is enrolled in the wrong eligibility category, resulting in the receipt of services to which the client is not eligible based on financial issues.
- **ER8 -** The client is enrolled in the wrong eligibility category, resulting in the receipt of services to which the client is not eligible based on non-financial issues.
- **ER9 -** The client is not eligible as the state did not comply with federal requirements.
- **ER10 -** The client may be eligible, but the state cannot provide the necessary documentation to support the eligibility determination.
- **ER11 -** The client is not enrolled in the underlying program (e.g., SSI, Title IV-E, SNAP) that resulted in his or her eligibility.
- **ER12 -** Other payment errors not captured by the codes listed above.
- **ER-TD -** The state incorrectly applies federal or state policy, but the client continues to remain eligible for the enrolled program or category.

As outlined in Appendix G below, the error codes have qualifiers that serve to provide states with a detailed and complete description of the cause of the error. Many qualifiers also identify whether the source of the error was the caseworker or the system.

The list of error codes and qualifiers is designed to capture as much detail as possible regarding errors or technical deficiencies. However, not all error codes or qualifiers will apply to every state, depending upon the state's business model for eligibility. CMS will be updating the qualifiers on a continuous basis to ensure they capture the types of issues that may be found during the case review. Examples of some of the error codes and qualifiers have been provided below.

1. **Federal non-compliance error example**: The state did not conduct the eligibility redetermination timely (e.g., within 12 months or the federally required timeframe.
2. **Eligibility criteria error example**: The client's income was incorrectly calculated by the state's eligibility system, which led to the individual being incorrectly determined eligible for Medicaid.

3. **Technical deficiency example**: An approval notice was not sent to the applicant after they were determined eligible for CHIP.

**Quality Control**

States are required to implement quality control measures to ensure accuracy of the reviews and to describe such measures in the pilot proposals. Examples of such measures would be performing a re-review on 10% of the sampled cases, on all errors, etc.

**Reporting Results**

Round 5 pilot results are due to CMS by June 30, 2017 and will be reported on the PETT 2.0 website.

During the ESC pilots, a number of tools were created to support the review process. States will be encouraged to use resource tools that will be provided in Round 5 or demonstrate to CMS that they have similar tools in place:

- **Policy collection tool** – Tool is used to track state policies documents that will be utilized for reviews (e.g., State Plan, state regulation, state policy manuals).
- **Case review checklist** – Developed for each case reviewed and walks through the status of each eligibility criteria. Used as a tool for states to aid in the review process.
- **Missing documentation/verification tracker** – Used to track what documentation is missing from the case file, the location of the documentation, and whether client contact is needed/utilized. Used as a tool for states to aid in the review process.

The tools listed above are part of the piloting process and it is proposed that the ERC will utilize similar tools in conducting state eligibility reviews. Use of these tools in Round 5 will allow states to provide feedback in order to make improvements and updates prior to when PERM eligibility resumes.

For Round 5 reporting, CMS will issue a more detailed reporting and corrective action guidance including a reporting spreadsheet and template at a later date. States will submit individual case review findings, as required in past PERM cycles and the Round 4 pilot, and will submit final findings and corrective actions to CMS via the PETT website. States will be required to confirm that the reported results are accurate and specify the state staff member designated to attest to the accuracy of the results.

**Case-Specific Results**

States are required to report results on all cases that were reviewed (not just the minimum number) through the Round 5 Pilot. States will be required to submit a findings spreadsheet (format to be released at a later date) that lists each PERM ID (provided by the SC) reviewed along with the results of the review of each case. States will be required to report all errors and deficiencies associated with each reviewed case. States will also report other case specific information (i.e. channel of application).

PLEASE NOTE:
States will receive a new reporting spreadsheet for Round 5, which will include new fields (e.g., FMAP reporting) and new drop-down boxes (e.g., new error codes, new qualifiers). States are required to use new spreadsheets for Round 5.

**Results Narrative and Corrective Actions**

States will also be required to submit a narrative with a discussion/analysis of the overall findings as well as a description of corrective actions. This narrative will be based on findings reported in Round 5 pilot. Corrective actions are required for each error and deficiency identified through the Round 5 pilot reviews.

Along with the Round 5 results and corrective actions, states are also required to provide an update on the Round 4 corrective actions, including an evaluation of the effectiveness of the corrective actions. This would include details on what corrective action is working and any updates to corrective actions that have been implemented for areas that are not working.

**Recoveries**

States are not required to refund the FFP for errors identified through these eligibility pilots. For errors identified through another audit or through other means outside of these pilots, states are subject to disallowances under the Medicaid recoveries regulation.

**Staffing and Administrative Matching**

States can utilize state staff (including existing PERM/MEQC review staff) or contractors to fulfill pilot requirements. If states use state staff for review, the state agency responsible for conducting the pilot reviews must be independent of the state agency that makes eligibility determinations (similar to the current PERM/MEQC independence requirements). The agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews must be functionally and physically separate from the agency and personnel that are conducting the eligibility review pilots. The staff responsible for eligibility policy and making eligibility determinations must not report to the same direct supervisor as the staff conducting the eligibility pilots. States are required to describe how the agencies maintain independence in the pilot proposal.

Administrative matching should be claimed under PERM for Medicaid and CHIP according to the sample size from each program. States should claim as they normally would for the PERM program. As specified in the Affordable Care Act: State Resource FAQ at; http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf, the enhanced funding for Medicaid eligibility systems operation and maintenance does not apply to PERM activities which are considered program integrity activities and eligible for the 50 percent FFP for Medicaid and 90 percent FFP for CHIP.

**Questions**

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

# APPENDICES A-G

**Appendix A: FFS Sample File Layout**

| Field No. | Field Designation | Field Description |
|---|---|---|
| 1 | PERM ID | This identifier is assigned by the SC |
| 2 | ICN | Unique claim identifier (e.g., ICN, TCN, other state issued number) |
| 3 | Claim type | State claim type indicator, typically identifying whether the claim is an institutional, medical, or crossover claim |
| 4 | Date Paid | The date a claim or payment was originally adjudicated or paid; not the check date (unless there is no adjudication date) |
| 5 | Medicare crossover indicator | Indicates whether the claim is a crossover claim from Medicare to Medicaid |
| 6 | Category of service | Classification for broad types of state/federal covered services<br>Can be T-MSIS category of service or state-defined service type |
| 7 | Source location | The system of origin/location in which the claim was originally adjudicated. |
| 8 | Payment status | Paid or denied indicator for each claim or claim line as it was originally adjudicated; should not reflect an adjusted payment status<br>"P" for paid, "D" for denied |
| 9 | Total computable amount paid on the header | Total computable amount for the claim (at the header).<br>Total Computable Amount = Federal Share + State Share + Any local share<br>Amount paid should be net of all recipient and third party cost sharing (co-payments, TPL, coinsurance, etc.) recipient. |
| 10 | Date-of-service from (claim) | Beginning DOS on the claim. |
| 11 | Date-of-service to (claim) | End DOS on the claim. |
| 12 | Recipient ID | Recipient ID number<br>Can be Medicaid ID or system-specific ID |
| 13 | Recipient Name | Recipient Name<br>States may submit recipient name according to state preference (e.g., can submit multiple fields for first, middle, and last name or a single field containing recipient full name) |
| 14 | Recipient date of birth | Recipient date of birth |

| Field No. | Field Designation | Field Description |
|---|---|---|
| 15 | Recipient gender | Recipient gender code<br>"M" for male, "F" for female |
| 16 | Recipient county | Recipient county |
| 17 | Total computable amount paid line | Total computable amount paid at the claim line.<br>Total Computable Amount= Federal Share + State Share + Any Local Share<br>Amount paid should be net of any co-payments, third-party, or other beneficiary liability |
| 18 | Date-of-service from (line) | Beginning DOS on the line<br>Should be included for each line of a claim |
| 19 | Date-of-service to (line) | End DOS on the line<br>Should be included for each line of a claim |
| 20 | Date paid line | Paid date for claim<br>Line |
| 21 | Sampling unit level | A code that is used to denote if the record is a header or a line claim<br>"H"= header, "L"= line |
| 22 | User option fields 1-10 | The state may supply additional fields as necessary. |

**Appendix B: Managed Care File Layout**

| Field No. | Field Designation | Field Description |
|---|---|---|
| 1 | PERM ID | This identifier is assigned by the SC |
| 1 | ICN | Unique claim identifier (e.g., ICN, TCN, other state-issued number) |
| 2 | Date paid | Original date of payment or adjudication |
| 3 | Amount paid | Total computable amount paid of the payment |
| 4 | Managed care program indicator | Indicator of the program (TANF, PACE, LTC, behavioral health) |
| 5 | Payment type | E.g., monthly capitation, delivery kick payment or other recipient-specific supplemental payment, individual reinsurance payment |
| 6 | Funding code | Indicates the funding source for the claim or claim lines (e.g., Title XIX, Title XXI) |
| 7 | Provider ID | Medicaid/CHIP ID for the managed care organization |
| 8 | Recipient ID | Recipient Medicaid/CHIP number |
| 9 | Recipient name | Recipient Name<br>States may submit recipient name according to state preference (e.g., can submit multiple fields for first, middle, and last name or a single field containing recipient full name) |
| 10 | Recipient rate indicator | Rate cell or rate group used to determine the payment for the recipient to the managed care plan |
| 11 | Recipient aid category | Eligibility type |
| 12 | Recipient DOB | Recipient date of birth |
| 13 | Recipient gender | Recipient gender code<br>"M" for male, "F" for female |
| 14 | Recipient county | Recipient county |
| 15 | Service area indicator | Indicator for the geographic service area if the service area is not the county |
| 16 | Source location | The system of origin/location in which the sampling unit was adjudicated |
| 17 | Coverage period from | Beginning date of the coverage period or DOS for the claim line, typically the first of the month |
| 18 | Coverage period to | End date of the coverage period or DOS for the claim line, typically, the first of the month |

| Field No. | Field Designation | Field Description |
|---|---|---|
| 19 | Payment status | Indicator if the claim is paid or denied<br>"P" for paid, "D" for denied |
| 20 | User option fields 1-10 | State supplied additional fields |

**Appendix C: Review of Eligibility Criteria (Elements)**

| Eligibility Criteria (elements) | Considerations |
|---|---|
| Income | Was the client's income information correctly entered into the system? |
| | Was the state's reasonable compatibility standard, as specified in the verification plan, followed? |
| | Were income calculations correctly made based on MAGI vs. non-MAGI status? |
| | Was the eligibility determination made appropriately based on income? |
| | Was the individual placed in the appropriate eligibility group based on income? |
| Residency | Was residency verified in accordance with state policies, including the state verification plan? |
| Age (Date of Birth) | Was age verified in accordance with state policies, including the state verification plan? |
| | Was the individual placed in the appropriate eligibility group based on age? |
| | Was the individual placed in managed care or managed care plan based on age? |
| Gender | Was the individual placed in the appropriate eligibility group based on gender? |
| Social Security Number/Identity | Were state and federal policies followed in verifying the applicant's identity? |
| Citizenship and Immigration Status | Was citizenship/immigration status verified in accordance with state and federal policies? |
| | If applicable, did the state appropriately apply the reasonable opportunity period policy? |

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| Eligibility Criteria (elements) | Considerations |
|---|---|
| | Was the individual placed in the appropriate eligibility group based on citizenship and immigration status? |
| Household Composition | Was the household composition constructed properly? |
| | Were all appropriate individuals included and excluded in the household? |
| Pregnancy Status | Was the individual placed in the appropriate eligibility group based on pregnancy status? |
| Caretaker Relative | Was the individual placed in the appropriate eligibility group based on caretaker relative status? |
| Medicare | Was Medicare status determined appropriately? |
| | Was the individual placed in the appropriate eligibility group based on Medicare status? |
| Application for Other Benefits | Was individual eligible to apply for other benefits? |
| Other Coverage | If the state has a waiting period, was the requirement met? |
| Assets | Were appropriate assets included/excluded from the state's calculation? |
| | Was the eligibility determination made appropriately based on asset criteria? |
| | Were assets calculated properly? |
| Transfer of resources and expenses | Did the state ask for appropriate documentation related to resource transfers? |
| | Was the individual eligible based on resource transfer criteria? |
| Medical eligibility requirements | Did the state ask for appropriate medical eligibility documentation? |

| Eligibility Criteria (elements) | Considerations |
|---|---|
| | Was the individual eligible based on medical eligibility requirements? |
| Expenses and Deductions | Did the state ask for appropriate documentation for expenses and deductions? |
| | Was the eligibility determination made appropriately based on expenses and deductions eligibility criteria? |
| Long-Term Care Specific Information (e.g., look back period assessment, spousal share, Miller Trust, etc.) | Did the state ask for appropriate documentation? |
| | Was the eligibility determination made appropriately based on long-term care criteria? |

**Appendix D: Review of Eligibility Process**

| Process Findings | Considerations |
|---|---|
| Notices | Were appropriate notices sent for all cases, and did the notice include all required and accurate information? |
| | Were notices sent in a timely manner? |
| Transfers from FFM | If the application was transferred from the FFM, was information reused appropriately in accordance with verification plan? |
| Caseworker/system Transfers | If both system edits and caseworker actions were part of the eligibility determination process, did the caseworker transfer processing back to the system appropriately? |
| | For system actions where information was received manually from an outside entity, was the information entered into the system appropriately and timely? |
| Applicant Information Requests | If information was requested from the applicant, was such information properly requested based on attestations and verifications, or existing data, and utilized properly in the eligibility determination? |
| Timeliness | Was case processed within the required state and federal timeframe? |

## Appendix E: Documentation Request Tracker

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | CASE INFORMATION | | DOCUMENTATION REQUEST | | | | DETERMINE WHETHER VERIFICATION OBTAINED DURING DETERMINATION PROCESS EXISTED (CASE COMMENTS, ELIGIBILITY SCREEN PRINTS, ETC.) | | IF STATE CAN PROVIDE ADDITIONAL DOCUMENTATION AND DOES NOT CONDUCT CLIENT CONTACT | | DOCUMENTATION REQUE | | | | | |
| 2 | PERM ID | MAGI/ non-MAGI | Type of Verification Requested | Description of Verification Requested | Reason for Request | Is state allowed to provide verification for review? | Description of Evidence Submitted | Result (i.e., can state provide additional documentation?) | Type of Documentation Submitted (i.e. electronic data source) | Results | Date 1st Attempt Made | 1st Attempt Method | Date 2nd Attempt Made | 2nd Attempt Method | Date 3rd Attempt Made | 3r Att Me |
| 3 | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | |

**Appendix F**: **FMAP Review Requirements**

Background

The Federal Medical Assistance Percentage (FMAP) is the rate specifying the federal share for medical expenditures authorized under state Medicaid programs. The FMAP rate is calculated for each state using a methodology specified in Section 1905(b) of the Social Security Act (the Act) and published each year. Within Medicaid programs, certain services may receive a different FMAP rate when specified through federal regulation. The Children's Health Insurance Program (CHIP) similarly has a federally-defined match rate formula for medical services, known as the Enhanced Federal Medical Assistance Percentage (e-FMAP), which is defined in Section 2101(b) of the Act. Both the FMAPs and e-FMAPs are subject to adjustments from periodic recalculations, which may be retrospectively effective.
In addition, the Affordable Care Act (ACA) implemented an increased FMAP rate for services provided to newly eligible individuals within the adult group, defined in 42 CFR §433.204(a)(1). This increased FMAP rate is 100% in calendar years 2014 through 2016, and decreases gradually each subsequent year until it remains at 90% from calendar year 2020 forward.

In the proposed PERM rule, CMS is moving away from identifying federal improper payments at the aggregate level and will begin identifying federal improper and correct payments at the sample level to further enhance federal reporting. This approach will require the collection of the FMAP rate applied to each sampled claim. Therefore, CMS is interested in developing a review methodology that captures how ***errors in eligibility category determination*** can affect improper federal payments.

For example, states that have expanded Medicaid under the ACA may receive an increased FMAP of 100% for claims in calendar year 2016 for newly eligible individuals covered under the adult category. However, if an individual were incorrectly determined eligible in this expansion category but should have been found eligible for Medicaid through a category that receives the state's regular FMAP, the overpayment of federal dollars on the claims would be improper. The overpayment is the difference between the increased FMAP and the state's regular FMAP for the claims payments. Additional examples are provided below in Exhibit 1.

**Exhibit 1: Examples of Review Findings with FMAP Applied to Federal Dollars in Error.**

| # | Claim Amount | Eligibility Category | Finding | State-assigned FMAP | Total Dollars in Error | State Dollars in Error | Federal Dollars in Error |
|---|---|---|---|---|---|---|---|
| Example 1 | $100 | SSI Adult | Correct | 50% | $0 | $0 | $0 |
| Example 2 | $100 | Parent | Not Eligible | 50% | $100 | $50 | $50 |

| # | Claim Amount | Eligibility Category | Finding | State-assigned FMAP | Total Dollars in Error | State Dollars in Error | Federal Dollars in Error |
|---|---|---|---|---|---|---|---|
| Example 3 | $100 | Childless Adult (Newly Eligible) | Eligible, with Incorrect Category (e.g., should have been Parent/ Caretaker) | 100% | $0 | ($50) | $50 |
| Example 4 | $100 | Childless Adult (Newly Eligible) | Not Eligible | 100% | $100 | $0 | $100 |

The first two examples show cases with a regular state FMAP rate of 50% and demonstrate how a correct or not eligible review determination would affect the total dollars in error (federal plus state) versus the federal dollars in error only.

In Example 3, the individual was determined by the state to be eligible in a new adult group with an increased. The review found that while the individual was eligible for Medicaid, he was placed in the wrong category and therefore was not newly eligible, and the claim should have received the regular FMAP. Although the case was not found to be not eligible and the total paid amount was not in error, there were federal dollars in error.

Example 4 also shows an individual determined by the state to be eligible in the new adult group with an increased FMAP. However, the review found that the individual was not eligible for Medicaid under any category. Because the claim had a 100% FMAP, there were more federal dollars in error for this case compared to Example 2, where the claim received regular FMAP.

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FMAP Review Requirements

For the Round 5 eligibility review pilot, states will need to include the FMAP rate as a component of the eligibility review. The state must be able to identify the FMAP rate that is associated with each distinct eligibility category and identify when an error in eligibility determination would have caused an error in FMAP claiming. Note that the eligibility pilots will only capture FMAP rates associated with an eligibility category, not any service-specific FMAP related to individual’s service claims. In addition, this review does not examine actual claiming activities (i.e., the state’s financial reports).

States should be able to identify cases where the individual was found eligible for an incorrect Medicaid category that then resulted in an FMAP error. These errors are captured through the error codes shown in the table below.

| Code | Description |
|---|---|
| ER6 | Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; financial issue |
| ER7 | Not eligible for enrolled eligibility category; resulting in incorrect FMAP assignment; non-financial issue |

There are a number of Medicaid eligibility categories that may potentially receive a higher federal match rate, but these groups will vary by state based on whether the state expanded Medicaid under ACA and which subgroups are considered newly eligible and therefore eligible for increased FMAP. In addition, some federal programs allow a higher FMAP for eligible individuals. Examples are provided in the below table using the federal eligibility categories defined through this pilot.

| Federal Eligibility Category/Group | Description of Potential FMAP Variations within States |
|---|---|
| MAGI – Parent Caretaker | In expansion states, any individual who was previously eligible in the state as a Parent Caretaker would receive regular FMAP while newly eligible adults in this category would receive the increased FMAP rate. If a state did not expand under ACA, all individuals eligible under this group would receive regular FMAP. |
| MAGI – Medicaid Expansion | In expansion states, any individual who was previously eligible in the state as a childless adult would receive regular FMAP while newly eligible adults in this category would receive the increased FMAP. |
| MAGI – Children under 19 | While most of these individuals would receive regular Medicaid FMAP, the higher CHIP e-FMAP is available for children transferring from separate CHIP programs to Medicaid as a result of eligibility changes in the ACA. |
| Qualified Individuals (QI) Program | Medicaid pays for the Medicare Part B premiums at 100% FMAP for individuals enrolled through this program in all states. |
| Breast and Cervical Cancer Program (BCCP) | Individuals enrolled through this program are eligible for 100% FMAP for Medicaid claims in all states. |

States will need to be able to identify all approved eligibility categories that have an allowable FMAP that is higher than the state's regular FMAP. When reporting the pilot findings, states will need to report on the following related to cases with increased FMAP:

- Number of increased FMAP cases reviewed
- Number of increased FMAP cases that were found correct
- Number of increased FMAP cases that were in error
- Number of ER6 and ER7 errors
- Associated federal overpayment or underpayment for each error

## Appendix G: Error Codes and Qualifiers

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| **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. | • Household composition or tax filer unit incorrect – caseworker<br>• Household composition or tax filer unit incorrect – system<br>• Tax filer status incorrect – caseworker<br>• Tax filer status incorrect - system<br>• Deduction incorrectly included/excluded – caseworker<br>• Deduction incorrectly included/excluded – system<br>• 5% MAGI disregard incorrectly included/excluded – caseworker<br>• 5% MAGI disregard incorrectly included/excluded – system<br>• Exempt income incorrectly included – caseworker<br>• Exempt income incorrectly included – system<br>• Countable income incorrectly excluded – caseworker<br>• Countable income incorrectly excluded – system<br>• Income conversion factor incorrect – caseworker<br>• Income conversion factor incorrect - system<br>• Resources calculated incorrectly – caseworker<br>• Resources calculated incorrectly – system<br>• Data entry error – caseworker<br>• Data entry incorrect – applicant<br>• Resources incorrectly included/excluded - caseworker<br>• Reported resources not included in calculations – caseworker<br>• Reported resources not included in calculations - system<br>• Income exceeds income limit, but was was calculated correctly – caseworker<br>• Income exceeds income limit, but was calculated correctly – system<br>• Financial information provided, not acted on – caseworker<br>• Income incorrectly calculated – caseworker (other)<br>• Income incorrectly calculated – system (other) | This code does not include cases where the individual was eligible for a different program or different eligibility category. |
| **ER2 – Not eligible for enrolled** | Case should not have been granted eligibility for medical assistance (i.e., both Medicaid or | • Residency requirement not met<br>• Citizenship requirement not met<br>• Social security number requirement not met | This code does not include cases where the individual was eligible for a different |

| Code | Description | Qualifiers | Not Included |
| --- | --- | --- | --- |
| **program; non-financial issue** | CHIP) due to a non-financial issue | • Individual had other insurance (CHIP only)<br>• Age requirement not met<br>• Blindness/disability determination not correct at time of last action<br>• Identity requirement not-met<br>• System or caseworker processed case incorrectly due to applicant entry error<br>• Non-financial information provided, not acted on – caseworker<br>• Other non-financial issue | program or different eligibility category. |
| **ER3 – Should have been enrolled in a different program (i.e., Medicaid or CHIP); 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 financial issue | • Household composition or tax filer unit incorrect – caseworker<br>• Household composition or tax filer unit incorrect – system<br>• Tax filer status incorrect – caseworker<br>• Tax filer status incorrect - system<br>• Deduction incorrectly included/excluded – caseworker<br>• Deduction incorrectly included/excluded – system<br>• 5% MAGI disregard incorrectly included/excluded – caseworker<br>• 5% MAGI disregard incorrectly included/excluded – system<br>• Exempt income incorrectly included – caseworker<br>• Exempt income incorrectly included – system<br>• Countable income incorrectly excluded – caseworker<br>• Countable income incorrectly excluded – system<br>• Income conversion factor incorrect – caseworker<br>• Income conversion factor incorrect – system<br>• Resources calculated incorrectly – caseworker<br>• Resources calculated incorrectly – system<br>• Data entry error – caseworker<br>• Data entry incorrect – applicant<br>• Resources incorrectly included/excluded - caseworker<br>• Reported resources not included in calculations – caseworker<br>• Reported resources not included in calculations - system<br>• Income exceeds income limit, but was calculated correctly – caseworker<br>• Income exceeds income limit, but was calculated correctly – system<br>• Income incorrectly calculated – caseworker (other) | This category does not include instances where the individual should have been enrolled in a different eligibility category within the same program (i.e., Medicaid or CHIP) |

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| | | • 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 | • Age requirement not met<br>• Blindness/disability not determined<br>• System or caseworker processed case incorrectly due to applicant entry error<br>• Blindness/disability determination not correct at time of last action<br>• Other non-financial error | This category does not include instances where the individual should have been enrolled in a different eligibility category within the same program (i.e., Medicaid or CHIP) |
| **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 | • Household composition or tax filer unit incorrect – caseworker<br>• Household composition or tax filer unit incorrect – system<br>• Tax filer status incorrect – caseworker<br>• Tax filer status incorrect – system<br>• Deduction incorrectly included/excluded – caseworker<br>• Deduction incorrectly included/excluded – system<br>• 5% MAGI disregard incorrectly included/excluded – caseworker<br>• 5% MAGI disregard incorrectly included/excluded – system<br>• Exempt income incorrectly included – caseworker<br>• Exempt income incorrectly included – system<br>• Countable income incorrectly excluded – caseworker<br>• Countable income incorrectly excluded – system<br>• Income conversion factor incorrect – caseworker<br>• Income conversion factor incorrect - system<br>• Resources calculated incorrectly – caseworker<br>• Resources calculated incorrectly – system<br>• Data entry error – caseworker<br>• Data entry incorrect – applicant<br>• Resources incorrectly included/excluded - caseworker<br>• Reported resources not included in calculations – caseworker<br>• Reported resources not included in calculations - system<br>• Income exceeds income limit, but was calculated correctly – caseworker<br>• Income exceeds income limit, but was calculated correctly – system | This category does not include instances where the individual was enrolled in a different category with the same FMAP rate. Such instances would be captured as a technical deficiency. |

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| | | • Income incorrectly calculated – caseworker (other)<br>• 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 | • Age requirement not met<br>• Blindness/disability not determined<br>• System or caseworker processed case incorrectly due to applicant entry error<br>• Blindness/disability determination not correct at time of last action<br>• Other non-financial error | This category does not include instances where the individual was enrolled in a different category with the same FMAP rate. Such instances would be captured as a technical deficiency. |
| **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 | • Household composition or tax filer unit incorrect – caseworker<br>• Household composition or tax filer unit incorrect – system<br>• Tax filer status incorrect – caseworker<br>• Tax filer status incorrect – system<br>• Deduction incorrectly included/excluded – caseworker<br>• Deduction incorrectly included/excluded – system<br>• 5% MAGI disregard incorrectly included/excluded – caseworker<br>• 5% MAGI disregard incorrectly included/excluded – system<br>• Exempt income incorrectly included – caseworker<br>• Exempt income incorrectly included – system<br>• Countable income incorrectly excluded – caseworker<br>• Countable income incorrectly excluded – system<br>• Income conversion factor incorrect – caseworker<br>• Income conversion factor incorrect - system<br>• Resources calculated incorrectly – caseworker<br>• Resources calculated incorrectly – system<br>• Data entry error – caseworker<br>• Data entry incorrect – applicant<br>• Resources incorrectly included/excluded - caseworker<br>• Reported resources not included in calculations – caseworker<br>• Reported resources not included in calculations - system<br>• Income exceeds income limit, but was calculated correctly – caseworker | |

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| | | • Income exceeds income limit, but was calculated correctly – system<br>• Income incorrectly calculated – caseworker (other)<br>• 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 | • Age requirement not met<br>• Blindness/disability not determined<br>• System or caseworker processed case incorrectly due to applicant entry error<br>• Blindness/disability determination not correct at time of last action<br>• Other non-financial error | |
| **ER9 – State non-compliance with federal regulation** | The state did not conduct eligibility determination or redetermination in accordance with federal regulations | • Citizenship not verified<br>• Citizenship not verified correctly<br>• Immigration status not verified<br>• Immigration status not verified correctly<br>• Social Security Number not verified<br>• Social Security Number not verified correctly<br>• Residency not verified<br>• Income not verified<br>• Redetermination not conducted timely (i.e., within 12 months or the federally required timeframe)<br>• Presumptive eligibility period ended - full eligibility determination not completed timely<br>• Application Form not signed<br>• Renewal Form not signed<br>• State did not do required disability/blindness determination at time of last action<br>• State did not provide the recipient with a pre-populated renewal form (for non-passive renewals)<br>• State did not seek to clarify discrepant information that does not meet reasonable compatibility standard | |

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| **ER10 – Cannot confirm eligibility; insufficient documentation** | Client under review may be financially and categorically eligible, but the state cannot provide required documentation to support the eligibility determination<br><br>This code will be used for cases where the state correctly obtained the verification, but did not maintain documentation appropriately. | • Application or review form not on file (unable to verify self-attestation)<br>• Citizenship verification not on file<br>• Social security number verification not on file<br>• Income verification not on file/incomplete<br>• Resource verification not on file/incomplete<br>• Residency verification not on file/incomplete<br>• Electronic data source verification not on file<br>• Inconsistent/incomplete information not resolved<br>• Case file not provided<br>• Post eligibility verification not on file<br>• Tax filer status not on file<br>• Electronic data source not accessed – caseworker<br>• Electronic data source not accessed – system<br>• State does not have medical record for blindness/disability determination (only needed if determination done as part of last action)<br>• State does not have sufficient documentation for blindness/disability determination<br>• Other verification not on file/incomplete | This code does not include instances where the state did not conduct the verification at all or in accordance with federal regulations. |
| **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.<br><br>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). | • SSI - enrollment not established or verified<br>• Title IV-E eligibility not established or verified<br>• Targeted Enrollment - eligibility for underlying program (e.g. SNAP) not established or verified<br>• Hospital presumptive eligibility (PE) – state did not follow appropriate processes for enrolling individual<br>• Other enrollment cannot be confirmed | |

| Code | Description | Qualifiers | Not Included |
|---|---|---|---|
| **ER12 – Other errors** | Other errors that do not fall under other codes. | • Individual was incorrectly denied/terminated resulting in an underpayment | |
| **ER-TD – Technical deficiencies** | The state did not determine or redetermine the case correctly, but the issue did not result in a payment error | • In addition to any qualifier used above:<br>• Approval notice information inconsistent<br>• Approval notice not on file<br>• Approval notice not sent<br>• Beneficiary premiums/spend down/cost of care incorrect calculations<br>• PARIS match not conducted at most recent redetermination<br>• PARIS match information not acted on | |