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State	File Type	Rec/Issue Type	Issue	Recorded
_All	Claims	Crossovers	MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT are defined in MSIS as the amount Medicaid paid towards the amount that Medicare applied to coinsurance or deductible. Many states have historically submitted the full amount applied to Medicare coinsurance and/or deductible as the MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT in MSIS even though many states use "lesser-of" payment methodology and therefore do not pay the entire amount applied to coinsurance and/or deductible by Medicare. If the sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT are not within 2 dollars of the MEDICAID-AMOUNT-PAID then the state is likely reporting the amount Medicare applied to coinsurance and/or deductible as the MEDICARE-COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT in MSIS regardless of how much the state actually paid towards them. If that is true then the MEDICAID-AMOUNT-PAID can be used to derive the amount paid towards coinsurance and deductible. For example, the deductible must be met before coinsurance applies so if the MEDICAID-AMOUNT-PAID is less than the amount Medicare applied to deductible and there are values reported for both MEDICARE-COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT the entire MEDICAID-AMOUNT-PAID must represent the amount paid towards the Medicare deductible. Please note that there are other state-specific reporting anomalies and erroneous data, both documented and undocumented, to consider when analyzing MEDICARE-COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT. Some may be difficult to identify in part because of the inconsistent application of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT across states.	2/13/2015
_All	LT	Bundled Payment	Some states submit separate LT claims for services provided by the facility that are not included in the bundled daily rate. These claims are not supposed to be reported with any covered days.	9/27/2013
_All	LT	LTC Days	In some states there is an over-reporting of Long Term (LT) care days. This occurs when the state includes covered days on claims for supplemental services as well as on the claim for the bundled services, including accommodations. Also, there are sometimes two original claims for the same time period because either the void of the original was not included, the state did not void the original and included both the original and resubmittal claim in the LT file, the claim included days that were paid for by the patient (spend down), or it is a crossover claim with days.	3/3/2011
_All	OT	Service Code Flag	In some states there are claims with invalid combinations of Service Code Indicator and Service Code format.	8/13/2008
_All	RX	Compound Drugs	The NCPDP rules for Medicaid reporting compound drugs have changed over the years. From 1999-2002 there were no line items. Starting in 2002 the NCPDP 5.1 rules required the states	3/3/2011

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			to choose to report either the most expensive rebatable drug or all of the line items. The line items do not include the Medicaid Amount Paid. The NCPDP D.0 version was released in 2009 with new rules. Fortunately in most states, compound drugs are less than 1% of all drug claims. It is very difficult to capture all the separate NDC's and the associated Medicaid Amount Paid from these claims.	
_All	RX	Compound Drugs	The states who inquired how they were to report compound drugs were told to put the word COMPOUND in the NDC field. It is unknown how states that didn't ask reported them. They may have excluded them, submitted the most expensive NDC with the Medicaid Amt Paid of $0, or for the entire compound or each NDC with $0 paid. For Q1FY2009 forward, we are investigating the best method of reporting compounds into MSIS.	3/3/2011
_All	RX	Crossovers	Starting in Q2FY2006 there was a big drop in the number of drug claims for dual enrollees due to the implementation of the Part D Medicare benefit.	3/3/2011
AK	Claims	Managed Care Encounters	Except for a few Early and Periodic Screening Diagnosis and Treatment (EPSDT) encounter claims, there aren't any encounter claims as the state doesn't have a managed care program.	12/10/2004
AK	Claims	NPI/Taxonomy	Per prior agreement with CMS, Alaska does not report NPI and taxonomy on MSIS files from its older Legacy system. On October 1, 2013 Alaska implemented a replacement MMIS which is expected to report this data on the T-MSIS file transmissions.	4/2/2014
AK	Claims	Service Tracking Claims	Alaska is not submitting any service tracking claims.	12/10/2004
AK	Eligibility	1115 Waivers	Effective 2004, CMS approved an 1115 waiver amending the Denali KidCare M-CHIP program. This waiver covered M-CHIP child applicants with family income of 150-175 percent FPL. Unlike other M-CHIP children, they were subject to a 1 year "waiting period" without insurance (the reason for which the state had to apply for an 1115 waiver). Alaska chose not renew the waiver and it expired as of September 30, 2009. Since that time, these children--who continue to remain as M-CHIP due to their status as Medicaid expansion eligibles but are no longer subject to the crowd out provisions--are now reported to MAS 3 instead of 5. (The state erroneously reported them to MAS 5 in Q1-Q2 FY10 but subsequently fixed this using correction records.)	3/3/2011
AK	Eligibility	CHIP	In addition to children reported to MASBOE 34 and 54, roughly 400 to 1,000 M-CHIP eligibles were mapped to MASBOE 35 and 55 each month. AK indicated that this was normal and that a BOE assignment may be changed if an enrollee falls into certain eligibility code/subtype combinations (e.g., related to pregnancy).	3/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
AK	Eligibility	CHIP	In Q1 FY08, AK's difference in M-CHIP and SEDS counts was greater than 10 percent. When asked about which source is more accurate, AK replied that the reporting methodology for SEDS calls for preliminary numbers to be reported 30 days after the end of quarter with the final number for that time period, including retroactive eligibility, being reported 30 days after the end of the next quarter. Meanwhile, MSIS reporting methodology has the SCHIP numbers reported by the 15th of the month following the end of the quarter, thereby excluding retroactive eligibility. AK believes such issues will be smoothed via retro records.	3/22/2011
AK	Eligibility	CHIP	Between 2004 and 2009, AK's M-CHIP applicants with income 151% - 175% FPL were transferred to the Denali KidCare 1115 waiver and MASBOE 54. These children are deemed eligible under AK's 1115 waiver guidelines; unlike children<150% FPL, they are subject to a 1 year "waiting period" without insurance. However, by mistake, MSIS reporting to MASBOE 54 did not begin for this group until Q1 FY06. M-CHIP children with income ><150% FPL remained in MASBOE 34.	7/6/2011
AK	Eligibility	CHIP	In Q3 FY2013, the difference between the MSIS [N = 32,224] and SEDS [N = 43,334] counts increased (26% difference). The count reported to SEDS increased by over 10K between Q2 and Q3 of FY13, while the count reported to MSIS stayed about the same. The state indicated the CHIP numbers in MSIS are as expected.	9/5/2014
AK	Eligibility	County Codes	Alaska's county codes do not follow the usual pattern of three-digit odd numbers. However, they are correct.	NA
AK	Eligibility	Dual Eligibility Codes	Alaska reports very few QMB and SLMB onlies (dual flags 01 and 03, respectively). In Alaska, the state supplement income standard is approximately 110 percent of poverty for a single individual, and 122 percent of poverty for a couple. Hence, the vast majority of QMB and SLMBs are eligible for full Medicaid benefits by virtue of their eligibility for the state supplement to SSI.	NA
AK	Eligibility	MASBOE	Alaska has a very generous state administered supplement for SSI, causing the number of enrollees reported to MASBOE 11-12 to be much higher than the counts of recipients in SSI administrative data.	NA
AK	Eligibility	MASBOE	Alaska has six month continuous eligibility guarantee for children.	NA
AK	Eligibility	MASBOE	In some years, Alaska's data show a seam effect, with enrollment lowest in month 1 of each quarter. Presumably this gets smoothed with retro records.	NA
AK	Eligibility	MASBOE	July is a peak employment time in Alaska, contributing to a decrease in Medicaid enrollment for children and adults each July.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
AK	Eligibility	MASBOE	Each month, AK reports about 400 M-CHIP enrollees to MASBOE 35. Generally, we don't expect to see children reported to BOE 5. In response, AK indicated that this is due to the fact that although a BOE assignment of 4 is processed on the basis of recipient age, the BOE can later be changed if the patient falls into certain eligibility code/subtype combinations (e.g., pregnancy) that otherwise map to BOE 5. AK also noted that the age calculation is based on the starting date of the quarter being processed.	3/8/2011
AK	Eligibility	Private Health Insurance	AK is currently reporting almost all of its full and partial dual populations as enrolled in a private health insurance plan (HI code '2'). The definition of the Health Insurance flag in the MSIS Data Dictionary reads" "Medicare is not considered private health insurance. Enrollment in a Medicaid/Medicare HMO does not constitute health insurance for this data element." This is likely a product of the state's miscoding enrollment in Medicare Part D as being private health insurance. Although this has been raised as an issue that needs to be corrected, the state has requested that it make necessary coding adjustments at a future date when similar maintenance work orders can be performed at one time. 5/21/2014 update: We raised the issue again with the state. Alaska indicated Medicaid implemented a replacement MMIS on 10/1/2013. The new system will comply with federal reporting via T-MSIS. Work on T-MSIS is underway and they expect that T-MSIS reports will comply with all data specifications for MSIS reporting.	10/7/2011
AK	Eligibility	Race/Ethnicity	AK reports all enrollees to either ethnicity code = 1 (Hispanic or Latino) or = 9 (Ethnicity Unknown). No one is reported to value = 0 (Not Hispanic or Latino). According to the state, this is a known issue relating to a Legacy MMIS design and CMS indicated it was acceptable to correct this once a replacement MMIS is implemented.	4/6/2012
AK	Eligibility	Restricted Benefits Flag	When asked why AK does not report any individuals with RBF = 2 (restricted benefits based on alien status), AK replied that the state identifies unqualified aliens with eligibility code 53 and these clients receive RBF=2 (bytes 3-4 = "AL" and 5-6 = "53"). However, if these individuals are pregnant and qualify for pregnancy services, they will receive eligibility code 11 with subtype AL (alien) and are reported with RBF=4 (bytes 3-4 = "AL" and 5-6 = "11"). However, the former are apparently nonexistent while the latter appear infrequently. Other pregnant women (who are not receiving emergency services) receive RBF = 1.	5/9/2011
AK	Eligibility	Restricted Benefits Flag	Between Dec 2012 and Jan 2013 Alaska state stopped reporting enrollees to RBF 'A' [entitled to benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF]. In 2012, the state reported only a few to this category over the last year (less than 100). Alaska indicated reporting parameters for this field were not changed. The values reported reflect eligibility fluctuations.	9/5/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
AK	Eligibility	Retroactive/ Correction Records	AK uses retroactive and correction records.	NA
AK	Eligibility	State-Specific Eligibility	AK began using a new format for its state specific codes in FY06. Bytes 1-2 are MARS money aid code; bytes 3-4 are 'subtype' code; and bytes 5-6 are 'eligibility' code. Prior to Q1 FY06, MSIS only received bytes 2 and 3 of the 3 byte state MARS money code.	NA
AK	Eligibility	TANF/1931	There appear to be problems with the TANF flag, particularly in FY2001 and FY2002, when the state reports many more TANF enrollees than ACF data suggest. There was a smaller, though still considerable, discrepancy in FY1999 and FY2000. The state began 9-filling its TANF data in FY2003. Once the state's new system is in place the state will be able to report TANF data reliably. Most recently, the state has said the target implementation date is April 1, 2012.	7/6/2011
AK	Eligibility	Waivers	AK previously had a 1915(b) Non-Emergency Transportation waiver for whom enrollees were not reported in MSIS eligibility files (the state indicated that these people were only identifiable retrospectively through claims). CMS subsequently reported that the transportation program now operates under state plan authority (a review of the state plan online confirmed this to be true effective January 1, 2007). Although AK continues to maintain that this waiver still exists, in this instance we believe there may be some confusion regarding the use of "waiver."	1/27/2010
AK	Eligibility	Waivers	Alaska's 1915(c) Adults with Physical Disabilities waiver (Waiver ID 'AD') had a large drop between Q2 FY12 and Q3 FY12. In the first month of Q2 (January 2012), the count for this waiver was ~1,200. In the first month of Q3 (April 2012), this count had dropped to ~125. Enrollment in this waiver was about 185 for Q4 FY12. This was expected due to a change in waiver classifications. The Adults with Physical Disabilities waiver became the Adults with Physical and Developmental Disabilities; the Older Alaskans waiver is now the Alaskans Living Independently waiver; the MRDD waiver is now the Intellectual and Developmental Disabilities waiver. The counts were expected based on the changes associated with these waiver re-classifications.	9/5/2014
AK	IP	Indian Health Services	About 20 percent of the claims are Indian Health Service (IHS) and therefore don't have ancillary codes as they are not billed on a Uniform Hospital Bill (UB-92) form.	12/10/2004
AK	IP	Medicaid Amount Paid Avg	The average Medicaid amount paid per hospital claim is high, but the state confirms it is correct.	12/5/2005
AK	IP	Provider Taxonomy	As of Q2 FY2012, state does not report provider taxonomy codes.	5/4/2012
AK	LT	Diagnosis	Some diagnosis codes are padded with zeros on the right as this is how providers formatted them on their submitted claims. The most common code with padded zeros is 311 (31100 and 3110).	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
			This situation was significantly improved starting with Q2FY2003.	
AK	LT	Medicaid Amount Paid Avg	The average Medicaid Amount Paid per day is about two times higher than expected, but is consistent across years.	8/12/2008
AK	LT	Patient Liability	There is a lower than expected percent of claims with Patient Liability.	12/10/2004
AK	LT	Provider Taxonomy	As of Q2 FY2012, state does not report provider taxonomy codes.	5/4/2012
AK	LT	Type of Service	Alaska has a low percentage of Type of Service 07 [Nursing Facility (NF)] claims in the LT files as they have a relatively low senior population and an active waiver program. They also have a state-operated Pioneers Home system, separate from Medicaid, which provides services to many people who might be served by Medicaid NF institutions.	12/10/2004
AK	LT	Type of Service	At least half the claims have a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under) which is much higher than expected.	12/10/2004
AK	LT	Type of Service	Through Q2FY07 AK did not report any claims with a Type of Service of 05 [Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)] or 02 (Mental Hospital/Aged) as they were not covered benefits. AK began reporting claims with TYPE-OF-SERVICE = 05 in Q3FY07.	3/28/2013
AK	OT	Managed Care Capitation	There are no capitation claims as Alaska doesn't have a managed care program.	5/4/2012
AK	OT	Provider Taxonomy	As of Q2 FY2012, state does not report provider taxonomy codes.	5/4/2012
AK	OT	Service Code Flag	Claims with state defined service codes are incorrectly reported with a Service Code Indicator = 6 (HCPCS)	NA
AK	RX	Date Prescribed	Date Prescribed is always missing.	12/15/2004
AK	RX	Family Planning	There aren't any claims with a Program Type of 2 [Family Planning (FP)].	12/10/2004
AK	RX	Indian Health Services	Alaska started reporting IHS as a Program Type in Q2FY2003.	12/10/2004
AK	RX	NDC	A small percent of NDC fields are 0-filled.	12/10/2004
AK	RX	Provider Taxonomy	As of Q2 FY2012, state does not report provider taxonomy codes.	5/4/2012
AK	RX	TPL	There are only a few claims with Other Third Party Payment, also known as Third Party Liability (TPL).	12/10/2004
AL	_All	Managed Care	There are no managed care encounters reported for beneficiaries enrolled in Medicare Advantage plans.	10/26/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
AL	Eligibility	0-filling	In Q1 FY10, zero-filling of both the plan type and waiver ID fields were not consistent with the other MSIS fields. This issue affected approximately 10-15 enrollees each month. This issue was fixed in Q2 FY10.	8/1/2011
AL	Eligibility	1115 Waivers	2006 - Current: AL currently reports about 750 - 1,000 persons as enrolled in Family Planning according to the restricted benefit flag (RBF=6) but does not assign the corresponding waiver ID ('FP') or waiver type ('F'); in addition, many - but not all - of these people are not assigned to MAS 5. AL has indicated that this is due to the fact that some family planning enrollees are correctly identified by their restricted benefit flag but are not for other fields (including state eligibility code, waiver ID/type, and MAS/BOE) because these enrollees have placed an application for another eligibility program and, consequently, the state system's logic maps these fields to reflect the new eligibility group for which the person's status is pending. AL has indicated that there is no way to fix this issue at this time.	9/22/2011
AL	Eligibility	CHIP	Alabama reported its M-CHIP children, but in FY 2001, M-CHIP enrollment declined and enrollment phased out by Q1 FY 2003. AL does not report any of its S-CHIP children in MSIS.	9/22/2011
AL	Eligibility	County Codes	Alabama assigns county code 100 to some of its Foster Care recipients.	1/10/2012
AL	Eligibility	Dual Eligibility Codes	2008: AL acknowledged that approximately 15,000 QI enrollees were no longer reported to MASBOE 31-32 as of June 2008, although most of these enrollees reappear by the next month (in July) and the remainder finally appear three months later (in October). In fact, those enrollees who resumed reporting in July never had a break in coverage, whereas the remainder who resumed in October did.	3/22/2011
AL	Eligibility	Dual Eligibility Codes	2010: AL indicated it had been erroneously reporting several hundred children as dual eligibles when, in fact, they were unconfirmed as such against the Medicare Enrollment Database (EDB). The state reported this would be corrected prior to the Q1 FY10 eligibility file submission. However, the remedy was delayed, and the correction was implemented in the Q1 FY11 eligibility file.	9/22/2011
AL	Eligibility	Dual Eligibility Codes	AL indicated that some reporting of full duals in MAS/BOE 31-32 and reporting of partial duals outside of MAS/BOE 31-32 is due to the fact that the state-specific eligibility group reported (which influences what MASBOE is assigned) may represent what group a person is "pending" for even though the person may be correctly assigned a current, conflicting dual code.	9/22/2011
AL	Eligibility	Dual Eligibility Codes	QI-1 enrollment increased by approximately 1,400 between May and June, 2010. This increase in enrollment was expected because AL re-opened the QI-1 program to new awards in June 2010. Also, in Q3 FY10, there was a 13% difference between MMA and MSIS reporting of QI-1 enrollment. The state indicated that this difference between MMA and MSIS reporting could be	9/22/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			related to a data timing issue during the period when new QI-1 enrollment resumed. The MSIS and MMA counts were in sync again in Q4 FY10.	
AL	Eligibility	Dual Eligibility Codes	Beginning in Q1 FY05, when AL implemented the monthly dual code, the state reported roughly 1,000 enrollees with MASBOE 11-12 to dual code 01 and restricted benefit code 3. The state informed us that this occurs because when recipients have full Medicaid plus QMB and lose their full SSI and full Medicaid eligibility, they receive one month of QMB-only coverage as an ex-parte month in order to allow them to reapply as a QMB-only at their Medicaid district office.	4/6/2012
AL	Eligibility	Dual Eligibility Codes	From January to February 2012 there was a larger than expected drop in the reporting of Other Full Duals (Dual Code =08) from about 16,000 to about 14,000; these individuals switched to from dual code 08 to 02. A slight decline in the count of 08s continued through Q4 FY12. In addition, there was a parallel drop in the count of 08s reported in the monthly MMA files that are also submitted to CMS, however, the drop in the MMA count has been more dramatic causing the two counts to diverge a bit (14% difference). This shift from dual code 08 to dual code 02 was due to an issue that SSA had with their SDX file processing in late 2011. The majority of these cases were SSI certified cases with full Medicaid being awarded QMB+. During the period of time that SSA was correcting their process; all AL Medicaid SDX processing was put on hold. Once the SSA problem was corrected and verified, AL Medicaid commenced its SDX processing which included processing all Held SDX files up to the current date.	2/15/2013
AL	Eligibility	Dual Eligibility Codes	Starting in Q2 FY13, for Other Full Duals (Dual Code = 08), we noted a larger than expected difference in MSIS versus MMA reporting. There are between 12-14% more Other Full Duals reported in MSIS than MMA. The state discovered that an unrelated batch program erroneously updated the "Status Change Date" on their Eligibility file which caused those deceased records to show the current month (November 2013) as the month the DOD (Date of Death) was reported. A large file from the Fiscal Agent was processed with this program in November 2013, January 2014 and March 2014. This caused the MMA to erroneously report non-eligibility on these records from the new date reported (November 2013) back to the individual's date of death which resulted in the 27,467 months reported on MMA. Due to the time elapse and the complexity of the program; there is not a feasible way to correct the report. The error has been corrected and subsequent reports should be correct. A similar spike in retro DET records (though not as high as November) with Medicaid Eligibility Status of No was reported in January and March due to the same error.	4/3/2014
AL	Eligibility	Managed Care	Prior to Q3 FY08, comparisons of PCCM counts between MSIS and CMS managed care data were substantially off (usually by 15 to 20 percent). However, between January and February	9/23/2010

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			2008, PCCM counts in MSIS increased by ~82,000 and are now compatible with CMS data (cause unknown). Also, enrollment in this plan and its companion waiver (waiver ID 'P1') is not always consistent because the state on rare occasions pulls data from separate sources that have differing begin/end dates. The state indicated the discrepancy should be minimal (i.e., less than 2 percent).	
AL	Eligibility	Managed Care	Enrollment in plan type 01 (comprehensive) decreased from approximately 25,000 in Q1 FY10 to approximately 17,500 in Q2 FY10. The state explained that this decrease was due to the withdrawal of one of its five contracted health plans (HealthSpring) from the state's capitation program. Enrollment in plan type 01 then increased to approximately 19,000 in Q3 FY10. AL indicated that this increase was due to consistent growth in enrollment in the four remaining plans.	2/23/2011
AL	Eligibility	Managed Care	Since Q1 FY99, AL had been reporting enrollment in a prenatal/delivery plan as managed care. However, both AL and CMS indicated in May 2009 that this plan should not be treated as managed care and AL stopped reporting this as of February 2008.	3/3/2011
AL	Eligibility	Managed Care	AL ended its PCCM "Patient First" program in Q2 FY04. All recipients were disenrolled from the program as of 3/1/04 forward. In Q1 FY05, AL reinstated its PCCM "Patient First" program. As of September 1, 2013, Patient First is no longer a waiver. A SPA was approved effective September 1, 2013. These eligibles will be reported under Managed Care, but no longer in the waiver.	9/22/2011
AL	Eligibility	Managed Care	AL previously reported enrollment in its Partnership Hospital Program (Plan ID 'H00') to Plan Type '08'. Under PHP, groups of hospitals in a geographic area formed a prepaid inpatient health plan that was reimbursed on a capitated basis; the plans then made payments to participating hospitals. All Medicaid enrollees were automatically enrolled with the exception of recipients with Part A Medicare coverage and certain pregnant women in the state's maternity care program. The program operated on a state-wide basis and had a small number of full duals (~5,000) whom the state confirmed did not have Medicare Part A. CMS reported PHP as PIHP in its annual managed care report. The state recently indicated that this program ended on September 17, 2010; therefore, all reporting of this plan ended by Q1 FY11.	9/22/2011
AL	Eligibility	Managed Care	Between Q1 and Q2 FY11, the number of enrollees with comprehensive managed care plans (plan type 01) increased from approximately 20,000 per month to approximately 24,000 per month. AL indicated that the state's Medicare Advantage Capitation Payment Program was experiencing consistent growth in recipient enrollment. Additionally, between Q1 and Q2 FY11, there was a change in participation in AL's capitation program: one plan dropped out while another plan was added effective January 1, 2011. AL anticipated a 25% increase in	9/22/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			enrollment due to the addition of HealthSpring in January 2011 as well as increased outreach efforts with the state's contracted plans.	
AL	Eligibility	Managed Care	The United Medicare Complete is classified by the state as a Health Maintenance Organization (HMO) for dual eligibles. This plan does not include drug benefits, and primarily covers copays and deductibles. About 4,500 full duals and 3,000 partial duals were reported to this plan in Q4 FY06. The plan does not appear to offer any Medicaid related services. Plan ID "M00" (plan type '01') includes the AL Medicare Advantage plans. These plans are not reported in CMS managed care data.	9/22/2011
AL	Eligibility	Managed Care	Alabama started a PACE program, Mercy Life of Alabama, in March 2012 but didn't add these enrollees to MSIS until July 2012 (Q4 FY12). These enrollees are reported under Plan ID 'PAC'.	2/15/2013
AL	Eligibility	MASBOE	AL reports enrollees who were initially certified into Medicaid as disabled in BOE 2 after they turn 65. In Q4 FY12, there were about 18,000 individuals who are over 65 and blind or disabled who are reported instead with MASBOE 12 (Cash and Blind/Disabled). The state's explanation of this reporting is that these individuals were SSI certified. Since AL is a 1634 state they must accept SSA's eligibility determination. If SSA determines the eligibility status as blind or disabled, they do not change it, regardless of age. The state had confirmed that it has noted the need to change this in future eligibility programming.	9/23/2010
AL	Eligibility	MASBOE	Between Q4 FY09 and Q4 FY10, enrollment in MASBOE 3A increased from approximately 430 to approximately 700.	2/14/2011
AL	Eligibility	MASBOE	Enrollment in MASBOE 45 increased from approximately 250 in Q2 FY10 to approximately 330 in Q4 FY10.	9/22/2011
AL	Eligibility	MASBOE	In Q2 FY13, the number of not eligible (MB 00) individuals increased 6 fold (from about 33,000 to about 180,000). In addition, there were several spikes and large dips. For example, MB 35 (poverty adult) spiked from 22,913 in M3 Q1 to 38,139 in M1 Q2, but then went back to comparable enrollment to Q1 in M2 Q2; MB 42 (Other B/D) spiked from 7,812 in M3 Q1 to 8,619 in M1 Q2, but then went back to comparable enrollment to Q1 in M2 Q2; and MB 45 (Other Adult) spiked from 373 in M3 Q1 to 465 in M1 Q2, but then went back to comparable enrollment to Q1 in M2 Q2. Similar spikes and large dips were also noted in the quarter's waiver enrollment where 1915(b) enrollment experienced a spike in enrollment from 570,396 to 636,046 from M3 Q1 to M1 Q2, but then went back to comparable levels by M2 Q2; 1915(c) enrollment dipped from 11,658 to 1,635 from M3 Q1 to M1 Q2, but then went back to comparable levels by M2 Q2; and the number of individuals not enrolled in a waiver dipped from 261,101 to 220,766 from M3 Q1 to M1 Q2, but then went back to comparable levels by M2 Q2.	8/13/2013

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AL	Eligibility	Private Health Insurance	When asked to explain the state's sudden increase in private health insurance coverage (from 6.3 percent in Q3 FY09 to 8.6 percent in Q4 FY09), AL replied that they "implemented our data match with BC/BS of Alabama in September 2009 [and] the initial load of new policies identified from the data match created over 600,000 insurance segments that were previously unknown to our policy file."	9/23/2010
AL	Eligibility	Private Health Insurance	When asked why the state reports only a few (usually less than 20) persons with a health insurance flag = 3 (compared to the tens of thousands with a health insurance flag = 2), AL responded that this was a function of internal coding that indicated private coverage purchased by the state. AL indicated these individuals are in the state's Health Insurance Premium Payment program for which Alabama Medicaid pays the insurance premium for the recipient because it has been determined cost-effective for Medicaid to do so.	9/23/2010
AL	Eligibility	Race/Ethnicity	AL reports all enrollees with Hispanic/Latino ethnicity with none of the five mutually exclusive race categories assigned, even though they are all reported as = 7 ("Hispanic or Latino and one or more races") in the combined race-ethnicity variable.	2/25/2010
AL	Eligibility	Restricted Benefits Flag	AL indicated that no children (BOE=4) receive a restricted benefit flag = 2 because "eligibility for elderly and disabled individuals or children receiving only emergency services" is not captured in their eligibility system.	9/23/2010
AL	Eligibility	SSN	Through Q3 FY09, AL has reported over 99 percent of its records with SSNs. Despite SSA high-group test results that questioned the validity of some of AL's SSNs, the state had previously maintained that its SSN data were reliable and that only SSNs were entered into the SSN field. However, the state more recently indicated that all persons with an "8" in the first byte of their SSN should be treated as persons whose SSN should be 9-filled.	3/3/2011
AL	Eligibility	State-Specific Eligibility	Alabama reports a four-byte state-specific eligibility group. Beginning in FY 2000, the deprivation code (bytes 3-4) became unreliable for eligibles in MAS/BOE 14 - 15. The information in these bytes comes from an external department in the state (DHR). These problems do not affect MAS/BOE mapping during the year.	NA
AL	Eligibility	State-Specific Eligibility	AL reports many state-specific eligibility groups that are not listed on its crosswalk. Additionally, many state-specific groups are mapped to the wrong MASBOE. The state has indicated that this happens because state aid categories and deprivation codes (two of the three components of AL's state-specific eligibility groups) reflect the category that a person is pending for rather than their current eligibility. The state is in the process of updating its system, and AL anticipates that this problem will be remedied once the update is completed.	9/22/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
AL	Eligibility	TANF/1931	In FY05, AL's TANF reporting in MSIS continued to be unreliable. The state was directed to 9-fill its TANF flag, which AL began doing as of Q2 FY05 onward.	3/3/2011
AL	Eligibility	Waivers	Enrollment in AL's Patient 1st waiver (waiver ID 'P1', waiver type '2') declined by about 20,000 people between February and March 2008. The state verified this and indicated there was no endogenous explanation.	10/27/2009
AL	Eligibility	Waivers	Enrollment in Alabama's Assisted Technology waiver (waiver ID 'TA') is generally low and sometimes sporadic.	8/1/2011
AL	Eligibility	Waivers	Enrollment in Alabama's Patient 1st waiver (waiver ID 'P1,' waiver type '2') is expected to be equal to enrollment in PCCM plans in the state. However, these numbers are often not equal because the state uses different files to feed information for these fields into MSIS. As of September 1, 2013, Patient First is no longer a waiver. A SPA was approved effective September 1, 2013. These eligibles will be reported under Managed Care, but no longer in the waiver.	8/1/2011
AL	Eligibility	Waivers	AL indicated that instances where an individual is assigned RBF = 6 (family planning services) but not MAS 5 (1115 waiver-related individuals) are correct because the state's system for identifying eligibility in such a program is preempted by aid categories that are internally changed to reflect enrollees' pending applications for other eligibility programs. The same programming logic is responsible for a discrepancy of about 1,000 persons between those with RBF = 6 and those with waiver type "F." This is an ongoing issue that is not particular to one quarter.	4/6/2012
AL	Eligibility	Waivers	In November 2012, there is new reporting to Waiver ID 'AC', Alabama Community Transition (ACT) Waiver '0878' with 6 individuals. This waiver was effective as of April 1, 2011. However, MSIS reporting did not begin until November 2012.	4/3/2014
AL	IP	Covered Days	Between Q1FY2008 and Q1FY2013, there are some FFS Non-crossover Original IP claims with MEDICAID-COVERED-INPATIENT-DAYS < 0. These claims do not appear in every quarter. There are relatively few of them. The State notes that, "Non-covered days are submitted by the provider and are not updated by the system. We do update the covered days in pricing and in audits. A change was put to the hospital days audit so that we set the audit but zero pay the claim and set the covered days to zero. So if a provider submitted a non-covered days of greater than zero and we set the covered days to zero because of the audit, you would get that situation." The State adds that, "Audits could result in the number of covered days not outright denying but cutting back the number of covered days which could result in negative inpatient days also."	3/25/2013
AL	IP	Family Planning	There were no IP claims with a program type of family planning until Q1FY2008.	8/24/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
AL	IP	Managed Care	Through FY2010Q4 there were very few non-crossover FFS claims in the IP file as everyone who did not have Part A Medicare enrollment was enrolled in a capitated PIHP managed care plan, known as the Partnership Hospital Program. From FY1999 to Q2FY2008 global payments for maternity care were incorrectly reported in the IP file. In Q3FY2008 those claims were moved to the OT file because they represent the professional component of maternity care, not the facility payments. The global maternity care payment was paid upon delivery of a baby, not on a per member per month basis. CMS has directed states to report global maternity/obstetric care payments as FFS payments rather than managed care payments.	3/25/2013
AL	IP	Total Non-Crossover FFS claims	In October 2010, AL ended its PHP (Partnership Hospital Plan) Managed Care Plan. AL began to pay IP claims on a FFS basis. This substantially changed the number of claims and the amount paid on both FFS Claims and Encounters. The Total Number of FFS Non-crossover Original Claims increased from 1,553 in Q4 2010 to 31,500 in Q1 2011. The Total Amount Paid grew from $5.735 Million to $148.428 Million over the same period. The Average Amount Paid per claim increased nearly 20%, from $3,950 to $4,700. At the same time, the number of Encounters fell from 31,400 in Q4 2010 to 620 in Q1 2011.	NA
AL	LT	Covered Days	Some facilities bill for more than a month, resulting in some claims having more than 31 covered days.	12/10/2004
AL	LT	TPL	Very few LT claims have Other Third Party Payment (or Third Party Liability/TPL).	NA
AL	LT	Type of Service	AL did not report any claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under) until Q1FY2008.	8/24/2012
AL	LT	Type of Service	According to http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.1.6_Annual_Report_FY11/2.3.1.6_FY11_An_Rpt-2-19-13.pdf Alabama closed its largest ICF in December 2011.	4/15/2014
AL	OT	Bundled Payment	Average MEDICAID-AMOUNT-PAID for outpatient hospital services (TYPE-OF-SERVICE=11) decreased by more than 25% between FY2011 and FY2012, and percentage of outpatient hospital services paid zero dollars ($0) also decreased more than 25%. Documentation available online shows that AL changed their outpatient hospital reimbursement methodology to be "encounter-based" (like FQHCs) from October 2009 through September 2011. In October 2011 they returned to a regular fee-for-service reimbursement methodology for outpatient hospitals. The MSIS data is presumably accurate despite the substantial changes in outpatient hospital expenditures.	12/17/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
AL	OT	Global Obstetric Care Payments	Until Q4FY2011 AL coded about 8,400 Global Obstetric Care Payments per month as TOS 21 (PHP) with no plan ID number and no corresponding managed care enrollment. These claims appeared on the State's OT files. AL indicated that, even though the services are covered under a 1915(b) waiver, the payments are actually FFS claims representing the delivery; not Cap Payments. The global obstetric care payment is paid at the time of delivery. They can be identified by the following Procedure Codes: 59400; 59510; 59610; and 59618. The State has agreed to fix these claims starting in Q4FY2011. Going forward, they will be coded as TOS 08 (Physician). Still in some quarters there were some PHP capitation payments that appear to be global maternity care payments.	5/29/2014
AL	OT	HCBS Waiver	Through at least Q2FY2013 there are consistently between two and three thousand waiver claims (PROGRAM-TYPE = 7) each quarter with TYPE-OF-SERVICE = 09 (Dental). The procedure codes on the claims indicate that they are HCBS waiver habilitation and personal care services, not dental services.	9/17/2013
AL	OT	Managed Care	The average amount paid on HMO capitation claims is lower than usual because their HMO plan is dual Medicaid/Medicare special needs managed care plan (D-SNP) and the risk part for Medicaid is just for coinsurance and deductibles. In 2008 all HMO capitation claims were paid $15. In 2010Q2 this increased to $30. In 2010Q4 this increased to $35. In 2011Q2 the payments rose to $60. In 2013 those payments are still $60.	9/25/2013
AL	OT	Managed Care Capitation	There are consistently about one-quarter fewer PCCM capitation claims than PCCM enrollments. AL has indicated in the past that the missing PCCM capitation claims are probably for adults enrolled in PCCM. About one-quarter of all PCCM enrollees are adults. In 2013 the state indicated that these individuals were likely assigned to PCCM providers at FQHC clinics. FQHC providers can participate in the PCCM program but do not receive a capitation payment.	6/27/2013
AL	OT	Managed Care Plan IDs	Alabama ended its Partnership Health Plan (PLAN-ID-NUMBER = H00) at the end of Q4 2010. The State had previously reported this as PLAN-TYPE = 08 (Other) with TYPE-OF-SERVICE = 21 (PHP). In Q4 2010, the State reported an average of 594,000 individuals per month in this plan. In Q1 2011, it reported 0 recipients in the plan. As a result of this change, the number of cap payments with TOS 21 fell substantially between Q4 2010 and Q1 2011. Alabama made roughly 1.8 million payments in Q4 2010 compared to 8,800 in Q1 2011.	7/20/2011
AL	OT	Medicaid Amount Paid	Between October 2009 and September 2011 AL paid outpatient hospitals on an encounter basis. Each encounter included a claim line with service code T1015. Expenditures for outpatient hospital services roughly doubled during this period. In October 2011 AL began reporting outpatient hospital claims on a fee-for-service basis. Outpatient hospital service expenditures decreased by nearly half in FY2012.	11/20/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
AL	RX	Adjustments	NDC's are not reported on credit claims until Q1FY2004.	12/19/2004
AL	RX	Compound Drugs	AL uses 9-fills on the NDC field to indicate compound drugs.	NA
AR	Claims	Adjustments	Sometimes only the Original and Resubmitted claims are submitted without the void, so that some claims can't be properly adjusted and the amount paid is overstated.	10/12/2006
AR	Eligibility	1115 Waivers	Arkansas has an 1115 Waiver program called ARKids B (called ARKids First when implemented in 10/97) (Waiver Type 1 and Waiver ID 'A9') and is reporting many of its poverty-related children into MAS/BOE 54. Most adults in MAS/BOE 55 only qualify for family planning benefits under an 1115 waiver approved in 1996 (Waiver Type F and Waiver ID 'B1'). AR indicated to us that, as far back as 1999, they had requested Title XIX funds to supplement this program but were not formally authorized to do so until January 2003 (with retroactive funding provided back to January 2001). However, not all children in ARKids B receive Title XXI funds: (1) some children who are otherwise eligible for Medicaid (ARKids A) choose to enroll in the ARKids B program instead, but AR indicated that allowance of this practice will soon cease; and (2) children of state employees are prohibited from accepting Title XXI funds so they're covered by Medicaid instead.	9/1/2009
AR	Eligibility	1115 Waivers	AR implemented a cash and counseling 1115 waiver called "Independent Choices" in 1998. This waiver did not have any eligibility expansion. This waiver expired in March, 2008. Similarly, AR implemented a TEFRA 1115 in 2003 that allowed the state to impose sliding scale premiums for some disabled children at risk of institutionalization. The waiver did have an eligibility expansion. These TEFRA children are reported to state group 49. In FY06, they were reported to MASBOE 54 while they were reported to MASBOE 42 in FY05 and earlier years. They should have been reported to MASBOE 52, which began in Q1 FY07.	3/3/2011
AR	Eligibility	1115 Waivers	In October 2006 (Q1 FY07), AR implemented a HIFA waiver (waiver ID 'A1', waiver type '5') that expanded eligibility to parents and spouses of Medicaid/SCHIP children and childless adults and spouses aged 19-64 with family income up to 200% FPL, who are employed by a participating employer. The waiver allows employers who did not previously provide health insurance to offer coverage through a public/private partnership. In addition this waiver also transitioned the state's previously implemented 1915(b) Primary Care Case Management waiver program known as ConnectCare (waiver type '2') from a 1915(b) waiver into the HIFA waiver. Benefits and service delivery of this group were not impacted. The expansion enrollees are not reported to MSIS because the enrollment information is not included in state's MMIS because the program is administered through a Third Party Administrator. The state did provide estimates of enrollment in this expansion as of October 2007 of 1,943 parents/spouses	8/5/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			(covered using Title XXI funds), 2,140 childless adults (covered using Title XIX funds) and 491 other enrollees (covered without state or federal funds). However the state did begin reporting in MSIS the ConnectCare part of the waiver to waiver type '5' in Q1 FY08. The ConnectCare group is not an eligibility expansion, but some of the enrollees reported to this component of the HIFA waiver are mapped to MAS '5' because they are expansion enrollees covered by another 1115 waiver expansion.	
AR	Eligibility	1115 Waivers	In the Q3 FY11 review, we noted that approximately 20 - 50 people had been reported with restricted benefits flag 6 (individual is eligible for Medicaid but only entitled to restricted benefits for family planning services) and Maintenance Assistance Status 5 (1115 demonstration) but not reported with enrollment in the family planning waiver (waiver ID 'B1,' waiver type 'F') in the second month of the quarter for several fiscal quarters. The issue was resolved in Q4 FY11.	4/6/2012
AR	Eligibility	CHIP	AR has an M-CHIP program (known as ARKids B) that is operated through an 1115 waiver (see 1115 Waivers section).	5/15/2009
AR	Eligibility	CHIP	AR has an M-CHIP program for older children to 100 percent FPL through September 2003. Children in this M-CHIP program were reported to both MSIS and SEDS. In addition, AR was also approved to cover children with family income to 200 percent FPL as M-CHIP, but this group of M-CHIP children were not identified in MSIS until Q1 FY07, and AR only began reporting this group to SEDS in FY06. These children may not have been reported as M-CHIP to either MSIS or SEDS prior to 2006 because the ARKIDS B 1115 waiver covering children to 200 percent FPL was operational in 1997 (before CHIP). Not all children reported to MASBOE 54 are M-CHIP, however. (See 1115 Waivers section for explanation why).	10/6/2010
AR	Eligibility	CHIP	In April 2004, AR added an S-CHIP program for unborn children up to 200% FPL. These S-CHIP children (mothers) are not included in MSIS data. These enrollees began appearing in SEDS reports in Q4 FY04. AR began reporting individuals with CHIP flag =3 (S-CHIP) in Q3 FY12. The individuals reported with this CHIP flag were reported with MASBOE 35 and state-specific groups 611U or 612U. These individuals were included in earlier MSIS files as well and appear to belong to the unborn child group. We asked the state if the previous reporting of these individuals was incorrect, and the state indicated that although these people were previously reported with CHIP flag = 2, that reporting was incorrect and these are S-CHIP enrollees. Additionally, the state corrected the MASBOE reporting for these individuals by moving them to MASBOE 00 effective Q4 FY12. They also have their monthly data fields reported.	10/6/2010
AR	Eligibility	CHIP	In Q1 FY07, AR implemented a HIFA waiver that extended M-CHIP enrollment to parents (childless adults were covered only by Title XIX funds). However, by mistake these individuals were	5/3/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			not included in MSIS data. Adult SCHIP enrollment was about 400/month in SEDS by Q4 FY07.	
AR	Eligibility	CHIP	In Q1 FY14, the state reported a new state specific eligibility group (611C), which was not included in the 2010 version of the MASBOE crosswalk we have. Enrollment in September 2013 was 432 and grew to 1,454 by the end of the quarter. These individuals are reported to MASBOE = 34 (Poverty-Related Children). The expansion of the ARKids First program prompted the state move these individuals. With the ARKids First program, a new rule was put into place that expanded the income level for beneficiaries in ARKids B. This expansion spurred DMS to make a decision to move many of the beneficiaries from the 01 CHIP program into the 61 eligibility group. In order to identify the beneficiaries that carried the CHIP waiver eligibility, the C indicator was added to those that were moved into the 61 eligibility group. This change was not official, but is being reported to keep track of the eligible beneficiaries in the MMIS. Other unofficial changes were made to other beneficiary eligibility files in error and are currently being corrected by DMS, specifically 61N and some 61U beneficiaries.	3/20/2014
AR	Eligibility	CHIP	Between December 2013 and December 2014, S-CHIP goes down from 2,028 to 2. This decrease was attributed to the Women's Benefit waiver ended and transitioning those individuals to the private option. However, in January 2015, S-CHIP enrollment increased to 353. We are asking the state for the reason for this decrease because we had expected S-CHIP enrollment to cease due to the end of the Women's Benefit Waiver and transition to the private option.	10/17/2014
AR	Eligibility	Dual Eligibility Codes	In FY06 and FY07, there were substantial differences between MSIS and MMA dual reporting. In FY06, for example, AR reported roughly 19 percent fewer duals than the MMA files. Large differences existed between full and partial dual counts. There were also substantial differences by dual code. By FY08, the partial counts compared well between MSIS and MMA. Problems continued with the distribution by full dual codes, but the total number of full duals compared well.	9/1/2009
AR	Eligibility	Dual Eligibility Codes	Through Q4 FY06, AR assigned dual code 02 (QMB plus) to all full duals. Beginning in Q1 FY07, most full benefit duals (including SSI duals) were shifted to dual code 08. AR officials explained that they do not have routine access to income information, allowing them to put SSI and other low-income duals in code 02. However, AR's monthly MMA data continue to show the vast majority of full benefit duals reported to dual code 02. MMA data also include dual code 04, while these persons are presumably reported to dual code 08 in MSIS data. We asked the state to reinvestigate this matter in October 2010 and they stated that they were not able to improve their reporting in this area.	1/19/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
AR	Eligibility	Dual Eligibility Codes	Through Q2 FY08, AR had been reporting many (~40) working disabled individuals ('10' in the first two bytes of the eligibility aid code) with dual code 05 (Qualified Disabled and Working Individuals). However, the working disabled (who receive full benefits) cannot be characterized as receiving only partial benefits (the only Medicaid benefit QDWI recipients receive is payment of their Medicare Part A premiums). When asked why MMA continues to report ~5 persons as QDWI while MSIS reported none, the state responded that the reporting process for the two sources differed and there is no way to identify these recipients in MSIS.	7/1/2011
AR	Eligibility	Managed Care	AR began reporting its PACE plan in the eligibility file as of Q1 FY09 (although the plan began in April 2006, there was no enrollment until 2008). Unlike other states, AR has two unique eligibility categories reserved for PACE participants: 09 and 15. The plan is reported with a Plan Type of '06' and a Plan ID of 'PACE'.	10/6/2010
AR	Eligibility	Managed Care	Beginning in Q3 FY02, CMS managed care data showed over half of Arkansas Medicaid enrollees participating in PCCMs and half in a transportation PHP. However, in FY04 through Q3 FY05, the state did not report enrollment in its transportation PHP in MSIS (plan type 08). AR began reporting some transportation enrollment in Q4 FY05. However, in Q4 FY05, AR only reported transportation managed care enrollment in month 1. Beginning with Q1 FY06, AR transportation managed care enrollment appears reliable. Plan Type 08 represents AR's Transportation 1915(b) Waiver program (ID="NET").	10/6/2010
AR	Eligibility	Managed Care	From 2005, AR's PCCM reporting was not consistent with the annual CMS managed care survey. In June of FY05, MSIS reported 15% more PCCM enrollees than CMS, and in June FY06, MSIS reported 20% fewer PCCM enrollees than CMS. In FY07, the difference dropped to 13 percent; was 12% in FY08; and was 14% in FY09. (There are also concerns about PCCM enrollment among the aged and disabled during this time.) In response, AR indicated that it identified a few minor issues with both reporting sources as well as the overall cause of the discrepancy (unspecified). After changes were implemented to both reports (the state maintained that PCCM reporting was fixed as of Q1 FY10), AR expected to see the numbers vary less, and while they may never match, they expected the discrepancy to fall below 10%. However, there was a 14% difference between counts in FY10. In addition, since Q1 FY09, AR has reported approximately 11% more PCCM capitation claims than enrollment records. The state indicated that this occurs because eligibility is determined a week prior to claims generation for the third month of each quarter.	2/25/2011
AR	Eligibility	Managed Care	Between Q1 and Q2 FY14, Plan ID 'NET' (Plan Type 08) (AR's 1915(b) transportation waiver program) goes from 461,760 to 641,789. When the private option was implemented, many recipients were moved from ARKids B (aid category '01') to	10/17/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			ARKids A (aid category '61'). Those in aid category '61' are also eligible for NET services, thus the increase.	
AR	Eligibility	MASBOE	Roughly 10 percent of eligibles in BOE 5 are 18 or younger. Nearly all of these enrollees are between ages 15-18, and are reported to MASBOE 35 and 55. These enrollees are most likely pregnant women or receiving family planning-only benefits.	NA
AR	Eligibility	MASBOE	Beginning in 2002, AR expanded Medicaid eligibility to extend full Medicaid benefits to aged persons with income <80% FPL. These persons are identified with the eligibility aid code '18S' and should be reported to MASBOE 31.	10/6/2010
AR	Eligibility	MASBOE	2000 - Present: Since 2000, AR has not submitted retro records (as originally expected). In addition, there are unusual patterns to monthly enrollment in most years (highest in month 1 of each quarter some years, highest in month 3 in other years, etc.). We have asked the state to wait a few weeks after each quarter before submitting their data. Because this would require major coding changes, the state declined to do so.	12/29/2011
AR	Eligibility	MASBOE	In Q1 FY14, enrollment to MASBOE = 24 (Medically Needy Children) decreased significantly, from 173 in September 2013 to 13 in December 2013. These individuals were in state specific eligibility groups 261, 271, and 761. The decrease was caused by a shift in enrollment, as Arkansas was trying to anticipate a program change to the MN needy program, which did not end up occurring. Aid category 26 is the Medically Needy (MN) AFDC-EC group, which has a very low income limit. Arkansas Medicaid was planning to terminate the MN program last year, and moved the children in this category as well as the UP-EC group (aid cat. 76) to ARKids A (category 61.) The children in 26 and 76 are eligible under ARKids A so the state moved them there to continue their eligibility after the MN program was eliminated. As it turned out, Arkansas Medicaid didn't eliminate the MN program so it wasn't actually necessary but they don't plan to move them back. They receive the same services in 61 so they plan to leave them there. We may see new children come into 26 or 76 as a result of this change.	3/20/2014
AR	Eligibility	MASBOE	Between Q1 and Q2 FY14, Arkansas began reporting a substantial number of individuals with Unknown MASBOES. These individuals were in State Specific Eligibility Groups 99, 99A, and 99B (most in 99A and 99B) (In Q2 FY14, there were 5,921 assigned to MB 99, and Q3 there were 8,526, and by Q4 it was down to 3 individuals. These individuals all became Aid Category 06 (i.e., private option) later in 2014 after they were captured under new Aid Category 06 logic implemented in July 2014 after the update for the new eligibility groups had been completed; this work was not completed until Q4. Once the state started the private option plan, certain populations transitioned; for example, the Women's Benefit waiver and HIFA waiver, which both ended on 12/31/13. Most of the pregnant	10/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			population covered under those waivers were moved to the new Aid Category 06.	
AR	Eligibility	MASBOE	In Q2 FY14 reporting to MASBOE 3A (BCCPTA) ends (from about 900 in Q1 FY14). Breast cancer recipients were moved to the private option category during this time. There are substantial shifts in MASBOE 45 (3,129 to 145,374), MASBOE 54 (80,041 to 69,091), and MASBOE 55 (50,274 to 139). Those in MASBOE 45 with Aid Category '06' and Age Indicator '2' were moved to the private option, as were those in MASBOE 55 (aid category '69' and age indicator '2'). Those in MASBOE 54 were either in aid category '01' with an age indicator '0' or aid category '69' with an age indicator '1'. Because the ARKids program changed the income limits for those enrolled in the '01' aid category, part of that population was moved to aid category '61' (i.e., ARKids A in October 2013). Those in aid category '69' who had limited services became eligible under new guidelines and were then moved to aid category '01', which has full services under ARKids A.	10/17/2014
AR	Eligibility	Private Health Insurance	Between Q1 and Q2 FY11, the number of enrollees in AR with third party health insurance (health insurance flag '2') increased from approximately 37,000 to approximately 43,000. The state indicated that this increase occurred because their TPL contractor was identifying more eligibles with coverage.	6/23/2011
AR	Eligibility	Race/Ethnicity	In Q1 FY11, AR reported 172 individuals to ethnicity code 5 and 172 fewer individuals to Hispanic/Latino in the ethnicity variable when compared to the race/ethnicity variable. These individuals should have been reported to ethnicity code 9 (unknown).	3/22/2011
AR	Eligibility	Race/Ethnicity	2007-2010: Beginning in Q3 FY07, AR reported an increasing percentage of enrollees as having an "unknown" race. The state indicated that this was due to a transition from a one-byte race code to a two-byte race code that has not yet been implemented by AR's fiscal agent. This transition (which incorporates 38 new state race codes) began in October 2010, and the percentage of individuals with unknown race decreased from approximately 30% in Q4 FY10 to approximately 5% in Q1 FY11. However, in Q1 FY11, the percentage of recipients with unknown ethnicity increased from 0% to approximately 35%. The state indicated that this was related to the transition and that the number of individuals with unknown ethnicity would decrease in Q2 FY11. However, in Q2 FY11, the percentage of enrollees with unknown ethnicity was 31%. When asked about this, the state indicated that this reporting could not be improved.	6/23/2011
AR	Eligibility	Restricted Benefits Flag	Beginning in 2002, AR expanded Medicaid eligibility to extend full Medicaid benefits to aged persons with income <80% FPL. These persons are identified with the eligibility aid code '18S' and should be reported with restricted benefits flag 1.	10/6/2010
AR	Eligibility	Restricted Benefits Flag	Beginning in Q1 FY10, AR reported enrollment in its Money Follows the Person (MFP) program (RBF = '8'). MFP enrollees	10/6/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals are eligible for enhanced FFP.	
AR	Eligibility	Restricted Benefits Flag	AR previously indicated that its MMIS did not have access to information that would identify aliens receiving emergency services. However, in October 2010 the state determined that individuals in state aid category 61_U are aliens who receive emergency services. As a result, AR did not use restricted benefits code '2' until Q1 FY11.	9/22/2011
AR	Eligibility	SSN	In Q1 FY08, AR reported 99.9 percent of enrollees with a Social Security Number, a dramatic increase from 94.4 percent in Q4 FY07. AR maintained that this was accurate but later acknowledged that it provides pseudo-SSNs to some individuals. These pseudo-SSNs can be identified by the presence of an '8' or '9' in the first digit of the SSN.	9/22/2011
AR	Eligibility	State-Specific Eligibility	A number of new eligibility groups are reported in Q2 FY15 with substantial enrollment: 062D through G (total enrollment about 107K) and 099C through G (total enrollment about 9K). We are asking the state for an updated crosswalk.	5/28/2015
AR	Eligibility	TANF/1931	The TANF flag is 9-filled for all eligibles.	NA
AR	Eligibility	Waivers	During Q4 FY08 AR reported a decline in its ARKids waiver (waiver ID 'A9', waiver type '1') by approximately 10 percent between June and July 2008 (when enrollment dropped from ~80,000 to ~72,000). This decline was originally cited as an error by AR and reportedly due to an anomaly in the code. The state said adjusted numbers would bring the July enrollment from 72,000 back to almost 80,000. However, this did not occur. Instead, the state subsequently clarified that the anomaly in the extraction process had in fact affected data prior to July 2008 and was due to the fact that "enrollment" was previously conditional on whether the individual was present in a quarterly (rather than monthly) segment. Monthly enrollment counts supplied by the state suggest that the ~72,000-person level reported July 2008 and onward is more accurate.	1/4/2011
AR	Eligibility	Waivers	In month 1 of Q1 FY11, 1 person was reported to the Respite Care for Children with IID or DD Waiver (waiver ID A7). According to our records, this waiver expired on 10/31/05.	6/23/2011
AR	Eligibility	Waivers	Through Q4 FY09, AR had an ongoing discrepancy between the number of enrollees reported in the state's 1915(b) non-emergency transportation plan (waiver ID 'NET'; waiver type '08') versus the number reported for the corresponding waiver (waiver ID 'A2'; waiver type '2'). The discrepancy each month was usually small in magnitude (a few hundred to a few thousand people each month) compared to the number of persons enrolled in the benefit itself. The state acknowledged this discrepancy and fixed its reporting as of Q1 FY10.	9/22/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
AR	Eligibility	Waivers	2008-2011: From Q1 FY09 until Q3 FY11, AR had a discrepancy between the number of persons reported as having enrollment in AR's ConnectCare waiver, which is Primary Care Case Management (waiver ID A1, waiver type '5'), and PCCM enrollment (plan type '07') for the corresponding month. The problem was chiefly due to the removal of ARKids enrollees (assigned to MASBOE 54) from PCCM managed care reporting but not the waiver itself. Prior to Q3 FY11, AR indicated that it had identified a loophole which allowed ARKids B enrollees (state aid category 01) to be erroneously reported with both waiver ID 'A1' and waiver ID 'A9.' After this loophole was corrected, the problem was solved.	12/29/2011
AR	Eligibility	Waivers	In months 1 and 2 of Q4 FY10, one person was reported to the Respite Care for Children with Physical Disabilities Waiver (waiver ID A6). According to our records, this waiver expired on 9/30/06. However, AR indicated that the recipient was enrolled in this waiver from 10/1/04 - 9/12/10. During Q2 FY11, AR again reported one person to this expired waiver. The state indicated that this occurred because this individual had an active waiver segment during that quarter. The state end-dated the segment effective February 2, 2011 and AR did not expect this waiver to appear in future MSIS files. However, one person was reported to this waiver in Q3 FY11 - Q1 FY12 before the problem was eliminated. In September and October 2013, one individual was again reported to waiver ID 'A6'. This occurred because an eligible with an active A6 waiver segment for this quarter. The State end-dated the segment effective 12/02/13 so it will not show up on any future reports.	1/23/2012
AR	Eligibility	Waivers	Between Q1 and Q2 FY12, enrollment in the Assisted Living/Living Choices waiver (waiver ID 'A8') increased from approximately 600 to approximately 660.	5/3/2012
AR	Eligibility	Waivers	Between Q1 and Q2 FY14, Arkansas Non-Emergency Transportation Waiver 1915(b) (Waiver ID 'A2') increases from 461,760 to 641,789. This mirrors increases seen in Plan ID 'NET'. Arkansas Family Planning 1115/Women's Health Waiver decreases from 55,691 to 75. The state confirmed that these waivers had ended and noted that the populations that were enrolled in these waivers are now eligible for the Private Option and should be reported there.	10/17/2014
AR	Eligibility	Waivers	Arkansas Safety Net Benefit HIFA Waiver (Waiver ID 'A1'/21-W-0005116/11-W-0021416) expired 12/31/13, but enrollment has remained relatively steady (actually increased slightly - was 427,246 in Dec 2014). We have asked the state whether this waiver ID is now being used for a different waiver or when they expect reporting to waiver ID 'A1' to stop.	2/13/2015
AR	Eligibility	Waivers	Women's Health Waiver (Arkansas Family Planning Waiver) (Waiver ID 'B1'/11-W-0074/6) expired on 12/31/13, but the state continued to report enrollment, which has decreased from 24 to 5 from October to December 2014, but has not ceased.	2/13/2015

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			The state has indicated that enrollment to these waivers should cease by the Q3 FY13 submission.	
AR	Eligibility	Waivers	Waiver ID 'A6' was previously used to report enrollment for the Respite Care for Children w/Physical Disabilities. This waiver expired in 2005, but in Q2 FY15, Arkansas reported 1 individual in both Jan. and Feb.	5/28/2015
AR	Eligibility	Waivers	Women's Health Waiver's (Waiver ID 'B1') enrollment increases from 1 to 5. We had expected no enrollment because of transition to private option (waiver expired 12/31/13), but Arkansas continues to report small enrollment to this waiver through Q2 FY15.	5/28/2015
AR	IP	Crossovers	Each quarter through at least Q1FY2013, AR reports a small number of crossover claims in the IP file with type of service "other" (TOS=19). They explained that these represent AR Seniors (QMB+). According to the MSIS data cube these claims represent a very small amount of money.	3/20/2013
AR	IP	Diagnosis	Each claim can only have a maximum of two diagnosis codes. This is evident in MSIS through at least Q1FY2013.	3/20/2013
AR	IP	Family Planning	Through at least Q2FY2013, there aren't any claims with a Program Type of 2 (Family Planning).	7/27/2012
AR	IP	Procedure Code	Prior to Q2FY2012 all principle procedure codes in the IP file were 5-digit numeric CPT codes appropriately identified with procedure-code-flag=1 (CPT). In Q2FY2012, 3 and 4-digit ICD-9 surgical procedure codes begin appearing in large numbers as principle procedure codes but the principle procedure code flag identifies them as CPT codes rather than ICD-9 codes.	7/27/2012
AR	LT	Crossovers	It was noted that in the Q1, Q2, and Q3FY2009 and 2010, and Q2FY2011 AR LT files the average Medicaid paid on crossover claims is a little higher than the average paid for LT non-crossover FFS claims. This is likely caused by the difference in nursing facility days per claim on non-crossover and crossover claims. Non-crossover claims in AR are mostly for weekly time periods. Crossover claims are more likely to represent monthly time periods.	7/27/2012
AR	LT	Patient Liability	Patient Liability is not reported on any LT claims through at least Q3FY2012.	7/27/2012
AR	LT	Type of Service	There aren't any claims with a Type of Service of 02 (Mental Hospital Services for the Aged), as is appropriate since this is not a covered service in Arkansas.	NA
AR	OT	Crossovers	In Q3FY2011 AR fixed a reporting problem for crossover claims that was causing inflated gross expenditures by repeating the total paid for the entire healthcare encounter on each service reported. Resolving this error will lead to a decrease in reported crossover expenditures of about $400 million annually. The fix will also cause the proportion of crossover claims paid zero to increase.	10/26/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
AR	OT	HCBS Waiver	According to link files through at least Q4FY2011, about one quarter of all people enrolled in HCBS 1915(c) waivers do not have any waiver claims. While these enrollees do not have any claims with Program Type 6 or 7, they do have a substantial number of claims and amount of expenditures for assigned Type-of-Service=19 (Other Services).	3/20/2013
AR	OT	Managed Care Capitation	The capitation claims contain different PHP Plan IDs than the eligibility files. In the eligibility file all PHP's have a Plan ID = NET. Between Q1FY2009 and Q1FY2010 the PHP capitation claims all have 9-digit numeric Plan IDs. This was corrected in Q2FY2010 so that all transportation capitation payments have Plan ID "NET" to match the EL enrollment.	7/6/2011
AR	OT	Managed Care Capitation	The majority of PCCM capitation claims are adjudicated in the first month of a quarter and have dates of service from the previous quarter. This makes it difficult to validate that the correct number of capitation payments have been made in relation to the number of enrollments per month. This can first be identified clearly in data quality reports in Q2FY2010 and continues through at least Q1FY2012.	10/26/2011
AR	OT	Managed Care Capitation	Until Q2FY2011 AR reported transportation encounters as capitation claims (TYPE-OF-CLAIM = 2; TYPE-OF-SERVICE=21) with a paid amount of zero dollars. Beginning in Q2FY2011 AR began reporting transportation encounters with TYPE-OF-CLAIMS=3 and TYPE-OF-SERVICE = 26 (Transportation).	3/20/2013
AR	OT	Managed Care Capitation	AR began reporting some PACE capitation claims in MSIS in Q3FY2011. PACE capitation payments for enrollees over 64 years old had previously been reported as FFS claims with procedure code Z3020. PACE enrollments between Q3FY2011 and at least Q1FY2012 were reported with plan ID 156033093. The EL enrollment has plan ID of "PACE". AR may continue to report procedure code Z3021 on FFS claims representing PACE capitation payments for individuals under 65 years of age.	5/1/2013
AR	OT	Managed Care Encounters	AR began reporting transportation encounters in Q2FY2011 with the 9-digit numbers similar to those previously seen on transportation capitation payments. Before Q2FY2011 these encounters were reported as capitation claims. Transportation PHP enrollment, capitation payments, and encounters have different plan IDs that cannot be directly linked. See Managed Care Capitation note.	5/31/2011
AR	OT	Service Code Modifiers	AR was reporting the wrong data into the Service Code Modifier field on OT and IP claims in 2008, 2009, and some 2010 OT claim files. The one-byte value is the type of service code (TOS) rather than the modifier. This was corrected in the Q4FY2010 OT file.	12/16/2011
AR	OT	Type of Service	On July 1, 2009, dental services became a covered Medicaid benefit for adults in AR. The percentage of dental claims increased accordingly.	12/3/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
AR	RX	Adjustments	The few FFS debit claims appear to be all, or mostly, service tracking claims while credit adjustments are all individual claims.	12/10/2004
AR	RX	Days Supply	Until Q2FY2006 there was larger than expected percent of claims with days supply greater than 30.	NA
AZ	Claims	Crossovers	There are very few crossover FFS claims. This is because most dual eligibles are enrolled in managed care.	NA
AZ	Claims	Indian Health Services	About half of the claims for people not enrolled in managed care are for people enrolled in the Indian Health Service.	NA
AZ	Claims	Managed Care	The LT managed care plans include HMO services as well.	NA
AZ	Claims	Managed Care Encounters	Arizona submits the amount paid to managed care providers in the Medicaid Charge field.	NA
AZ	Claims	MSIS ID	Starting with 2005 Q1 about 200,000 MSIS ID's were changed to a new format. This is a one-time change. This created a linkage problem between the claims and eligibility files with about 25% of the claims and eligibility MSIS ID's not linking in 2005. Over time, the linkage has improved and the problem is only seen in the LT and RX files in 2006. This however, creates a problem with the unique identification of enrollees over time.	NA
AZ	Claims	Procedure Code	AZ 2011 Q2-4 IP and LT files: the procedure code field for claims in these files that are normally 8-filled (8 characters), are filled with 7 characters 8 and 9 strings.	10/19/2012
AZ	Claims	Type of Service	It is possible that all mental health claims may not be in file. Some IP psych claims may be in the IP and not the LT file.	12/15/2004
AZ	Eligibility	1115 Waivers	Effective 2001, AZ's 1115 expansion group also included single adults and childless couples (who are reported in MSIS). Although documentation on the CMS website indicates that these individuals are funded through Title XXI funds, they are funded through Title XIX and, therefore, do not need to be assigned a CHIP flag other than = 1 (AZ eligibility staff confirmed this). Also, although parents of Medicaid/CHIP children were included in the waiver expansion as well, these individuals are not reported in MSIS because they are S-CHIP and the state opted not to report them.	10/7/2011
AZ	Eligibility	1115 Waivers	A contact from CMS indicated Arizona ended its HIFA parents' coverage program as of October 1, 2009 (Q1FY10). The state has confirmed that this is correct. Also, the MSIS reporting for the waiver's other enrollees (single adults and childless adults who, unlike the parents of covered children, are reported in MSIS) declined from ~225,000 in October 2009 to ~160,000 in September 2010 -- the state explained that this was due to a freeze on AHCCCS.	4/23/2012
AZ	Eligibility	CHIP	Arizona has an S-CHIP program for children, but did not begin reporting it in MSIS until Q1 FY07. The state does not have an M-CHIP program for children. Beginning in 2002, SCHIP	7/1/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			coverage was extended to parents of SCHIP children under a HIFA waiver. These S-CHIP adults are not included in MSIS.	
AZ	Eligibility	CHIP	SEDS and MSIS CHIP counts have steadily increased in their difference. As of FY13, there is a 30% difference between the two. This issue has been raised with the state.	8/30/2013
AZ	Eligibility	County Codes	County Code 012 is the proper FIPS code for La Paz county, which was formed out of Yuma county in the early '80's.	NA
AZ	Eligibility	Dual Eligibility Codes	AZ MSIS data consistently report the majority of individuals in MASBOE 12 (disabled individuals receiving cash assistance) as having Dual Code 00. AZ maintains that many of the SSI cash individuals in AZ that are disabled do not qualify for Medicare.	10/7/2008
AZ	Eligibility	Dual Eligibility Codes	AZ has consistently reported several thousand dual eligibles (approximately 4,500 per month in FY08) to MASBOE 15 (rather than 11 or 12), almost all of them assigned to Dual Code 08. A review of those persons in MSIS who did not match up to the Medicare Enrollment Database (EDB) showed that the majority of the approximately 2,500 non-matches in 2005 were assigned a BOE = 1 or = 2, not = 5. The issue, which continues, may be something to raise with the state when other, major issues are resolved.	5/19/2009
AZ	Eligibility	Dual Eligibility Codes	AZ stopped reporting Dual Code 04 (SLMB-plus) as of Q1 FY08; previously, it had been ~ 300 persons per month. State eligibility staff verified that this was expected.	7/29/2009
AZ	Eligibility	Dual Eligibility Codes	MMA counts and MSIS counts differ greatly starting in FY12. This issue was raised with the state and the state explained that this is mainly because of when the files are submitted. This issue should not be raised in future reviews.	8/30/2013
AZ	Eligibility	Dual Eligibility Codes	AZ reported <215 partial duals [Dual Eligibility code '01', '03', '05', or '06'] as Comprehensive managed care plan enrollees [Plan Type '01'] as per month in Q1-Q1 FY12, Q1 FY13, Q4 FY13, and Q1 FY14. In Q3-Q4 FY12 and Q2-Q3 FY13 no partial duals were assigned to a Plan Type.	10/13/2014
AZ	Eligibility	Managed Care	AZ reports its LTC plans as MCO/HMOs in CMS June data each year. In addition, some Family planning only capitation programs also appear to be reported as MCO/HMOs in the CMS data. Thus, any comparison of MSIS managed care data to CMS June managed care data has to be done at the individual plan level, separating the CMS MCO/HMOs into HMO, LTC and FP plans.	9/22/2008
AZ	Eligibility	Managed Care	Each month, AZ reports plans for some individuals (usually less than 1,000) with Plan IDs "CTYPRI" or "DOCMAT." These IDs represent prisoners who are not actively enrolled in a plan with associated cap payments but nonetheless retain eligibility. At CMS's request, AZ will continue to report these plan IDs with a corresponding Plan Type = "08". "DOCMAT" represents someone residing in the Arizona Department of Correctional facility or Arizona Department of Juvenile correctional facility	3/10/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			and whose AHCCCS coverage is suspended; "CTYPRI" represents someone residing in a county jail or county detention center and whose AHCCCS coverage is suspended.	
AZ	Eligibility	Managed Care	1. There are currently ~20,000 children per month who are not reported as enrolled in the state's CRS (Children's Rehabilitative Services) managed care plan but nonetheless have associated claims reported as a PHP (which are assigned the CRS managed care Plan ID of 999111). For example, the Q2 FY10 OT file shows a reported 63,472 cap claims for this plan for the quarter. These people should have been identified in the eligibility file along with a Plan ID = '08'.	4/23/2012
AZ	Eligibility	Managed Care	2009-2010: AZ confirmed that it had not been fully reporting enrollment in its Behavioral Health Services managed care plan; rather, until Q4 FY10, it had been reporting only those persons who utilized services provided by the plan instead of all of those for whom capitation payments were made.	4/23/2012
AZ	Eligibility	Managed Care	Until Q4 FY09, AZ had been reporting Plan Type 08 for enrollees with coverage through the Indian Health Service. However, AZ's eligibility contact confirmed that these enrollees' services are covered through fee-for-service, rather than managed care, arrangements. This IHS enrollment was reported with Plan ID 999998.	4/23/2012
AZ	Eligibility	MASBOE	Generally, AZ MASBOE counts show a seam effect, with enrollment higher in Month 1 and declining in months 2 and 3. Hopefully correction records smooth out enrollment.	NA
AZ	Eligibility	MASBOE	Beginning in April 2001, Arizona extended full Medicaid coverage to single adults and childless couples in MAS/BOE 54/55. State groups 585 (<40 percent FPL) and 595 (spenddown to 100 percent FPL or less) are for adults with no children who are not otherwise eligible for Medicaid.	12/22/2009
AZ	Eligibility	MASBOE	2008-2009: Between Q2 FY08 and Q3 FY09, AZ miscoded enrollees in state-specific group 850. Those enrollees in MASBOE 35 assigned to state-specific group 850 should have been assigned restricted benefit flag 3 and assigned to MASBOE 31 or 32 depending on their ages.	3/3/2011
AZ	Eligibility	MASBOE	In 2001, Arizona extended full Medicaid benefits to the aged and disabled with income <100 percent FPL (reported in group 372).	3/3/2011
AZ	Eligibility	MASBOE	Since 1982, AZ has had a special 1115 waiver enabling the state to require all its enrollees to use HMOs. However, only those enrollees whose eligibility is tied to special provisions in the 1115 waiver are reported to MAS 5.	3/3/2011
AZ	Eligibility	MASBOE	Enrollment in AZ's Medicaid program appears to shift abruptly over the course of FY10. According to AZ's MSIS data, overall enrollment increased from ~1.35 million in September 2009 to ~1.45 million in October 2009 (an increase of more than 100,000 in one month). Then, throughout the course of the	4/23/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			fiscal year, enrollment gradually decreased to ~1.15 million in September 2010. Most of this gradual enrollment decrease occurred among adults and children (BOEs = 4 and = 5). This decrease was caused by the freezing of AHCCCS, which meant that no one was added to the program, and when a person dropped off, they were permanently dropped; The decrease being seen is due to this and the HIFA waiver ending.	
AZ	Eligibility	Restricted Benefits Flag	During FY10, enrollment in Restricted Benefits Flag = 2 (restricted benefits based on alien status), declined dramatically during FY10 (from ~95,000 in October 2009 to ~38,000 in September 2010). We've asked the state to confirm whether these shifts in enrollment were expected.	4/23/2012
AZ	Eligibility	Retroactive/ Correction Records	AZ data show some seam effect issues, but these are generally resolved with retro/correction records.	NA
AZ	Eligibility	SSN	The very low percentage of 9-filled SSNs (confirmed by high group test results for special analyses of Q1 FY07 and Q4 FY08 files that showed thousands of enrollees with an invalid SSN) led AZ to acknowledge that it had been applying pseudo-SSNs to certain individuals who could be identified by looking for an "8" or "9" in the first byte of their SSN (excluding those with 9-filled SSNs). The state has indicated that it will at some point abandon pseudo-SSNs beginning with an "8" (since SSN is reclaiming that number effective June 2011) but will advise us further as changes occur in the future.	3/3/2011
AZ	Eligibility	State-Specific Eligibility	Arizona froze their AHCCCS Care program as of 7/8/11, which caused decreases in reporting to MB 55 and state eligibility groups '585' and '587'.	9/26/2012
AZ	Eligibility	Waivers	The enrollment in Family Planning was cut in half during FY11. The state has been asked to clarify why this happened.	7/11/2013
AZ	IP	Family Planning	There aren't any claims with a Program Type of family planning due to special population in FFS.	12/10/2004
AZ	IP	Revenue Code	About one quarter of the claims are missing UB-92 revenue codes as they are Indian Health Service claims.	12/10/2004
AZ	IP	Service Code	Compared to other states, AZ has a high percentage of IP FFS Non-crossover claims with no Ancillary Service Code. The State indicates that these are primarily Indian Health Service (HIS) claims.	5/2/2011
AZ	LT	Adjudication Date	Since 2001, virtually all LT claims have been adjudicated in Month 3 of each quarter. The State notes that providers normally bill a complete quarter at one time. Furthermore, the State does not pay for services in advance.	4/29/2011
AZ	LT	Covered Days	Beginning Q2FY2002, Arizona is unable to provide the IP covered days for Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22). There are very few claims with this Type of Service.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
AZ	LT	Indian Health Services	Arizona started reporting the Program Type of Indian Health Service in Q2FY2004.	12/10/2004
AZ	LT	Patient Liability	The percent of claims with Patient Liability is lower than expected.	12/10/2004
AZ	LT	TPL	There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) due to the small FFS population.	12/10/2004
AZ	LT	Type of Service	There are no claims with a Type of Service of Aged Mental Health.	10/9/2005
AZ	LT	Type of Service	From Q3FY2010 to Q1FY2011, there were no FFS Non-crossover claims with TOS = 02 (Mental Hospital, Aged) or 05 (ICF/IID) on the LT file.	5/2/2011
AZ	OT	Amount Charged	The amount charged is mostly missing.	12/10/2004
AZ	OT	HCBS Waiver	There aren't any FFS or encounter claims with a Program Type of Waiver Services. Arizona says that waiver services are being provided as part of managed care.	NA
AZ	OT	ICN-Line	AZ reports ICNs, but not Original Line Numbers (LINE-NUMBER-ORIG) on its FFS Non-crossover OT claims.	5/2/2011
AZ	OT	Managed Care	There are about 10,000 claims under the managed care Plan ID 079999 with TOS = 20 that should have TOS = 21. We found this error in 2012 Q3, although files in 2011 and presumably before 2011 also have this error.	12/23/2014
AZ	OT	Managed Care Capitation	Arizona sometimes makes multiple capitation payments per person/month/plan to cover different plan services.	12/10/2004
AZ	OT	Managed Care Capitation	AZ did not start submitting LTC plan capitation claims until Q2FY2008.	6/27/2010
AZ	OT	Managed Care Capitation	All Cap Claims for TOS 21 (PHP) have PLAN-ID-NUMBER = '07999'.	5/2/2011
AZ	OT	Managed Care Plan IDs	FP enrollees are reported as enrolled in HMOs. I.H.S enrollees erroneously reported as enrolled in managed care. The BHO Plan ID's are different between the EL and claims files.	3/3/2011
AZ	OT	Managed Care Plan IDs	Prior to Q4FY2010, Plan IDs (PLAN-ID-NUMBER) on the OT file did not match those on the EL file. Plan IDs on the OT file were 6-Character All Numeric (e.g., '010088'). Those on the EL were 10-Character Alpha-numeric (e.g., '559695479A'). Except for PLAN-ID-NUMBER = '999111', which appears on the EL file, but not on the OT file, the Plan IDs match as of Q4FY2010.	5/2/2011
AZ	OT	Managed Care Plan IDs	The following plan IDs stopped enrollment prior to 9/30/2011 but continue to report "run-out" encounters for services with dates-of-service prior to their terminations: 010124, 110003, 110015, 110025, 110065, and 999111.	12/2/2014
AZ	OT	Medicaid Amount Paid	Up until 2003, Arizona was putting the total Medicaid Amount Paid from the claim header for OPD claims on each line item claim. This results in overstating the amount paid. Beginning in	12/15/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
			2003, they created a summary OPD claim with the Medicaid Amount Paid for all line items, but without the line item service codes. The line item claims will show the details of the services, but the Medicaid Amount Paid will be $0 on each line item claim. There are lots of OPD claims.	
AZ	OT	Service Code	Service codes are missing on some claims.	3/16/2011
AZ	OT	Service Code	Compared to other states, a very high percentage of FFS Non-crossover OT claims have a SERVICE-CODE-FLAG = '88' or '99'. The State indicates that a large proportion of them are Indian Health Service (HIS) claims.	5/2/2011
AZ	OT	Supplemental Cap Claims	There are large supplemental payments with a Type of Service of HMO caps in some quarters of the OT file that are for transplant reinsurance.	5/27/2005
AZ	OT	Type of Service	Since most people are enrolled in capitated managed care plans, FFS distributions are not always as expected.	12/10/2004
AZ	RX	FFS Claims	AZ reported no FFS RX claims for December 2010. The State reviewed its work and has verified that the figure is accurate.	5/5/2011
AZ	RX	ICN	AZ does not report Internal Control Numbers (INTERNAL-CONTROL-NUMBER-ORIG) on any of its FFS RX claims.	5/2/2011
AZ	RX	TPL	The Other Third Party Payment (TPL) amount is always missing.	12/10/2004
CA	Claims	Link	A large percentage of CA enrollees do not have any expenditures primarily due to FP only enrollees also non-qualified aliens who are only entitled to emergency services.	NA
CA	Claims	MSIS ID	MSIS ID is missing on a few claims	12/10/2004
CA	Eligibility	1115 Waivers	Until Q4 FY 2009, California had one section 1115 research and demonstration authority waiver (Wavier Type 1); the California In-Home Supportive Services Waiver (IHSS Plus) (Waiver ID '17') allowed low-income elderly and disabled residents to hire their own caregivers. This waiver did not extend Medicaid benefits to otherwise ineligible individuals. Through Q4 FY09, CA was incorrectly reporting the Senior Care Action Network (SCAN) (waiver ID '02') as an 1115 waiver. However, this is a Medicare Advantage Special Needs Plan that contracts with the CA Department of Health Care Services to provide services for the dual eligible Medicare/Medicaid population subset residing in Los Angeles, San Bernardino, and Riverside counties.	7/6/2011
CA	Eligibility	1115 Waivers	California introduced a large 1115 Waiver program; Family Planning, Access, Care and Treatment (FPACT), in December 1999, which initially covered family planning benefits for working age women. Enrollment immediately exceeded one million persons. As of 2005, the waiver also extends benefits to men. On March 24, 2011, CMS approved the Family Planning, Access, Care, and Treatment (Family PACT) State Plan Amendment (SPA). This amendment transitions the FPACT waiver to the Medi-Cal state plan. The amendment is effective	5/7/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			retroactively to July 1, 2010. The state indicated that: "Under the SPA, additional family planning services and supplies previously reimbursed exclusively with state General Fund are eligible to receive a 90 percent federal matching rate and additional family planning related services will receive reimbursement at the State's regular FMAP rate." As a result of this change, in Q4 FY10, the state moved family planning enrollees from MASBOE 54 and 55 to MASBOE 34 and 35 and continued to report them with restricted benefits flag 6. However, in Q4 FY10 the state incorrectly continued to report these enrollees with enrollment in the family planning waiver. The state corrected this in the Q1 FY11 file.	
CA	Eligibility	1115 Waivers	In 2010, CMS approved the California Bridge to Reform Demonstration 1115 Waiver. The most immediate impact of this waiver on MSIS reporting is the moving of up to 400,000 seniors and persons with disabilities into Medicaid managed care, which started in June 2011. The state indicated that these enrollees would be reported with waiver ID 24 and waiver type 1. Additionally, as part of California's Bridge to Reform Demonstration 1115 Waiver, the state extended coverage to low-income adults through a Low Income Health Program (LIHP) that is provided at the option of each county. For MSIS, California would be able to report Medicaid enrollment for LIHP enrollees in the eligibility files, but would not be able to process claims for these enrollees since expenditures are paid by certified public expenditures (CPEs), which are not processed through MSIS. Therefore, CMS requested that California not report LIHP enrollees on either MSIS eligibility or claims files for Q1 FY11 forward.	6/25/2012
CA	Eligibility	All	Between Q4 FY11 and Q1 FY12, the number of enrollees reported in the file increased by about 1.3 million. The total number of records in the file grew from about 9.8 million to 11.1 million. ITSD's response to the increase is that in submission #12, enrollment fell because FPACT beneficiaries were missing from the 6/5 file. With FPACT included in this submission (#14), there was an increase of ˜ 1.3M due to a redistribution of aid codes recommended by the CA DHCS Medical Eligibility Division. This shift also caused large fluctuations for MASBOEs 21, 22, 25, 3A, 32, 34, 35, 41, 42, 44, 45, and 48 between September and October 2011.	7/2/2014
CA	Eligibility	CHIP	California reports its M-CHIP enrollees and its S-CHIP population. Additionally, some M-CHIP enrollees in state-specific eligibility groups 7C, 8N, and 8T are correctly mapped to MAS/BOE 44. These children are undocumented aliens eligible for emergency services only. The state's S-CHIP population (Healthy Families Program) began transitioning to Medi-Cal starting in FY13 so the S-CHIP population has seen significant decreases in this timeframe.	7/6/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
CA	Eligibility	CHIP	S-CHIP enrollment declines from 765,162 in Oct. 2012 to 1,628 by Dec. 2013. The state confirmed that this is due to the Healthy Families Program transition to Medi-Cal.	10/21/2014
CA	Eligibility	CHIP	Over the course of FY2013, S-CHIP enrollment declined substantially from 765,162 in Oct 2012 to 23,973 in Sept 2013. This decline was due to the transition of people from the Healthy Families Program to MediCal, and enrollment continued to fall through FY 2014.	10/23/2014
CA	Eligibility	Date of Birth	Starting in Q1 FY12, we noticed that individuals in MASBOE 35 (Poverty related Adults) were being reported to age group 15-18. We would generally expect these individuals to be reported as children (BOE = 4). There were about 59,500-64,000 individuals in all quarters of FY12 in MASBOE 35 reported to age group 15-18.	7/29/2014
CA	Eligibility	Date of Death	All dates of death are 8-filled or 9-filled.	NA
CA	Eligibility	Dual Eligibility Codes	The CA monthly MMA file reports roughly 20,000 fewer full duals to dual code 08 than MSIS. MMA processing checks the government response file to confirm Medicare eligibility; MSIS does not, resulting in a small overcount.	NA
CA	Eligibility	Dual Eligibility Codes	Until Q2 of FY03, CA mistakenly coded its 100% FPL group (state group IH) to dual code 04 (because special income disregards up to 33% of FPL allowed actual income to exceed 100% FPL). CA switched to using dual code 02 effective Q2 FY03. This dual code 02 includes persons whose income can exceed 100% FPL. This also explains why CA does not use dual code 04.	NA
CA	Eligibility	Dual Eligibility Codes	About 85 percent of aged enrollees were identified as EDB duals in 2005, a lower percentage than in most states. This may occur because CA has a larger population of qualified aged immigrants who do not yet qualify for Medicare coverage. In addition, CA has some aged non-qualified aliens who only qualify for emergency services under Medicaid.	3/3/2011
CA	Eligibility	Dual Eligibility Codes	Beginning in Q1 FY10, CA reports approximately 30 - 200 non-duals to restricted benefits flag 3 each month. This issue has been ongoing in CA. The state has indicated that it is unable to fix this.	2/8/2012
CA	Eligibility	Dual Eligibility Codes	Starting in Q1 FY12, California began assigned dual code 08 (Other Full Duals) as the default assignment for full duals. In previous quarters, they were able to report more individuals to the more nuanced full dual codes (e.g. QMB+ Dual Code 02 or SLMB+ Dual Code 04). However, a programming change caused the system to default and not parse these individuals into the more specific full dual groups. On a call with the state, CMS accepted this reporting and asked that it be documented in the anomalies.	6/4/2014
CA	Eligibility	Managed Care	California reports four to five million enrollees in dental PHPs each month. Only about 400,000 of these enrollees are reported	7/10/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			in CMS counts, however. As it turns out, a small portion of California's dental enrollees are enrolled in "true blue" dental PHPs. These are the persons that appear in the CMS PHP data. The remaining enrollees participate in a hybrid FFS/PHP dental plan. The CMS data do not count these plans as PHPs, but MSIS does.	
CA	Eligibility	Managed Care	From 2004 forward, MSIS and the annual CMS managed care report consistently report some managed care plans differently. All of the enrollees CMS previously reported in plan type "Other" are enrollees in the Senior Care Action Network (SCAN) plan. Enrollment in this plan is reported to plan type 1 (HMO) in MSIS and is now reported as an HMO by CMS as well. Roughly 800 MSIS "Other" managed care enrollees are in the "Positive Health Care" Plan, a hybrid PCCM which is reported as an HMO in CMS data. An additional 100 enrollees are also reported to plan type "other" in MSIS. These enrollees are part of the Family Mosaic Project, an emotional and mental health support PIHP, which is reported as a PIHP in the CMS report. The numbers of enrollees in SCAN, Positive Health Care, and the Family Mosaic compare very well between CMS and MSIS.	10/7/2011
CA	Eligibility	Managed Care	An increasing number of Aged Partial Duals and Disabled Partial Duals are reported to Plan Type 1; in FY12, FY13, and FY14, there were about 1,500 partial duals assigned to Plan Type 1 (HMO).	1/10/2013
CA	Eligibility	Managed Care	California had higher than expected increases in their Comprehensive and Dental plans (Plan Types 01 and 02) throughout FY14. The state indicated that the increases in Comprehensive plans was expected given than a number of new plans came online during this period. California will do code revisions to correct dental reporting in both eligibility and claims files, mostly concentrated in the Delta Dental Plan of California (Plan ID 422). California assigns healthcare plan code 599 (or HCP599 in its data warehouse and in PERM) to all beneficiaries that are not enrolled in a dental managed care plan. This is done to track fee-for-service dental claims. CA is planning code changes to be reflected in Q1 FY15 to put back HCP599 and delete HCP422 as default dental HCP. All beneficiaries are assigned HCP422 (need to change back to HCP599) if not enrolled in a dental managed care plan. The significant increase in HCP422 enrollees are also due to ACA.	1/6/2015
CA	Eligibility	MASBOE	CA covers all aged and disabled to 100% FPL.	NA
CA	Eligibility	MASBOE	2003-2009: From Q1 FY04 to Q4 FY05, approximately 100-400 individuals in state group 'OV' were assigned MASBOE 4A, an invalid combination. These individuals should have been assigned MASBOE 44-45, depending on age. This was corrected in Q1 FY06. In addition, several individuals were reported to MASBOE 49 from Q2 FY04 - Q1 FY09.	9/15/2009
CA	Eligibility	MASBOE	2003: Beginning in July 2003, CA implemented a Child Health and Disability Prevention (CHDP) program as a "gateway" to	7/1/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			improve access to Medi-Cal and the state's S-CHIP program through an automated pre-enrollment process. This CHDP program uses an on-line application to determine temporary enrollment (up to 2 months). CHDP Medicaid enrollment is reported in state groups 8U, 8V, and 8W, all reported to MASBOE 44. By January 2005, monthly enrollment in these groups was roughly 101,000.	
CA	Eligibility	MASBOE	2008-2009: CA had an increasing problem of persons mapped to MASBOE 99 (7,000 by Q2 FY09). These persons were reported to state codes C1-C9, D1-D9 and 46, which were not included in CA's MASBOE crosswalk at the time. The crosswalk was updated and these individuals were remapped to appropriate MASBOE groups in Q3 FY09.	9/22/2011
CA	Eligibility	MASBOE	Between Q2 and Q3 FY10, enrollment in MASBOE 41 dropped from approximately 37,200 to approximately 34,400 and enrollment in MASBOE 42 dropped from approximately 39,800 to approximately 36,800. The state indicated that this occurred because in May and July 2009 the state implemented payment reductions for SSI/SSP which caused some individuals to be discontinued from SSI/SSP. These individuals were then eligible to continue receiving no-cost full-scope Medi-Cal benefits until the counties completed redeterminations. During that time period, these individuals were temporarily placed in MASBOE groups 41 and 42. After the redeterminations were completed, individuals were either moved to a different aid code or lost eligibility. These movements after redeterminations were the cause of the drop in MASBOE groups 41 and 42 during this time period.	9/22/2011
CA	Eligibility	MASBOE	From Q1 FY 2009 to Q4 FY 2009, CA had large increases in MASBOE 41 (13 percent) and 42 (28 percent). The state said that this is a product of the reduction in the SSP payment and DHCS response to the maintenance of effort requirements of ARRA and ACA. DHCS maintained the eligibility at the May 2009 level, notwithstanding the two subsequent reductions in the SSP. As a result, more individuals were able to retain eligibility or become eligible.	10/7/2011
CA	Eligibility	MASBOE	CA reports Medicaid Buy-In participants to state aid code 6G. These individuals should be assigned MASBOE 42, but CA assigned them to MASBOE 32 until Q4 FY10. In Q1 FY11, CA assigned Medicaid Buy-In paricipants in state aid code 6G to MASBOE 42. However, starting in FY12, CA again began assigning Medicaid Buy-In participants to MASBOE 32 instead of MASBOE 42.	2/8/2012
CA	Eligibility	MASBOE	In Q3 FY09, CA started reporting persons to MASBOE 28. These individuals have a state specific code of 46 and should be mapped to MASBOE 48. We asked the state to correct this, and the state did so in Q4 FY10.	2/8/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
CA	Eligibility	MASBOE	Starting in Q2 FY11, California began reporting individuals with unknown MASBOEs (99). By FY12, California had eliminated reporting of unknown MASBOEs.	11/7/2012
CA	Eligibility	MASBOE	Starting in Q1 FY12, California began reporting their Medicaid Buy-in enrollees to MASBOE 32 (Poverty related/Blind/Disabled) instead of to MASBOE 42. In previous quarters, they were reporting this group correctly to MASBOE 42. A programming change which caused MASBOEs to be assigned by aid code group instead of via 1:1 mapping caused this group, which is in the disabled aid code group, to be assigned to MASBOE 22 instead of 42. On a call with the state, CMS accepted this change in reporting and indicated it should be documented, but that no further action was required by the state to correct it. However, in the 12th submission of this quarter, the state had mostly corrected this issue (all but about 400 individuals in "6G" were reported correctly to MASBOE 42). However, by the 14th submission, all of the "6G" individuals were reported to MASBOE 32 instead. We have asked the state to correct this reporting because they had a recent submission where they had the reporting correct.	6/4/2014
CA	Eligibility	MASBOE	Starting in Q2 FY13, there were some shifts in MASBOE reporting, particularly for MASBOEs 24 (Medically Needy Child) and 34 (Poverty Related Child). MASBOE 24 decreased 33% from 231,763 to 155,596, while MASBOE 34 increased 62% from 754,522 to 1,224,765. The 33% decline in the number of Medically Needy Child between Feb 2013 and Apr 2013 is due to their transition to Poverty Related Child. However, the increase in the Poverty Related Child is mostly due to Healthy Family Transition program (in addition to those from Medically Needy Child). Poverty Related Child is expected to increase until Q1 2014.	10/23/2014
CA	Eligibility	MASBOE	Increases in MASBOEs 24, 25, 44, and 45 from Jan. through March 2014. The state indicates that these increases were expected due to the Medicaid Expansion and associated impacts. There were similar types of increases in most categories, even though the primary was the Medicaid expansion group. There was an overall increase in Medicaid of approximately 2 million members in 2014. MB 24 (MN Child) increases by 17% from 209,130 to 244,382 MB 25 (MN Adult) increases by 16% from 461,100 to 536,343 MB 44 (Other Child) increases by 23% from 527,391 to 648,517 MB 45 (Other Adult) increases by 24% from 1,699,783 to 2,113,571	1/6/2015
CA	Eligibility	Private Health Insurance	CA reports over 500,000 individuals each month to health insurance flag 4. The state indicated that this reporting is accurate and that it occurs when the eligibility record indicates health coverage but does not indicate who paid for the health insurance. This flag does not include individuals enrolled in Medicare Risk HMOs.	6/10/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
CA	Eligibility	Private Health Insurance	Between Q4 FY09 and Q1 FY10, the number of enrollees with third party and state health insurance (health insurance code 4) increased from approximately 405,000 to approximately 525,000. The state indicated that this increase may have been due to the long lag period between the Medi-Cal eligibility files used for the creation of these file submissions.	4/6/2012
CA	Eligibility	Race/Ethnicity	The race field is unknown for four to ten percent of the Medicaid population.	NA
CA	Eligibility	Restricted Benefits Flag	Beginning in Q4 FY09, CA reports a few enrollees each quarter to RBF 8 and MASBOE 00. This usually occurs in month 3. In October 2010, we asked the state to correct this, but they are unable to do so.	2/22/2011
CA	Eligibility	Restricted Benefits Flag	CA assigns restricted benefits flag = 5 to beneficiaries in hospice.	9/22/2011
CA	Eligibility	Restricted Benefits Flag	In November 2009, CA started reporting Money Follows the Person (MFP) program enrollment. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. MFP enrollees are assigned RBF code 8 in MSIS.	9/22/2011
CA	Eligibility	SSN	Roughly one quarter to one third of eligibles have 8-filled SSNs each quarter. This results in part from the fact that SSNs are not reported for the 1+ million persons who are 1115 FPACT Waiver eligibles. In addition, SSNs are often not available for unborns, newborns, undocumented aliens, and immigrants.	NA
CA	Eligibility	State-Specific Eligibility	Although state-specific eligibility codes 86 and 87 are supposed to include individuals over age 21 only, some counties assign younger individuals to these groups. Therefore, some enrollees in aid codes 86 and 87 are assigned BOE 4 even though the state eligibility crosswalk indicates that all enrollees in these eligibility codes should be mapped to BOE 5.	6/10/2011
CA	Eligibility	TANF/1931	TANF status is reported as "unknown" for about 100,000 to 150,000 eligibles beginning in Q1 FY 2000. L.A. county was unable to report TANF status. This continues through FY 2009.	9/14/2009
CA	Eligibility	TANF/1931	Starting in December 2010, California reported 41% fewer TANF enrollees than were reported by ACF. The state explained the reason of the discrepancy as the way the state has been compiling TANF enrollment data using 5 aid codes, instead of the 12 codes used by the Department of Social Services (through which TANF is administered).	11/7/2012
CA	Eligibility	Waivers	CA combined the Health Insuring Organizations of California Waiver (Waiver ID '04') and the Partnership Health Plan of California Waiver (Waiver ID '05'). Beginning in Q1 FY10, the combined waiver is reported with Waiver ID '04.' After the Q4 FY10 review, the state indicated that this waiver would be reported with the same ID but as waiver type 1 beginning in October 2010. This is the same waiver ID and type that the	7/6/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			state indicated it would use for its Bridge to Reform Demonstration 1115 Waiver enrollees. In December 2012, the state clarified that the HIO waiver would be rolled into the Bridge to Reform Demonstration waiver and reported with Waiver ID '24'.	
CA	Eligibility	Waivers	CA introduced a large Specialty Mental Health Waiver (MSIS waiver ID '10,' waiver type '2') in November 2000. Under this waiver, Medi-Cal covers mental health services that are delivered through behavioral health managed care organizations to most Medi-Cal recipients, hence a large enrollment.	9/22/2011
CA	Eligibility	Waivers	Enrollment in CA's Assisted Living Pilot Project waiver, a 1915(c) waiver (waiver ID '18') did not appear in MSIS until Q3 FY07. The waiver was implemented in March 2006 (Q2 FY06). Enrollees in the waiver were included in MSIS.	9/22/2011
CA	Eligibility	Waivers	CA has confirmed that it implemented its Pediatric Palliative Care Waiver (Waiver ID '22') in January 2010. However, this waiver did not appear in the Q2 or Q3 FY10 files. The state indicated that this was an error and corrected this reporting in the Q4 FY10 file.	2/8/2012
CA	Eligibility	Waivers	After the Q4 FY10 review, CA indicated that individuals enrolled in its 1915(b) Santa Barbara San Luis Obispo Regional Health Authority Waiver (waiver ID '06') were rolled into its 1115 Bridge to Reform waiver starting in Q1 FY11. The state indicated that once this happened, these enrollees would no longer be included in MSIS or reported to waiver ID '06.' The state confirmed that these enrollees would be reported to waiver ID '24', the ID assigned to the Bridge to Reform 1115 Demonstration waiver starting in Q1 FY 11.	5/7/2012
CA	Eligibility	Waivers	Enrollees in the 1915(b) Intermediate Care Facility/Developmentally Disabled-Continuous Nursing Waiver (Waiver ID '08') were transitioned to the 1915(c) Developmentally Disabled - Continuous Nursing Care Waiver (Waiver ID '23') in October 2009. However, in Q1 FY10, CA did not report enrollment in waiver ID '08' or waiver ID '23.' We asked the state to correct this reporting in future files and they indicated that they would. Waiver ID 23 appeared in the Q2 FY10 file but not the Q3 FY10 file. The state indicated that this was an active waiver, but did not provide further explanation for the lack of reporting in Q3 FY10. This waiver was also not reported in the Q4 FY10 file. Reporting enrollment in this waiver resumed in the Q1 FY11 file.	5/7/2012
CA	IP	Diagnosis	There is a maximum of two diagnosis codes on IP claims.	12/15/2004
CA	IP	DRG	DRG is missing as it is not used for reimbursement.	12/10/2004
CA	IP	Patient Status	The percent of claims with a Patient Status of "still a patient" is higher than expected. This is perhaps due to the inclusion of Short/Doyle facilities.	12/10/2004
CA	IP	Procedure Codes	Procedure codes 3 to 6 are not available from the state.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
CA	IP	Revenue Code	A larger percentage than expected of UB-92 Revenue Codes are not reported because of Short/Doyle and LA (Los Angeles) waiver hospitals. Claims may belong in LT file.	12/10/2004
CA	LT	Diagnosis	Diagnoses 2 to 5 are not available in the state source file, and therefore are not on the MSIS file.	12/10/2004
CA	LT	LTC Days	Compared with other states, CA ranks near the bottom in terms of Avg LTC Days (N = 8.96). However, the value for this field can be misleading. It is largely a function of how services are billed. During Q1FY2010, more than 46% of all FFS Non-crossover Original claims were billed weekly (6 - 8 Days). Only 6.1% were billed monthly (28 - 31 Days). In contrast, the value of Avg LTC Days for Iowa is 29.28 Days. Nearly 94% of FFS Non-crossover Original claims were billed monthly. Less than 1.0% were billed weekly.	8/26/2011
CA	LT	Patient Liability	The percent with Patient Liability is lower than expected.	12/10/2004
CA	LT	Patient Liability	The percentage of FFS non-crossover claims with patient liability should be higher. This is because the percentage of Medi-cal only beneficiaries with Share-of-Cost are lower than other states.	4/22/2015
CA	OT	Managed Care Capitation	Until April 2010, CA has paid the capitation claims for managed care based on a preliminary count of enrollees, but then uses the 6 month, then 12 month MEDS data to finalize the payments. So they have not known the final population that is capitated until 12 months later. This delays the reporting.	NA
CA	OT	Managed Care Capitation	There is a significant shortfall of HMO capitation claims in Q2-4FY2009. The state's explanation is that it often takes up to a year before the capitation payments are finalized. They are not included in MSIS until they are finalized. However they may be able to fix and resubmit the files.	3/3/2011
CA	OT	Revenue Code	Outpatient hospital claims have Service Codes, not UB-92 revenue codes	12/10/2004
CA	RX	Managed Care Plan IDs	In Q2 2008, CA began to report some FFS RX claims with a PLAN-ID-NUMBER not 8-filled. From Q2 2008 until Q3 2009, these claims appeared with PLAN-ID-NUMBER = 'Other Non-Missing Value'. In Q4 2009, they began to appear with PLAN-ID-NUMBER = '000'. They represent from 5.4% to 5.8% of all FFS Rx claims each quarter. The State indicates that they are FPACT (Family Planning Access Care and Treatment) FFS claims. The PLAN-ID-NUMBER for these claims should be 8-filled.	NA
CA	RX	NDC	There are many claims in the RX file with state-defined service codes (with a length of seven bytes or fewer) in the NDC field. Those are valid codes defined in California's MSIS application's attachment on service code definitions.	12/10/2004
CO	Claims	Managed Care Capitation	State reports capitation claims for Colorado Access Enhanced Care and Rocky Mountain HMO, as well an encounter claims for Rocky Mountain HMO, plans that identified as Administrative	4/26/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
			Services Only (ASO) plans. CMS guidance to states was that ASOs were not to be reported in MSIS.	
CO	Claims	Managed Care Plan IDs	In order to link the Plan IDs in the eligibility file with the claims, the last 4 bytes of the EL Plan ID need to be dropped.	3/15/2011
CO	Claims	Managed Care Plan IDs	As of Q2 FY2012, Plan IDs are still being reported as 8-digits in the OT file, while 12-digits in the EL file	5/7/2012
CO	Eligibility	0-filling	In Q2 FY10 forward, CO reported individuals in MASBOE groups other than 00 with a CHIP flag of 0. As of Q3-Q4 FY10, the TANF field was 9-filled for approximately 74,000 individuals in MASBOE 00. The state also 9-filled the TANF fields for individuals enrolled in MASBOE 00. The state had indicated that it would work on this issue.	7/16/2012
CO	Eligibility	CHIP	CO did not report any S-CHIP child enrollment in SEDS from FY05 - FY10 (cause unknown). Some S-CHIP SEDS reporting occurred in FY04.	8/30/2010
CO	Eligibility	CHIP	Effective 9/1/04, (Q4 FY04), CO began reporting its S-CHIP program in MSIS. The S-CHIP program covers children, plus the state has a HIFA waiver to extend S-CHIP coverage to pregnant women to 185% FPL effective Q1 FY03. Colorado does not have a Medicaid expansion Child Health Insurance Program (M-CHIP) program. In 2006, CO updated its Title XXI HIFA waiver to include covering ESI expenses for S-CHIP children whose parents have access to employer coverage.	9/22/2011
CO	Eligibility	CHIP	Each month in Q3-4 FY10 through Q1 FY14, around 14,000 individuals in MASBOE groups 11, 12, 31, and 32 received a CHIP flag of 0 (not eligible). We would normally expect individuals who are in these MASBOE groups to be reported with a CHIP flag of 1 (Medicaid eligible and no CHIP). This reporting is linked to the missing Dates of Birth. CO previously indicated that reporting would be improved by a CSR currently on the priority list, but a timeline for this improvement has not been communicated at this time. When asked specifically about the CSR referenced above, the state indicated that they were not able to find a CSR currently in process or planned that would capture this improvement to reporting, but that the corrections that have been made to MAS BOE for T-MSIS do address this issue.	3/18/2013
CO	Eligibility	County Codes	CO has one even numbered county code (014) representing Broomfield County in suburban Denver.	1/14/2009
CO	Eligibility	County Codes	Reporting to Unknown County code: Despite previous improvements to Unknown County (reporting had gone down to about 50), but was up to 111 by end of Q4 FY12, then jumps to 216 in Q3 FY13 and settles in at 206 Q4 FY13 and 153 by Q1 FY14.	4/18/2014
CO	Eligibility	Date of Birth	In Q2 FY10, CO reported approximately over 14,000 individuals with missing or invalid birthdates. According to the state, they could only identify 10 records with invalid birthdates and no	5/9/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			records with missing DOBs. The mis-assignment of the CHIP flag (i.e., CHIP = 0) is linked to the missing Date of Birth.	
CO	Eligibility	Dual Eligibility Codes	In FY07 and FY08, CO reported 5 to 9 percent more full duals and 17 to 27 percent fewer partial duals, compared to MMA data.	9/17/2008
CO	Eligibility	Dual Eligibility Codes	Overall, approximately 90 percent of CO's aged Medicaid enrollees are dual eligibles. Within MASBOE 11, approximately 85 percent are reported to either dual code 02 or 08, while 15 percent are reported to dual code 00 (cause unknown).	5/20/2009
CO	Eligibility	Dual Eligibility Codes	Dating back to at least Q4 FY04 (when data quality reports began providing cross-tabs of dual code and state eligibility group), CO mistakenly miscoded certain categories of partial duals. As a result, individuals in groups with "AB " (space in the third position) in bytes 4-6 of the state eligibility code were mapped to dual codes other than "01" (QMB-only). Other instances included " CS" (space in the first position) in bytes 4-6, which should have been mapped only to dual code "03" (SLMB-only) and " CT" (space in the first position) in bytes 4-6, which should have been mapped only to dual code "06" (QI). The state corrected this in Q1 FY10, leading to increases in enrollment in QMB only, SLMB only, and QI-1 and a decrease in enrollment in QMB+.	8/30/2010
CO	Eligibility	Dual Eligibility Codes	From Q4 FY04 forward, CO reports most of its full duals, including SSI recipients, to dual code 08. In past quarters, most duals in MASBOE 11-12 were reported to dual code 02, as expected. CO has been asked several times to fix this. The state most recently responded that dual codes were assigned based on the state's client third-party liability (TPL) codes. These codes do not indicate that there is a problem with CO's dual coding.	2/22/2011
CO	Eligibility	Dual Eligibility Codes	From Q2 FY10 forward, CO reported approximately 6,500 partial duals with enrollment in MASBOE 11 or 12. The state indicated that this reporting was based on the eligibility crosswalk. We've asked the state to clarify who is included in this group of enrollees.	7/16/2012
CO	Eligibility	Dual Eligibility Codes	In Q2 FY10, comparisons between MSIS and MMA counts of most dual groups improved. However, the state reported 70 SLMB+ individuals in MMA and very few SLMB+ individuals in MSIS.	7/16/2012
CO	Eligibility	Dual Eligibility Codes	Between September 2013 and October 2013, there were some noticeable shifts in dual enrollment. These shifts did not match up with MMA reporting, causing considerable discrepancy between MSIS and MMA. QMB+ (Dual Code = 02) enrollment increases from 14,018 to 35,195 (171% fewer in MMA than MSIS). SLMB+ (Dual Code = 04) enrollment increases from 1 to 5,640. Other Full Duals (Dual Code = 08) enrollment decreases from 51,313 to 25,715 (49% more in MMA than MSIS) The state noted that during September and October 2013, there were	7/10/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			several changes made in both CBMS, where our client eligibility is determined, and the MMIS. CBMS Project #2609, to change eligibility determination for clients in all Medical categories was implemented in that system on 09/29/2013, and affected client records coming into the MMIS. CBMS Project #4187 to implement a new rules engine for HCPF non-MAGI clients was also implemented in September/October 2013, and also affected client records coming into the MMIS. In the MMIS itself, numerous clients were moved from Managed Care into our Accountable Care Collaborative Program as part of an effort to open this program to a larger size of our client population. The state has indicated that they cannot definitively determine which of these items may have caused the discrepancy between the MSIS and MMA data reporting, or if it was a combination of implementing various aspects of all of these items.	
CO	Eligibility	HIC Numbers	HIC numbers are 9-filled for about five percent of dual eligibles.	NA
CO	Eligibility	Managed Care	Two of CO's "Colorado Access" managed care plans (Plan IDs 04022075 and 04022091) ended on 6/30/05. Managed care plan 'Denver Health' (Plan ID 76971759) ended on 12/31/05. In addition, in July 2006, CO's last HMO, 'Colorado Access' (Plan ID 04022042) announced it would end its state contract in 8/06 due to underpayment. CO Access will continue to provide services for Medicare, Child Health Plan, and Medicaid Behavioral Health enrollees.	12/10/2007
CO	Eligibility	Managed Care	In June 2007 and June 2008, CO's PCCM enrollment data in MSIS are not reliable and enrollment is overcounted (cause unknown).	6/25/2009
CO	Eligibility	Managed Care	2010: CO continues to report several thousand persons who are otherwise assigned MASBOE '00' as enrolled in some form of managed care. Asked to stop doing this, the state responded that a timeline for the requested change is not yet available due to insufficient state resources.	8/1/2011
CO	Eligibility	Managed Care	From 2003 forward, Rocky Mountain HMO (Plan ID 04100020) is reported as a PIHP, not HMO, in CMS' annual managed care report. It is reported as an HMO in MSIS. However, because it is an administrative services-only plan, the state has been asked to stop reporting it. Additionally, Colorado Access Enhanced Care (Plan ID 12630586) is also an ASO and should not be reported as an HMO is MSIS. As of Q2 FY11, CO continued to report these plans as HMO and the request to stop reporting these plans was reiterated. In FY13, reporting to the Rocky Mountain HMO stopped in MSIS.	10/7/2011
CO	Eligibility	MASBOE	CO shows many more SSI recipients in MAS/BOE 11 - 12 than SSA data, but this may relate to a state-administered SSI supplement. In addition, CO appears to report most disabled SSI recipients over age 65 to MASBOE 11.	NA
CO	Eligibility	MASBOE	Between April and December 2010, those reported in MASBOE = 14 (Cash, Child) increased from about 108,000 to 246,000	2/22/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			However, there was no similar increase in enrollment in MASBOE 15. CO stated that the increase in MASBOE 14 enrollment was the result of outreach efforts to enroll more eligible children. Between April and December 2010, those reported in MASBOE = 14 (Cash, Child) increased from about 108,000 to 246,000 and those reported in MASBOE = 15 (Cash, Adult) increased from about 66,000 to 92,000. Then between September and October 2013, those reported in MASBOE = 14 (Cash, Child) decreased from about 300,500 to about 38,000.This all appears to be linked to state-specific eligibility group '043 B' [i.e., Aid Category '04', Grant Code '3', Recipient Case Status Code 'blank', and SISC Code 'B'].)Colorado responded that they believe this is due to the implementation of several projects in the Colorado Benefits Management System (CBMS), the State's eligibility determination system, related to Senate Bill 1931 in and around April 2010, which increased the FPL percentage for several Family Medical and Child programs, thus making more children and adults eligible for Medicaid services. In addition, the CHP+ program was implemented in April 2010. Finally, additional reports on eligibility determinations for CHP+ started to be received from Colorado counties in April 2010. All of these items contributed to the increase in reported enrollments and eligibility that you see. The state indicated that this explanation can be conclusively established after Colorado has finished coding the MMIS for T-MSIS, and can then use that file format to complete all of its back-dated file runs for MSIS.	
CO	Eligibility	MASBOE	2007 - 2010: CO continues to report a number of enrollees classified as "undocumented aliens receiving emergency services" (represented by the letter 'J' in the fourth byte of the state eligibility group code) to MAS values other than '4' (although some are reported to MAS '4').	3/3/2011
CO	Eligibility	MASBOE	From FY02 through Q3 FY04, CO mapped 50 to 100 persons to the invalid MAS/BOE combinations of 19, 39, or 49 each month. MASBOE 49 reappeared from Q1 FY05 forward, with roughly 70 persons reported each month. These individuals were coded as foster children, but may not be eligible due to their ages. These problems continued in FY06 through Q1 FY09.	3/3/2011
CO	Eligibility	MASBOE	Some unusual MASBOE patterns were noted in FY10 and FY11. Between April and June 2010, those in MASBOE = 34 (Poverty Related, Child) decreased from about 175,000 to 66,000. Then between September and October 2013, those reported to MASBOE = 34 increased from about 87,800 to 365,800. Colorado responded that they believe this is attributed to the increase in FPL, the implementation of CHP+ and subsequent move of eligible children into this program from other Medicaid programs or from a non-eligible status, and due to the more complete reporting we began to receive from counties related to client eligibility. For the increase between September and October 2013, research into project and MAS BOE changes during this time frame, for both MMIS and CBMS, is	3/18/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			inconclusive. Major system initiatives during this time centered on the Affordable Care Act and changes to MAGI/non-MAGI client classifications; however, information specific to income changes for eligible children could not be found. We believe we can provide more conclusive information on this after Colorado has finished coding the MMIS for T-MSIS, and can then use that file format to complete all of its back-dated file runs for MSIS.	
CO	Eligibility	MASBOE	Starting in FY12, numerous fluctuations in MASBOEs particularly 42, 44, and 45. The state has been asked whether there were any program policy changes to cause these shifts, but have not yet responded.	4/18/2014
CO	Eligibility	MASBOE	Between Q2 FY10 and Q2 FY11, there were some unusual patterns in MASBOE = 48 (Foster Care Children). Enrollment of children in foster care fell from about 18,000 in January 2010 to 12,000 in April 2010. It then rebounded to 18,000 in July 2010, and fell again to 12,000 between September and October 2010. Enrollment increased again between December 2010 and January 2011. Colorado researched these changes, but their findings were inconclusive. Possible explanations for these unusual data patterns could be due to inconsistent reporting received from TRAILS, the State's foster care system. The state plans to provide more conclusive information on this after Colorado has finished coding the MMIS for T-MSIS, and can then use that file format to complete all of its back-dated file runs for MSIS.	7/10/2014
CO	Eligibility	MASBOE	Colorado began a Money Follows the Person program in Jan. 2011 and were supposed to be assigned to state-specific eligibility groups 021 E1, 023 E1, 051 E1, 053 E1 starting in Q3 FY13. Colorado has started to report enrollment in those state specific eligibility groups and to MB = 42, but did not begin reporting to Restricted Benefits Flag = 8 (Money Follows the Person). Colorado identified this as a coding oversight in MMIS for MSIS. The state has identified this item for T-MSIS and have ensured it will be corrected there with the new valid value of 'D'.	7/10/2014
CO	Eligibility	MASBOE	The enrollment shifts for MASBOE 42, 44, and 45 are linked to state-specific eligibility group '0433B' [i.e., Aid Category '04', Grant Code '3', Recipient Case Status Code '3', and SISC Code 'B'], which appears to be associated with medical transitional assistance. Reporting of MASBOE = 44 (Other, Child) fell from about 16,000 in April 2010 to about 4,900 in May 2010. Enrollment gradually increased again to about 13,000 by December 2010. It experienced another jump between June and July 2011, from about 19,600 to 28,700. Enrollment in this group again fell to about 19,680 by September 2013, and then declined to 8,400 by October 2013 and increased to 14,750 by November 2013. In MASBOE = 45 (Other, Adult) between January 2012 and September 2013, reporting dropped from about 13,140 to 10,720. Enrollment in this group declined to 8,900 by October 2013, and increased to 12,900 by November 2013. In MASBOE = 42 (Other, Blind/Disabled) between January	7/10/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			2012 and September 2013, reporting increased from about 7,830 to 22,320, but decreased to 7,800 by October 2013. The state conducted research into these changes, but their findings were inconclusive. Through work on the T-MSIS project, they have discovered that there were several inconsistencies in how MAS BOE was coded for MSIS. They have corrected these through T-MSIS. The state plans to provide more conclusive information on this after Colorado has finished coding the MMIS for T-MSIS, and can then use that file format to complete all of its back-dated file runs for MSIS.	
CO	Eligibility	Race/Ethnicity	2010: When asked why the most recent race/ethnicity reporting showed that almost 32 percent of enrollees (approximately 185,000 individuals) were reported as having a race/ethnicity "unknown," CO replied "we are reporting the information provided by the clients."	9/22/2011
CO	Eligibility	Restricted Benefits Flag	As of Q3 FY10, there were about 6,500 enrollees in MASBOE 11 and 12 who are assigned partial dual codes (01, 03, and 06 for QMB-only, SLMB-only, and QI, respectively)being mapped to Restricted Benefits Flag = 3 (restricted dual eligible). By December 2013, the number of enrollees following this pattern had increased to about 10,800. It appears these partial duals can be identified as follows: Those with the letters 'AB' in the 3-4 bytes of the state-specific eligibility group are QMB-only, Those with the letters 'CS' in the 4-5 bytes of the state-specific eligibility group are SLMB-only, Those with the letters 'CT' in the 4-5 bytes of the state-specific eligibility group are QI. Colorado has ensured that the MAS BOE assignment for QMB, SLMB, and QI clients is accurate in T-MSIS. When Colorado finishes coding the MMIS for T-MSIS, and can then use that file format to complete all of its back-dated file runs for MSIS, this reassignment in MAS BOE will be evident.	4/9/2013
CO	Eligibility	TANF/1931	CO began 9-filling its TANF field in Q1 FY06.	10/22/2009
CO	Eligibility	Waivers	Waiver ID 'CD' (1915 (c)) starts reporting in Q3 FY13 with enrollment of 2, grows to 22 by end of Q1 FY14. This waiver, Consumer Directed Care for the Elderly (0417.01) was rolled in waiver EB (HCBS Waiver for Persons who are Elderly, Blind, and Disabled, 0006.R05.00) in June 2010, so future reporting to Waiver ID 'CD' was not expected. The state has indicated that Waiver ID 'CD' is now being used for a new waiver program, Colorado Choice Transitions (CCT), which was implemented as part of the federal Money Follows the Person (MFP) Rebalancing Demonstration to help facilitate the transition of Medicaid clients from nursing or other long-term care facilities to the community using home and community based services and supports. Colorado received $22 million in 2011 to implement MFP through 2016.	4/18/2014
CO	IP	DRG	Colorado recodes DRGs into state DRGs	10/7/2011
CO	LT	Managed Care Encounters	In late FY2011 through FY2013 Q4, a number of state's claims are being reported as crossover encounter claims (TOC=3,	4/12/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
			XOVER=1). We believe this results from the reporting values other than +88888 (not applicable) in either the MEDICARE-COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT field.	
CO	OT	Crossovers	Crossover claims show an increase of over 40% between Q3FY2010 and Q4FY2010. State confirms the number but is unable to provide an explanation for the increase.	3/21/2011
CO	OT	Managed Care Capitation	Rocky Mountain Health Plan is a non-risk MCO (04100020). However CO submitted capitation claims in 2007 and 2008 for this plan.	NA
CO	OT	NPI	As of Q2 FY2011, NPIs are missing in the file.	5/7/2012
CO	OT	Provider Taxonomy	As of Q2 FY2011, provider taxonomy is missing in 60% of claims.	5/7/2012
CO	OT	Service Code	In 2007, several local codes appear in the Service Code (SERV_COD) field of Home Health claims which the state has no record of. According to the state, Home Health services are revenue code-base services billed on a UB-04 claim. The Revenue Code was used to adjudicate the claim and although the Procedure Code was included in MSIS, they were not used. The providers might be using the Procedure Code for reference purposes.	NA
CO	OT	Service Code	The Service Code is missing on numerous claims because the UB-92 is used for Home Health (HH), waiver, hospice and outpatient hospital.	12/10/2004
CO	OT	Type of Service	Colorado purchases private health insurance for some enrollees. The premium payments are Type of Claim (TOC) 2 and Type of Service 19.	12/10/2004
CT	_All	CHIP	Through at least 2014Q1 Connecticut does not report any Title XXI separate CHIP enrollment or claims. The state's CHIP fact sheet indicates that 22,270 children were ever enrolled in separate CHIP in Connecticut during federal fiscal year 2008.	11/3/2014
CT	_All	Data System Change	CT implemented a new MMIS called "Interchange" in January 2008.	NA
CT	Claims	Managed Care	In December 2007 one of the HMOs moved to modified FFS reimbursement and then transitioned back to risk based managed care. During the time they were FFS, the state was unable to report those FFS claims.	3/3/2011
CT	Claims	Managed Care Encounters	CT began reporting encounters in Q1FY2010. They did not report encounters for one of the three major HMOs because the HMO does not report amount charged or amount paid to the state. CT began reporting these encounters in Q3FY2011 so that at least the utilization data could be collected.	11/22/2011
CT	Claims	Medicaid Amount Paid Total	CT terminated all managed care contracts on December 1, 2007. Managed care contracts were renegotiated in July 2008 and people were slowly re-enrolled through the rest of 2008	1/3/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			until enrollment topped off in early 2009. This affected FFS claim frequencies causing increased FFS claims and expenditures. Managed care enrollment was again entirely terminated on January 1, 2012 because it was determined that the managed care plans were restricting access to care, inflating administrative costs, and therefore not successfully reducing health care costs. The program became a managed fee-for-service program aided by an administrative-services-only (ASO) contractor.	
CT	Claims	Total Non-Crossover FFS claims	There were large increases in the total number of Non-Crossover FFS claims in the IP and OT files during Q4FY2010. This is due to the inclusion of claims data for Medicaid Low Income Adults (MLIA), a group of new Medicaid expansion beneficiaries. These expansion beneficiaries can be identified in the eligibility file as an eligibility group beginning with 'J'.	NA
CT	Eligibility	0-filling	Since February 2010, CT has begun reporting a handfull of MFP (RBF= 8) enrollees to MASBOE = '00' each month. The state has said that this is because MFP enrollees are within the medically needy population and must meet a deductible each month in order to qualify for Medicaid. In months in which they do not meet their deductible, they are not Medicaid eligible and therefore reported as MASBOE = '00.' It appears that these are mostly reported to groups A6, D6, DX, and D3. We have asked the state to report these individuals to RBF= '00' in months in which they did not meet their deductible and thus were not eligible for Medicaid or MFP. It appears that this issue was corrected starting in Q4FY12. In addition, CT's retro-correction records appeared to eliminate all MFP enrollment during calendar year 2011. This does not appear to be an issue in calendar year 2012.	9/28/2012
CT	Eligibility	CHIP	CT has an S-CHIP program, but it is not reported in MSIS.	7/6/2011
CT	Eligibility	County Codes	CT reports approximately 800 individuals each month to county code 000, which are mostly out of state clients. In addition, some individuals living in CT have a town code 170, which results in a county code of 000.	3/12/2010
CT	Eligibility	Dual Eligibility Codes	Starting in Q1 FY 2009, Connecticut has a number of beneficiaries with dual code = 00 (not eligible for Medicare) that are also assigned to RBF= 3 (restricted benefits based on Medicare dual-eligibility). CT has told us that this happens because the state verifies Medicare eligibility with the Medicare database when creating the MSIS files but sometimes the individual's Medicare eligibility doesn't show up in the database right away even though the person is in fact Medicare eligible. These individuals are in fact duals with restricted benefits. CT corrected this issue starting in Q2 FY 2011, with correction records correcting the issue back to Q2 FY 2010.	7/6/2011
CT	Eligibility	Dual Eligibility Codes	Connecticut passed legislation effective October 1, 2009 that expanded eligibility for the Medicare Savings Programs. Specifically, the legislation authorized an increase in the income	12/21/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			disregard and eliminated the asset test. The State Plan Amendment denoting these changes is pending. The increased income disregard allows households with incomes of 232% of the federal poverty level to qualify for QI-1. Households with incomes of 217% of the federal poverty level can qualify for SLMB and households with incomes of 197% of the federal poverty level can qualify for QMB. As a result of these changes, existing SLMB and QI-1 recipients became eligible for QMB as of October 1, 2009. Additionally, many SLMB plus became eligible for QMB plus causing shifts from dual code 04 to 02. These shifts were also seen in the MMA data. Additionally, as a result of these changes, throughout FY 2010, CT's partial dual enrollment has been steadily increasing. In Q4 FY 2011, QMB enrollment jumped while SLMB, SLMB plus, and QI-1 enrollment suddenly dropped.	
CT	Eligibility	Family Planning	CT implemented Family Planning coverage via a state plan amendment (SPA) and began reporting enrollees in MSIS in April 2012. The state assigns these individuals to ME codes 'M7' and 'M8', and RBF '6'.	11/6/2012
CT	Eligibility	Managed Care	CT mistakenly reported a new managed care plan (ID= 000046292) in the Q3 FY 2011 MSIS EL file. The state has said that this is not a managed care plan, but rather MFP enrollees who had overlapping managed care eligibility were mistakenly assigned this new plan ID. This issue was resolved in the Q4 FY 11 submission.	12/21/2011
CT	Eligibility	Managed Care	Through Q4 FY 2011, CT reports a very small number of individuals to managed care plan ID= 004140422 (Anthem Blue Care Family Plan) which ended on 1/31/2009. The state has said that is has corrected this error, but we continued to see 1 individual assigned to this plan in Q4 FY 2011.	12/21/2011
CT	Eligibility	Managed Care	Beginning in January 2012, Managed Care reporting in Connecticut ceases. This is because the state has replaced all managed care plans with a managed fee-for-service model for Medicaid, non-dual beneficiaries - effective January 1, 2012. The new managed fee-for-service model in Connecticut incorporates features of care coordination and management, quality metrics and reimbursement approaches designed to achieve improvement in patient care and outcomes. The state has assumed administrative responsibility and financial risk for the new system, using the services of a contracted Administrative Services Organization. ASOs are paid primarily on a fee-for-service basis. Two ASOs were implemented in 2010, and include Benecare (a Dental ASO) and Value Options (a Mental Health ASO). These two organizations are reported as "other" managed care in the 2010 CMS Managed Care Summary even though they are not really managed care. The state also has plans to implement similar "Integrated Care Organizations" for dual eligibles at some time in the future, but had not yet done so as of September 2012.	5/29/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
CT	Eligibility	Managed Care	The 2011 CMS Managed Care Enrollment Report shows enrollment of 535 individuals in Husky Primary Care PCCM, which is not reported in the MSIS data (cause unknown). The plan was an alternative to HMO enrollment for Husky 1915(b) waiver enrollees, and was available only in select areas of CT (Greater Hartford, Greater New Haven, Greater Waterbury, and Greater Windham). In response to the Q4FY12-Q1FY13 MSIS review, CT said that this PCCM is no longer active, but did not say when the plan was discontinued.	10/3/2012
CT	Eligibility	MASBOE	In many years, CT exhibits a "seam effect" between the third month of a quarter and the first month of the next quarter. The state reports a large number of retroactive eligibles, however, which presumably smooths out the seams. However, this was not seen in the FY 09 data.	3/3/2011
CT	Eligibility	MASBOE	CT reports a number of individuals age 19+ to MASBOE 14, which is supposed to be for section 1931 children under age 18, or under age 19 who are regularly attending a secondary school or the equivalent of vocational or technical training. This issue was corrected in Q2 FY 2011.	7/6/2011
CT	Eligibility	MASBOE	Connecticut is a 209(b) state and reports less than one-third of the SSI population in MAS/BOE 11 - 12. Some SSI recipients are reported to MAS 41-42, but they cannot be identified with existing data. In addition, SSI disabled children who qualify for Medicaid are not reported to MAS/BOE 12.	4/6/2012
CT	Eligibility	MASBOE	Beginning in April 2010, CT expanded Medicaid eligibility to childless adults with income up to 133% FPL. As a result, enrollment in MASBOE 45 jumps substantially between March and April 2010. In FY 2012, CT has sought CMS approval to cover this population under a waiver instead; however, it appears that this waiver was not approved by CMS.	9/25/2012
CT	Eligibility	Restricted Benefits Flag	In FY09 Q2, CT implemented a Money Follows the Person (MFP) program. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. MFP enrollees are assigned an RBF code 8 in MSIS.	3/24/2011
CT	Eligibility	Restricted Benefits Flag	Although CT's eligibility system can identify aliens who receive emergency services (restricted benefit flag 2), until Q3 FY 2012, MSIS data extracts were created using a data warehouse where such information is not retained. Thus, CT did not report anyone to RBF= '2' until Q3 FY 2012, when it made adjustments to its processes to enable reporting of these data.	12/21/2011
CT	Eligibility	SSN	CT reports about 600 to 700 duplicate SSNs each quarter. The state continues to correct existing errors, but as errors get corrected new ones are created.	3/3/2011
CT	Eligibility	TANF/1931	Connecticut cannot identify its TANF population. The field is 9-filled for all eligibles.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
CT	Eligibility	Waivers	In Q1 and Q2 FY09, enrollment in Husky Plan A (waiver ID 'M1') dramatically increased as managed care plans start to enroll individuals. Enrollment in this waiver should match total enrollment in managed care plans. In Q2, the state did not report all individuals in a managed care plan to Husky Plan A; however, in Q3 the state submitted retro records to correct for this error.	3/12/2010
CT	Eligibility	Waivers	In Q3 FY09, CT started reporting enrollment in the Mental Health Waiver (CMS ID: 0653.R00.00) with waiver ID 'H1' and waiver type '3'. As part of the same waiver, in FY12 CT also implemented HCBS for persons with mental illness in nursing homes. Enrollees are also reported to Waiver ID 'H1'.	3/12/2010
CT	Eligibility	Waivers	In Q3 FY 2013, CT begins to report a new waiver, 'A2', waiver type '3' in the MSIS EL files. We have asked the state to clarify if this is the 'CT Home and Community Supports Waiver for Persons with Autism' (CMS Waiver # 0993.R00.00).	1/12/2014
CT	IP	DRG	The DRG and DRG grouper are missing as they are not used for reimbursement.	12/10/2004
CT	IP	Family Planning	In 2008 Q3, CT stopped reporting Family Planning program type in the IP file.	6/18/2013
CT	IP	Managed Care Encounters	Since CT began reporting IP encounters in 2010 Q1 about a third of their IP encounters only have one diagnosis. This continued through 2012 Q4 when CT's comprehensive managed care program was discontinued.	6/18/2013
CT	IP	Managed Care Encounters	Since CT began reporting IP encounters in 2010 Q1, only about one-fourth of their IP encounters have had an accommodation code. This continued until comprehensive managed care was discontinued in FY2012.	6/18/2013
CT	IP	Revenue Code	Chronic disease hospital claims are in the IP file. This impacts UB-92 Revenue Codes, Patient Status codes and length of stay.	12/10/2004
CT	OT	Adjustments	There are often a large number of FFS claim adjustments in the OT file for claims with type of service Other Services (TOS 19), Personal Care Services (TOS 30), Targeted Case Management (TOS 31), and Rehabilitation Services (TOS 33) because of retro-active rate changes made by the Department of Developmental Services.	6/16/2011
CT	OT	Managed Care Plan IDs	Since CT began reporting OT encounters in 2010Q1 the state has reported a small number of encounters with a 9-filled Plan ID. CT explained that these represented FQHC services. CT pays FQHC claims out of the MMIS on their health plans' behalf so that they can collect data in the MMIS for FQHC cost-settlement. CT then collects the FQHC FFS portion of the payment from the HMO. Because the base FFS rate is the responsibility of the HMO and considered part of their capitation CT's MMIS reports them as encounters. There is a risk that these encounters are also reported by the health plan causing duplicate encounter records. There are up to about 10,000 potentially duplicate encounters	6/18/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			reported per quarter. This should be resolved following the discontinuation of comprehensive managed care in CT in FY12.	
CT	OT	Type of Service	In Q3FY2011 TCM claims changed from quarterly auto-generated bundles of 90 daily claims per bundle to weekly billing of weekly claims. The daily claims had been paid $7/day. The new weekly claims were paid $175/week.	NA
CT	OT	Type of Service	The percent of HH claims is high because the state is able to submit line item services instead of just a summary bill.	12/10/2004
CT	OT	Type of Service	In September 2008 dental benefits were carved out of comprehensive managed care contracts and administered as FFS benefits by an administrative services only vendor (ASO). This caused an increase in FFS original non-crossover dental claims and expenditures in MSIS.	12/19/2011
CT	RX	Date Prescribed	DATE-PRESCRIBED was not reported prior to FY2006Q1.	6/18/2013
CT	RX	Medicaid Amount Paid	CT carved RX benefits out of their comprehensive managed care contracts in January 2008 causing an increase in RX claims and expenditures.	12/19/2011
CT	RX	Medicaid Amount Paid $0	CT had a sharp increase in the percent of FFS claims reporting $0 Medicaid Paid. This is due to a Medicare Part-D copay requirement for dual-eligible individuals that went into effect January 1st, 2010.	NA
DC	Claims	Crossovers	There are fewer than expected percent of crossover claims until about 2007.	4/21/2011
DC	Claims	Data System Change	In December 2009 (Q1FY2010) DC implemented a new MMIS.	NA
DC	Claims	TPL	There are very few claims in the IP, LT, and OT files with Other Third Party Payment amounts (or Third Party Liability/TPL). There were no LT claims with Other Third Party Payment amounts until Q3FY2008.	4/22/2011
DC	Eligibility	1115 Waivers	In March 2007, enrollees in DC's state-sponsored Alliance Health program were found eligible for and enrolled in the District's Medicaid program via an 1115 waiver for childless adults between ages 50-64 (waiver ID '01', waiver type '1').	11/30/2009
DC	Eligibility	1115 Waivers	DC operated the 'Program to Enhance Medicaid Access for Low-income HIV-infected Individuals' [Waiver ID '06'] as an 1115 waiver from FY 2005 [at least] through December 2010 [Q1 FY 2011]. The District assigned all individuals in the waiver to SSG '880' and MB 55. Average monthly enrollment for the period Q1 FY 2009 through Q4 FY 2010 was about 300. Participants subsequently became eligible for Medicaid and DC let the waiver expire in December 2010.	12/17/2013
DC	Eligibility	1115 Waivers	In 2002, the District of Columbia received approval from CMS to implement the 1115 Childless Adults Demonstration waiver. The earliest version of the waiver covered adults 50 – 64 years with incomes <= 50% FPL. This demonstration was authorized to operate from 01Feb2003 through 30Sep2011, although it	12/17/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			appears to have ended in June 2010. DC assigned virtually all enrollees in the waiver to SSG '370' and Waiver ID '01'. From Q1 FY 2008 through Q3 FY 2010, monthly enrollment was about 1,300 – 1,500. DC stopped reporting this waiver to MSIS after June 2010. Pursuant to the ACA, DC again decided to maximize coverage for childless adults. CMS approved a State Plan Amendment [SPA] that allowed expansion of Medicaid coverage to childless adults with incomes <= 133% FPL. The expansion's effective date was 01Jul2010 and it subsumed beneficiaries that were previously covered under the 1115 demonstration noted above. Adopting this option eliminated the need for the 1115 Demo as it was originally designed and implemented. The District began to report enrollment in this group during July 2010. It assigns these enrollees to SSG '774'; but does not assign them to a waiver, since they are now covered under the State Plan. Enrollment in the group was about 35,000 in July 2010. It increased to roughly 43,000 in September 2012. In 2010, CMS approved a second iteration of DC's Childless Adults Demo, which further expanded Medicaid coverage to low-income childless adults with incomes > 133% and <= 200% FPL. The Demo had effective dates of 01Nov2010 through 31Dec2013. The extension of the demo provides continuity of coverage for these enrollees until the District implements its Basic Health Plan [BHP], as authorized by §1331 of the ACA. DC codes these individuals with SSG '775' and assigns them to Waiver ID '01'. Initial enrollment in December 2010 was about 2,700. Enrollment has increased modestly over time and was about 3,900 in September 2012.	
DC	Eligibility	CHIP	M-CHIP enrollment in MSIS appeared to decline sharply during Q4 FY 2012. Reported enrollment fell from about 19,600 in Q3 FY 2012 to 6,600 in Q4 FY 2012. There was no concurrent decrease in M-CHIP reporting to SEDS. In fact, monthly enrollment did not decline during the quarter. DC inadvertently assigned all enrollees to MB 00 in July and August 2012. As a result, M-CHIP enrollment was reported as 0 for both months.	12/17/2013
DC	Eligibility	Dual Eligibility Codes	DC has indicated that the selection criteria for MMA is different than MSIS, thus the comparison between MSIS and MMA is not valid.	7/11/2013
DC	Eligibility	Dual Eligibility Codes	There was substantial variability in reporting dual-eligible enrollees between Q1 FY 2008 and Q4 FY 2012. However, the total number of duals reported has stayed generally within the range of 19,000 to 23,000 per month. Prior to Q1 FY 2010, duals made up about 13% of the total Medicaid population. Since that time, the proportion has declined to less than 10%. DC reported QMB-onlys [Dual Code '01'] as far back as Q1 FY 2008, when it reported about 2,500 per month. Enrollment increased gradually over time and reached more than 6,100 in September 2011, when the District abruptly stopped reporting QMB-only enrollment. DC also reported QMB Plus [Dual Code '02'] enrollment as far back as Q1 FY 2008. QMB Plus enrollment has shown considerable month-to-month variation.	12/17/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Enrollment was relatively stable from October 2007 through March 2010, with enrollment ranging from 16,400 to 17,500 over the period. Enrollment fell to about 13,500 in July 2010 and stayed in the 13,500 – 14,000 range until June 2011, when it increased considerably. Starting in October 2011 [Q1 FY 2012], enrollment jumped to more than 21,000. It continued to increase incrementally since then. Enrollment for September 2010 was about 23,300. DC started to report SLMB-only [Dual Code '03'] enrollment in October 2009. During the first two reporting quarters [Q1 – Q2 FY 2010], enrollment was less than 200 per month. Beginning in March 2010, DC began to report monthly SLMB-only [03] enrollment in the 250 – 300 range. Enrollment in September 2012 was about 350. DC began to report limited SLMB Plus [Dual Code '04'] enrollment in December 2009. Enrollment has remained in the range of 20 – 35 per month since then. The numbers are quite low and often change considerably from month to month.	
DC	Eligibility	Managed Care	Since it began reporting its transportation broker plan, the District has reported several hundred partial duals (with restricted benefit flag = 3) as having the plan.	3/15/2011
DC	Eligibility	Managed Care	DC ended its contract with the comprehensive HMO Plan 'Health Right' (Plan ID #026791900) in May 2010. Enrollment in the plan fell from 19,800 to 120 between April and May 2010. Most of the Health Right enrollees moved to the Unison Health Plan of the Capitol Area (Plan ID #039431900). Enrollment in Unison increased from 12,700 in April 2010 to 29,100 in May 2010. As of Q4 FY 2012, DC still reports a small number of enrollees each month (< 200) to Plan ID #026791900.	12/17/2013
DC	Eligibility	Managed Care	DC reports the plan 'Health Services for Children with Special Needs' [HCSN] as two HMOs with Plan IDs #026228900 and #035149400. As of Q1 FY 2008, average combined enrollment was about 3,400 per month, with less than 100 assigned to Plan ID #035149400. Since that time, enrollment in HCSN has gradually, but consistently, increased. Average combined monthly enrollment as of Q3 FY 2012 was about 5,100, with 225 in Plan ID #035149400. Our notes indicate that this plan is reported as a 'Medicaid-only PHP' in the managed care report the District submits to CMS.	12/17/2013
DC	Eligibility	Managed Care	In Q1 FY 2008, DC began to assign about 39,000 – 40,000 enrollees per month to the MTM transportation plan [Plan ID #000039117600]. Throughout 2008, however, it defined MTM as Plan Type '01' [Comprehensive]. As of Q1 FY 2009, the District began to report MTM as Plan Type '08' [Other]. In Q1 FY 2009, average monthly enrollment was about 41,300. This has increased gradually over time. Average monthly enrollment in Q3-Q4 FY 2012 was about 55,300.	12/17/2013
DC	Eligibility	Managed Care	Since individuals enrolled in the District's Alliance Safety Net Program were found Medicaid-eligible in 2007, DC continues to	12/17/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			report the three associated plans in MSIS. This includes Plan IDs '038056500', 038064600' and '039430200'.	
DC	Eligibility	Managed Care	The count of enrollees with transportation enrollment (Plan Type 08 – 'other') increased from about 45,000 in March 2011 to about 53,000 in April 2011. Enrollment stayed at about 53,000 through Q4 FY11. DC indicated the following service request was implemented in mid-April 2011 to satisfy the following requirement: "All Medicaid beneficiaries, irrespective of Managed Care eligible program code, begin their Medicaid eligibility in FFS and thus TRB until their Service Management with the MCO begins which could be up to 60 days. In this interim, FFS and TRB have total responsibility for payment of all claims. "Prior to the implementation, a TRB span was created only for members with eligibility in a select number of program codes, typically those that are not MCO eligible. That was changed to allow TRB enrollments for members with an MCO eligible program code until an MCO enrollment is established.	2/27/2015
DC	Eligibility	MASBOE	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.	NA
DC	Eligibility	MASBOE	Between December 2009 and January 2010, the number of children assigned to MB 48 [Other - Foster Care Child] reported to MSIS increased from about 4,000 to more than 5,600. DC attributed the increase to the addition of state aid category '762' [MA Subsidized Adopted, Child] to MB group 48.	12/17/2013
DC	Eligibility	MASBOE	DC indicated previously that it had assigned some enrollees to State Specific Groups [i.e., aid categories] based on their status in a waiver or grant program, not their eligibility pathway. It assigned individuals enrolled in its IID/DD Waiver [Waiver ID '05'] to SSGs '873' or '873Q' and MB 42. It assigned individuals enrolled in its Money Follows the Person grant program to SSGs '814', '814Q', '854', '854Q', '874' or '874Q' and MB 42. DC noted that fixing the problem would require a system change, which it could not do at the time [Q2 FY 2010]. MPR consequently told the District to leave its reporting unchanged. MPR would document the anomaly.	12/17/2013
DC	Eligibility	MASBOE	DC mistakenly assigned all EI records for July and August 2012 [Q4 FY 2012] to MASBOE 00. The error affects numerous other fields in the file, including Dual Eligibility Code, RBF, waivers, Plan ID, etc. As of 17Dec2013, the issue has not been resolved. It is likely that DC will need to resubmit a corrected file.	12/17/2013
DC	Eligibility	MASBOE	From Q1 FY 2008 through Q3 FY 2010, DC assigned about 1,600 – 1,800 enrollees per month to MB 55. The District further assigned them to one of two aid categories: '370' or '880'. DC's documentation indicates that beneficiaries in aid category '370' were enrolled in the MA 1115 [50-64] Demo. These individuals were non-TANF Adults who were not Medicare-eligible. They qualified for full Medicaid benefits. Beneficiaries in aid category '880' were enrolled in the MA 1115 Special Needs Demo. This group also included non-TANF Adults who were not enrolled in	12/17/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Medicare. They too qualified for full Medicaid benefits. Individuals in the Special Needs 1115 Demo received FFS care. Those in the Special Needs [50-64] Demo received services under managed care only. Our data show that the District phased out reporting of SSGs '370' and '880' in Q2 FY 2011. Starting with Q2 FY 2011, DC began to report everyone with MB 55 to state aid category '775'. SSG '775' includes childless non-pregnant adults, less than 65 years, with incomes <= 133% FPL. The District began to report about 2,800 enrollees per month starting in December 2010. Enrollment has continued to increase over time and was almost 3,800 in June 2012.	
DC	Eligibility	Private Health Insurance	The percentage of enrollees with third-party insurance [HEALTH-INSURANCE '2'] increased substantially between December 2009 and January 2010. Enrollees with private health insurance made up 1.8% of the population in December 2009, compared to 5.5% in January 2010. DC indicated that the increase was a result of its MMIS conversion around that time. The percentage of enrollees with third-party insurance continued to increase between Q2 FY 2010 and Q3 FY 2012. In June 2012, it reached 8.1%.	12/17/2013
DC	Eligibility	Restricted Benefits Flag	DC began to report enrollment in its Money Follows the Person [RBF 8] program in Q2 FY 2009. From Q2 FY 2009 – Q4 FY 2009, monthly enrollment was less than 20. Beginning in Q1 FY 2010 and continuing through Q4 FY 2012 average monthly enrollment has stayed in the 20 – 40 range. Initially, the District assigned all participants to MB 49 and State Aid Categories '874' and '874Q'. It began to assign participants to MB 42 in Q2 FY 2010. In Q3 FY 2011, the District started to assign a few recipients to state aid categories other than '874' or '874Q'. However, since there are multiple aid categories in MB 42, it is difficult to determine the new category to which the state is assigning MFP enrollees.	12/17/2013
DC	Eligibility	Retroactive/ Correction Records	DC did not use retroactive or correction records from Q1 FY 2008 through Q4 FY 2012.	12/17/2013
DC	Eligibility	SSN	The percentage of 9-filled SSNs varied considerably from Q1 FY 2009 through Q4 FY 2012. During FY 2009, the average rate of missing SSNs was about 4.2%. This grew to 5.7% in FY 2010. There was a marked increase between Q1 FY 2010 [3.5%] and Q2 FY 2010 [6.2%]. The rate of 9-filled SSNs fell to 1.3% during FY 2011. It increased again to 8.9% during FY 2012. In a previous communication, DC indicated that the differences found in FY 2010 were the result of the District's enhanced capability to correct invalid SSNs. It is unclear what accounts for the changes since then.	12/17/2013
DC	Eligibility	TANF/1931	Between Q4 FY06 and Q1 FY07, the District of Columbia experienced a substantial drop in its TANF caseload as it transferred some enrollees to a state-funded program. This transfer caused enrollment to drop from 37,415 in September 2006 to 12,183 in October 2006, according to ACF-TANF data.	3/14/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			Nevertheless, it appears MSIS is continuing to report both state and federal numbers as if they were all receiving federal TANF assistance.	
DC	Eligibility	Waivers	DC previously operated an 1115 waiver for low-income HIV-positive enrollees [Waiver ID '2']. The district used the waiver to reimburse participants for the purchase of water filters. Our documentation indicates that participants were not formally enrolled in the waiver and reporting was based on actual use. As a result, reporting to this waiver was inconsistent. The district allowed the waiver to expire on 31Dec2010, as enrollees had become Medicaid-eligible.	12/17/2013
DC	IP	DRG	DRGs are not included on about one-third of the claims until Q4FY2002 when they were reported on most IP claims.	12/15/2004
DC	IP	Family Planning	The number of family planning claims decreased substantially from Q1FY2010 to Q2FY2010. DC confirmed that coding corrections were made in Q2FY2010 to improve the accuracy of identifying family planning.	4/6/2012
DC	IP	Length of Stay	The average length of stay is about eight days which is higher than expected. The state confirms it is correct.	2/10/2011
DC	IP	Medicaid Amount Paid Avg	The average amount paid per IP FFS non-crossover claim has always been higher than expected. Prior to 2003 it was around $10,000; by Q1FY2003 it increased to about $12,000; in Q1FY2010 it was about $14,000.	3/10/2011
DC	LT	Diagnosis	Since 1999 and continuing through at least Q2FY2009 more than 90% of DC LT claims have had either no diagnosis (dx) code or a dx of 7999, a valid dx but probably not appropriate in that high of a concentration. Each of those quarters fewer than 10% of DC LT claims have contained dx codes that are valid and potentially appropriate. Up to 14% of 2010 Q1 LT claims contained valid and potentially appropriate dx.	3/4/2011
DC	LT	TPL	Other Third Party Payment (or Third Party Liability/TPL) is not reported in the LT files until Q3FY2008. Beginning in Q3FY2008 and continuing forward (through at least Q1FY2010), very few claims (<1%) were reported with TPL, common for LT claims in other states.	3/4/2011
DC	LT	Type of Service	The percent of claims with Type of Service 02 (Mental Hospital Services for the Aged) and 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 and Under) is quite variable from quarter to quarter, probably because there are so few of them and also the billing cycle.	12/10/2004
DC	OT	Adjustments	In the DC 2009 Q1 OT file there were four out of approximately 20,000 void and/or credit claims with positive paid amounts.	NA
DC	OT	Crossovers	After Q1FY2010 crossover expenditures drop to one-twentieth or about five percent of what they had been in prior quarters. DC explained that a pricing error that occurred during claims	NA

State	File Type	Rec/Issue Type	Issue	Recorded
			adjudication caused the average paid amount of crossover claim to exceed the average paid amount of non-crossover claims.	
DC	OT	Crossovers	Since at least Q2FY2008, DC has reported over 90% of OT crossover claims as type of service 19 - Other Services. The average amount paid for these services is very high for crossover claims. At the same time, there have been no crossover claim with a type of service of 08 - Physician. DC has reported that this is a claims adjudication error that was resolved in 2010 and would be resolved thereafter in MSIS with adjustment claims.	4/21/2011
DC	OT	Diagnosis	Prior to Q2FY2010 DC reported a filler diagnosis code on many claims in the OT file that were originally billed in the institutional format including primarily outpatient hospital and home health.	11/15/2011
DC	OT	Family Planning	The number of family planning claims decreased substantially from Q1FY2010 to Q2FY2010. DC confirmed that coding corrections were made in Q2FY2010 to improve the accuracy of identifying family planning.	4/6/2012
DC	OT	FQHC	The District of Columbia did not begin reporting claims with a Program Type of 4 (FQHC) until 2002.	3/3/2011
DC	OT	Managed Care Capitation	In Q1FY2007 DC enrolled people in a transportation managed care plan. From inception through Q4FY2008 DC reported the transportation capitation claims as FFS.	NA
DC	OT	Managed Care Capitation	There were roughly 60,000 fewer capitation payments adjudicated in July of 2009 than any other month in calendar year 2009. The missing capitation claims were likely reported as FFS claims. The missing capitation claims likely represent all capitation payments for enrollments in the transportation PHP and two small comprehensive HMOs for the month of July 2009.	4/21/2011
DC	OT	Managed Care Encounters	In the Q2FY2010 claims files adjudication date on encounters did not all fall within the three months of Q2FY2010. Adjudication date on some encounters preceded the quarter because it represented the date that the encounter was transmitted from the managed care plan to the state Medicaid agency, rather than the "finalized" date used to pull the records for MSIS.	4/6/2012
DC	OT	Medicaid Amount Paid	The distribution and payment for services varies widely from quarter to quarter.	12/10/2004
DC	OT	Medicaid Amount Paid	There is one original, FFS non-crossover claim in the Q1FY2009 OT file with an invalid Medicaid paid amount of $5,555,555.	3/8/2011
DC	OT	Medicaid Amount Paid Avg	In Q3FY2009 the average amount paid to physicians and other practitioners rose noticeably and remained high through at least Q4FY2009.	4/21/2011
DC	OT	Revenue Code	All claims with a Type of Service of 11 (Outpatient Hospital) have Service Codes instead of UB-92 Revenue Codes as they bill using the CMS-1500 claim form.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
DC	OT	Service Code	In Q4FY2000 the state started submitting claims with state-defined Service Codes.	12/10/2004
DC	OT	Type of Service	DC has always reported a larger than usual proportion of FFS non-crossover claims as type of service 19 - Other Services.	NA
DC	OT	Type of Service	In Q2FY2010, DC began reporting ambulatory surgical center (ASC) payments as outpatient hospital services (TYPE-OF-SERVICE=11) rather than clinic services (TYPE-OF-SERVICE=12) as they had previously reported. DC explained that reporting ASC services as outpatient hospital services was consistent with CMS-64 categorization requirements.	NA
DC	OT	Type of Service	In Q3FY2009 DC began using unspecified dialysis code (90999) to represent bundled dialysis services provided by clinics. The high proportion of managed care enrollment causes FFS claim data to be dominated by waiver services and other high-cost managed care carve-outs like dialysis.	NA
DC	OT	Type of Service	The average FFS non-crossover amount paid for type of service 8 (physicians) nearly doubled between 2009Q2 and 2009Q3 and remained high thereafter.	NA
DC	OT	Type of Service	There were very few claims with Type of Service of 09 (Dental) in the OT file until 2007 and 2008 continuing through to 2010. Washington DC confirmed that the low numbers prior to 2008 were correct.	4/19/2011
DC	OT	Type of Service	DC implemented a new MMIS in Q2FY2010 causing them to redesign MSIS as well. The reclassification of their Medicaid program into MSIS types of service and the different data structure of the new system caused substantial shifts in both type of service frequencies and the composition of each file type. Most noticeably, personal care services are seen for the first time, rehab claims and expenditures increased, home health, other services decreased, clinic decreased, and outpatient hospital service claims increased while expenditures decreased. DC explained that ambulatory surgical centers were reclassified from clinic to outpatient hospital services in order to match DC's CMS-64 reporting.	11/15/2011
DC	OT	Type of Service	Beginning in Q2FY2010, DC began reporting dentures as "other services" (TYPE-OF-SERVICE=19). This is consistent with older versions of CMS-64 and MSIS instructions from the State Operations Manual (Chapters 2500 and 2700 respectively) but it is no longer consistent with the MSIS data dictionary (as early as version 2.6 and continuing through at least through 3.1).	1/23/2012
DC	RX	Adjustments	When an RX claim is adjusted in DC the claim is voided and resubmitted as a new original claim. When large adjustments are done the measures for new original claims can be skewed by the adjustments. In Q2FY2009 DC's pharmacy benefits manager adjusted a large number of high cost drugs which made the average amount paid for all new original claims appear to be well above average.	6/7/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
DC	RX	Adjustments	After implementation of a new MMIS in Q2FY2010 a small number of void claims were reported with positive dollar amounts. The number of claims is limited and should not appear after Q3FY2010. These void claims are related to adjustments of claims that were converted from the old system. There is logic for a certain coverage category in the new system that splits the original claim into an administrative fee and ingredient costs.	11/15/2011
DC	RX	Family Planning	There are very few claims with a Program Type of 2 (Family Planning).	12/10/2004
DE	Claims	Adjustments	There are very few adjustments (less than one percent). Delaware confirms this is correct.	12/10/2004
DE	Claims	FFS Claims	Beginning in FY2012Q3, the state enrolled almost all of their Medicaid eligibles in MCOs which assumed responsibility for nursing home clients, HCBS waiver clients and duals in the community. These MCOs provided almost everything except dental, pharmacy and mental health services. This change is reflected in reported claims from FY2012Q3 onwards. Data comparisons before and after FY2012Q3 will need to account for this change.	2/8/2013
DE	Claims	TPL	There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) as Delaware is a "pay and chase" state	12/10/2004
DE	Eligibility	1115 Waivers	CMS initially approved the Diamond State Health Plan [DSHP] 1115 Demonstration in 1995, and Delaware implemented the program on 01Jan1996. The Demonstration requires enrollment in managed care for most Medicaid recipients. It is designed to create program efficiencies and to permit the expansion of coverage to individuals who would otherwise not be Medicaid-eligible. Through 31Dec2013, DSHP expanded Medicaid State Plan coverage to uninsured adults with incomes < 100% of the Federal Poverty Level [FPL] and provided family planning services to women who lost Medicaid eligibility or comprehensive DSHP benefits. The state's authority to provide family planning services expired on 31Dec2013. Starting on 01Jan2014, DSHP expanded Medicaid eligibility to individuals with incomes = 133% of FPL. This group includes dual eligible recipients, disabled workers, and most people receiving care in an institutional or HCBS setting. The program, called DSHP-Plus, provides long-term care services and support [LTSS] to eligible individuals through a mandated managed care delivery system.	1/30/2014
DE	Eligibility	CHIP	Delaware began to report complete separate CHIP [CHIP-CODE '3'] eligibility to MSIS in October 2010 [Q1 FY 2011]. From Q1 FY 2011 through Q4 FY 2013, the state has reported an average of 6,300 separate CHIP enrollees per month with relatively little month-to-month variation in the data.	1/30/2014
DE	Eligibility	CHIP	Delaware has a very small Medicaid-expansion CHIP [CHIP-CODE '2'] plan. Between Q1 FY 2009 and Q4 FY 2013, the monthly enrollment reported in MSIS has normally been in the range of 30 – 55 members. The state reports substantially fewer	1/30/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			members to SEDS. Since Q4 FY 2011, the difference in MSIS versus SEDS reported has ranged from 15% to 40%. The only exception to this pattern occurred in Q4 FY 2011, where Delaware reported total M-CHIP enrollment of 3,535 to SEDS; but only 149 to MSIS. At this point, we cannot explain this outcome and plan to ask the state for an explanation.	
DE	Eligibility	County Codes	Each month Delaware reports 1,200 to 2,000 enrollment records with COUNTY-CODE '000'. This generally represents = 1.0% of all records on the EL file. The state says that this is caused by enrollees who move out of state during a given quarter (for example, into an out-of-state LTC facility). Since Delaware's system is designed to report the member's last known address, reporting a valid County Code in these instances is a problem.	1/30/2014
DE	Eligibility	Dual Eligibility Codes	Delaware historically has had difficulties in assigning dual eligibility. The state has worked through most of these issues and, as of Q4 FY 2013, it reports Dual Eligible Codes '01', '02', '03', '06' and '08'. However, it has never been able to report anyone to Dual Eligible Code '04' [SLMB Plus].	1/30/2014
DE	Eligibility	Dual Eligibility Codes	Each month the state reports a small number [= 100] of individuals to MASBOE 31-32, RBF '3', and DUAL-ELIGIBLE-CODE '99' [Eligible's Medicare status is unknown]. These members have not been assigned to duals codes '01', '03', or '06' due to systemic delays in confirming Medicare coverage.	1/30/2014
DE	Eligibility	Dual Eligibility Codes	In Q4 FY 2010 Delaware began to assign a small number of members each month to Dual Eligible Code '99'. The state continued to do this through Q4 FY 2013. The enrollment count reported to MSIS rose modestly over this period, from an average of 45 per month in Q4 2010 to 76 per month in Q4 2013. According to previous communications with Delaware, the dual status of these individuals was unknown at the time of reporting. The state indicated that it is trouble shooting the issue; but has not proposed a solution as of Q4 FY 2013. However, a previous anomaly note suggests that everyone in this group had an aid category that identifies them as partial duals. Ostensibly this means that the state could correctly identify their dual state from their aid category.	1/30/2014
DE	Eligibility	Managed Care	In Q3 FY12, DE implemented an amendment to its 1115 waiver that moved many nursing home enrollees into managed care. This new group of managed care enrollees is called DSHP Plus (the 'plus' representing the additional long term care services the HMOs provide to this group).	1/14/2013
DE	Eligibility	Managed Care	DE started a PACE program in February 2013. Enrollment increased steadily, but counts remain low.	1/30/2014
DE	Eligibility	Managed Care	Delaware employs LogistiCare [Plan ID 'A0000000074'] as its non-emergency transportation [NEMT] managed care provider. According to previous communications with the state, all members, except for partial duals and aliens receiving only emergency services, qualify for this benefit. The state assigns	1/30/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			this plan to Plan Type '08' [Other]. Between April 2009 [Q3 FY 2009] and September 2013 [Q4 FY 2013] enrollment in the plan grew from about 144,600 members per month to 186,700 per month. This represents an increase over the entire period of 29.2%.	
DE	Eligibility	Managed Care	For quite some time [since at least Q2 FY 2008] Delaware has been phasing out its PCCM program. While negotiating with CMS to renew its 1115 waiver, the state asked for permission to phase out enrollment over time. The state no longer includes PCCM on its list of MCOs from which members can choose during open enrollment. New members cannot join the program, except under unusual circumstances. As a result, Delaware views the decline in PCCM enrollment as both expected and desirable. Overall PCCM enrollment has declined from 10,400 in January 2008 to 2,400 in September 2013 [-77.1%].	1/30/2014
DE	Eligibility	MASBOE	DE has a state-administered SSI supplement. In addition, most disabled SSI recipients over age 65 appear to be reported to MASBOE 11.	NA
DE	Eligibility	MASBOE	As of Q4 FY 2013, Delaware still does not have a 'medically needy' program. Therefore, the state does not assign anyone in MSIS to MAS '2'.	1/30/2014
DE	Eligibility	MASBOE	The state assigns all members in its Medicaid Buy-in Program [Medicaid for Workers with Disabilities] to state-specific groups 'J1' – 'J5' and MASBOE 42. While the program had an official start date in October 2009, the reality was quite different. According to the state, computer systems and other logistics were not fully operational at launch time, and formal outreach was not extensive. Consequently the state did not enroll clients into the program from October to December 2009 [Q1 FY 2010]. A few members were added during between January to March 2010, and a small number of additional clients have entered the program subsequently. As of Q4 FY 2013, there were about 35 participants in the program.	1/30/2014
DE	Eligibility	Private Health Insurance	Between Q FY 2010 and Q4 FY 2013, the number of member reported with Private Health Insurance increased from about 8,300 to 14,000 per month. The result is an increase in the proportion of members with private health insurance from about 4.5% to about 6.0%. Delaware initially indicated that the increase was due to a startup of automated data matching between the files of private insurers and the state's Medicaid eligibility files. Delaware noted previously that the rise in Q2 FY 2010 was the result of data about clients of Blue Cross only. The state added that it expects more information as a result of more file processing from its other MCOs. As of Q4 FY 2013, while the absolute number of clients with private insurance has increased, the proportion of members with private insurance has not changed appreciably since Q2 FY 2010.	1/30/2014
DE	Eligibility	Restricted Benefits Flag	When asked why several dozen individuals are consistently reported to MASBOE 31-32 with a dual code = 00 but a	12/7/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			restricted benefit flag = 3, DE indicated that the discrepancy was due to a lack of evidence of active Medicare eligibility even though the client in question was assigned a state-specific eligibility group code for partial dual eligibles. DE indicated this was likely due to system delays in confirming Medicare status.	
DE	Eligibility	Restricted Benefits Flag	Delaware assigns everyone receiving family planning benefits under its 1115 Family Planning waiver to Waiver ID '01', Waiver Type 'F', state aid category 'F3', RBF '6', and either MASBOE 54 or 55. Between Q4 FY 2009 and Q4 FY 2013, average enrollment in the program was about 4,000 per month.	1/30/2014
DE	Eligibility	Restricted Benefits Flag	Delaware began to enroll participants in its Money Follows the Person [MFP] program [RBF '8'] during Q1 FY 2009. Enrollment has been relatively low since the start. Through December 2011, reported enrollment never exceeded 10 in any given month. However, enrollment increase to 23 in January 2013 and grew slowly to reach 42 in September 2013.	1/30/2014
DE	Eligibility	Retroactive/ Correction Records	2006 - 2009: For several years (at least since 2006), DE's correction records were 0-filling the MASBOE and other key fields for certain months before the month that a correction was applied. As a result, if someone had a correction in month 3, month 1 and month 2 would have many of its fields erroneously 0-filled; if someone had a correction in month 2, month 1 would have many of its fields erroneously 0-filled. The state appears to have fixed this problem as of Q2 FY10. Retroactive and correction records that apply to 2008 and 2009 are unreliable.	3/3/2011
DE	Eligibility	Retroactive/ Correction Records	DE submits retro/correction records. These records may consist of one-third of all the records reported on a given quarter's eligibility file, yet only a small number (less than one percent) actually make a change to an original record. The state says that it is unable to fix this issue at this time.	4/19/2011
DE	Eligibility	SSN	Since at least Q1 FY 2009, Delaware has reported some eligibility records each quarter with missing SSNs. The proportion of missing SSNs remained in the 6.0% - 7.0% range until Q1 FY 2011, when it fell to about 5.5% .It has declined further since then; and was about 4.5% as of Q4 FY 2013. In a previous communication, that state indicated that many of the missing SSNs are for children = 6 years old. Prior to Q2 FY 2009, Delaware '0-filled' all of the missing SSNs. Beginning in Q2, the state began to 9-fill them.	1/30/2014
DE	Eligibility	TANF/1931	As of Q4 FY 2013, Delaware still '9-fills' the field TANF-CASH-FLAG.	1/30/2014
DE	Eligibility	Waivers	Since 2010 Delaware has made significant moves toward providing most health services through managed care. The state consolidated three of its five 1915c waivers in December 2010. It rolled Waiver ID '02' [The Elderly and Disabled Waiver], Waiver ID '03' [The Assisted Living Waiver], and Waiver ID '06' [The Acquired Brain Injury Waiver] into Waiver ID '08', which became the new Elderly and Disabled Waiver. The state then	1/30/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			implemented an amendment to its 1115 waiver in Q3 FY 2012 that folded the 1915c waivers '04' [HCBS Waiver for HIV/AIDS Clients] and '08' [HCBS Waiver for the Elderly and Disabled] into the Diamond State Health Plan [DSHP] 1115 Demonstration. As currently approved, the DSHP waiver expands Medicaid State plan coverage to uninsured adults with incomes < 100% of the FPL, and family planning services to women who lose Medicaid eligibility or comprehensive DSHP benefits. The amended Demonstration also provider long-term care services and supports (LTSS) to eligible individuals through a mandated managed care delivery system called DSHP Plus.	
DE	IP	DRG	DRGs are not included as they aren't used for reimbursements.	12/10/2004
DE	IP	Family Planning	There aren't any claims with Program Type of 2 (Family Planning).	12/10/2004
DE	IP	Patient Status	There weren't any claims with a Patient Status of 30 (Still a Patient) until 2002.	12/10/2004
DE	IP	Revenue Code	The state pays for bundled services for Services for Children, Youth and their Families (DSCYF) that includes inpatient care. These claims do not have UB-92 revenue codes, Patient Status or Admission Date. The number of these bundled claims nearly doubled between Q1 and Q2FY1999.	12/10/2004
DE	LT	Adjustments	There was a big increase in adjustments in Q2FY1999 as that is when the claims are adjusted to accommodate rate changes.	12/15/2004
DE	LT	Covered Days	There are no covered days on claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 and Under).	12/10/2004
DE	LT	Crossovers	In December of 2010 DE realized they are repeating the amounts in the deductible and coinsurance fields for LT crossover claims. It is not clear how long this has occurred. We asked them to fix this issue going forward.	12/27/2010
DE	OT	Crossovers	Beginning with Q4FY2002, Delaware will begin submitting OT XO claims with one record per line item, without Medicaid Pd, Coinsurance/Deductibles, and Charge as those amounts are only carried on the header. They will submit a separate header claim with those summary amounts.	12/10/2004
DE	OT	Place of Service	Place of service is missing on the majority of claims.	12/10/2004
DE	OT	Type of Service	Payments for PCCM services are service based and not paid as capitation claims.	NA
DE	OT	Type of Service	Starting with Q4FY2002, the state began submitting Home Health services at the line item level resulting in more Home Health claims with a lower Medicaid Amount Paid.	12/10/2004
DE	OT	Type of Service	Starting in the Q2-Q4FY2003 OT files, about 50% of the claims have a type of service of 'other services'.	9/4/2005

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State	File Type	Rec/Issue Type	Issue	Recorded
DE	OT	Type of Service	In the Q3FY2010 OT file there is a large increase in the number of claims. This is because the state's school distracts submitted a large backlog of claims. Most of these claims are for RN services, psychologist services, physical, occupational, and speech therapy, transportation, and other misc. services.	12/27/2010
DE	OT	Type of Service	In 2003, claims with a Type of Service of 26 (Transportation) made up between 26 to 40 percent of all services. Starting with Q1FY2003, there will be a transportation managed care program.	3/3/2011
DE	OT	Type of Service	There was a change in the distributions on some types of service from Q1 to Q2FY1999 due to inconsistencies in submission of bills. Also, prior to January 2000, people with private health insurance were not allowed to enroll in managed care. About 2000 people were moved to managed care as a result of the rule change.	3/3/2011
DE	RX	Bundled Payment	Some drugs are included in the NH bundled rate and not as individual drug claims.	8/22/2005
DE	RX	Compound Drugs	All compound drugs are coded as "COMPOUND" in the NDC field.	12/10/2004
DE	RX	Date Prescribed	Date Prescribed is always missing.	12/10/2004
DE	RX	New Refill	New Refill Indicator is always missing.	12/10/2004
FL	_All	MSIS ID	The MSIS IDs on the claims and most of the EL records are nine bytes, with a check digit in the 10th position. There are a few EL records with a nine-byte MSIS ID. The check digit was not always set the same between claims and eligibility. Since the nine-byte MSIS ID uniquely identifies enrollees, the EL file can be unduplicated by dropping the 10th byte, sorting the file by the nine-byte MSIS ID and dropping the duplicate records. The claims files can be made to link correctly with the EL files by dropping the 10th byte as well.	12/10/2004
FL	Eligibility	1115 Waivers	The Florida Medicaid Reform 1115 waiver (waiver type 1, waiver ID 22) was approved in October 2005, but implementation did not begin until July 2006. This waiver did not expand Medicaid eligibility. Instead, it set up a system to allow beneficiaries to choose managed care plans that best suited their needs (including customized benefit packages that also included all mandatory services). In addition, it established an Enhanced Benefit Account program, providing incentives for healthy behaviors. From July 2006-2007, this waiver was gradually implemented across 5 counties: Broward, Duval, Baker, Clay and Nassau. Expansion to further counties may occur as well. MSIS reporting for this waiver did not begin until Q4 FY08.	5/21/2009
FL	Eligibility	1115 Waivers	FL's 1115 Consumer Directed Care waiver (waiver ID '01', waiver type '1'), also known as "Cash and Counseling," allows individuals to purchase needed personal care services with a monthly cash allotment. It does *not* extend Medicaid eligibility. 12/1/2014 update: This waiver expired in February	9/24/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			2012, however, ~2,200 members were reported in March 2012, falling to ~1,500 in December 2013. The state indicated this overlap is due to individuals being transitioned into the iBudget waiver [0867.R00.00 - FL DD Individual Budgeting 1915c Waiver]. The transition is expected to be fully implemented by June 2013.	
FL	Eligibility	1115 Waivers	In October 2005, a MEDS-AD 1115 waiver was approved (waiver type 1, waiver ID 23), and it was implemented in January 2006. This waiver expanded Medicaid eligibility by extending full Medicaid benefits to certain aged and disabled persons with income<88% FPL (duals and nonduals). These individuals had previously been covered as part of an optional group by FL and were reported to MASBOE 31-32. With the implementation of Part D, FL switched to covering the nonduals in this group under the MEDS-AD 1115 if the nonduals were not in an institution, hospice, or HCBS. Nonduals and duals were also covered in the 1115 Medicaid expansion group, if they needed institutional care, hospice, or HCBS, and they were not otherwise eligible for Medicaid. Both before and after the 1115 was implemented, these individuals were reported to the same state codes (MM SA, MM SD, MI MA, and MI MD). However, by mistake, FL failed to report these 1115 enrollees to MASBOE 51-52 from Q2 FY06 through Q3 FY08 (continuing to report them to MASBOE 31-32 instead), and it did not begin reporting them to waiver ID 23/waiver type 1 in MSIS until Q4 FY08. This waiver also included pharmacy case management services for expansion enrollees with six or more ongoing medications.	3/3/2011
FL	Eligibility	1115 Waivers	FL's 1115 Family Planning waiver (waiver ID '03', waiver type 'F') extends family planning benefits (only) for 24 months to women who would otherwise be ineligible for Medicaid. Enrollment in this waiver experienced several dramatic shifts over the FY 2009 and 2010 period. Ultimately, enrollment declined from more than 50,000 per month to ~2,500 per month as of Q3 and Q4 FY10. FL's response to CMS and Mathematica's questions re: this waiver was: "The Family Planning Waiver while reporting incorrectly has only approximately 3200 - 4000 recipients. This number was obtained by running a query on the MSIS data. While the previous submitted files contained incorrect numbers we are putting in measures to insure that the next submission of data files FY10 Q3 forward will contain the correct data."	10/19/2011
FL	Eligibility	1115 Waivers	2008-2009: Apart from Family Planning waiver reporting FL had been submitting in MSIS (between ~50,000 - ~70,000 enrollees each month before inexplicably dropping to ~2,500 per month in December 2009), CMS waiver staff indicated in September 2010 that the Family Planning waiver had an enrollment count of approximately 450,000 people. Despite raising this issue in the context of a state review, CMS MSIS staff accepted the state's response that this waiver comprised much fewer people. Update: There were other abrupt changes in FP reporting: from June [N = 3,000] to December N = 75,000] 2011, then from	10/20/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			January [N = 75,600] to February [N = 44,500] 2012. Enrollment in September 2013 was about 62,500. The state indicated "Family Planning enrollment is determined by the Department of Children and Families (DCF). FMMIS only reports the data as received by DCF."	
FL	Eligibility	1115 Waivers	Beginning in August 2014, Florida's Managed Medical Assistance Program [number 11-W-00206/4, Waiver Type '1'] will no longer be reported to Waiver ID '22'. Beginning in January 2014, the state plans to begin report the waiver to six IDs (26-31) by separate program components.	12/1/2014
FL	Eligibility	1115 Waivers	Florida's 1115 Consumer Directed Care Plus (CDC+) waiver [Waiver Type '1'; Waiver ID '01'] ended in February 2008 according to CMS and online documentation. At that time, it was turned into a state plan option. CDC+ members transitioned to the state plan or the 1915(c) Individual Budgeting waiver. However, as of December 2013, the state continues to report ~2,000 members to this waiver. The state indicated this is happening because they are still transitioning members from the CDC+ waiver to iBudget.	2/20/2015
FL	Eligibility	1115 Waivers	Enrollment in the MEDS-AD 1115 waiver [Waiver ID '23'] declined from 50,400 in January to 39,900 in December. The Demonstration Program Renewal Request on CMS's waiver portal reported that enrollment totaled 41,275 in January 2013 and was projected to increase to 45,281 by December. The state (senior management staff at AHCA headquarters and recipient eligibility staff) indicated there was no definitive reason for the decline in enrollment in this waiver. The state also noted reporting of actual vs. projected number of recipients enrolled in the waiver contributed to the inconsistencies in the reporting between MSIS and CMS's program documentation. The source of the enrollment data displayed on CMS's waiver portal came from FL's AHCA headquarters. The state compared some factors used by headquarters and HP, FL's fiscal agent that provides Florida's quarterly MSIS files to CMS and confirmed the following: 1. Both sources are only reporting recipients in program aid categories MH M, MI M and MM S. Program aid categories are assigned by DCF (Department of Children and Families). 2. MSIS reports actual number of recipients enrolled in the waiver out of the FLMMIS for a 3 month period. 3. CMS's program documentation reflects a projected number of recipients that AHCA headquarters believe will be enrolled in the waiver based on the prior 2 years of data out of the DSS. FLMMIS is the sole source of data for the DSS data warehouse (Decision Support System). The DSS store's the data in a style more conducive to broad, analytical ad hoc querying using large tables. CMS originally requested the state develop a plan of action to correct the reporting issue, but retracted that request based on this information. The MSIS figures appear accurate.	6/10/2015
FL	Eligibility	CHIP	Florida reports enrollment in its M-CHIP program, which has declined over time and was less than 1,000 per month in FY09.	3/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			Until it ended as of Q4 FY08, enrollment reported in its S-CHIP program had been incomplete and only for eligibles ages 1 to 5 who transferred from Medicaid.	
FL	Eligibility	County Codes	When asked why so many people (~12,000 per quarter) were being reported with County Code = '999', the state indicated that this is for residents who are out of state. We will advise FL in the future that this should be changed to '000' per the Data Dictionary.	10/7/2011
FL	Eligibility	Dual Eligibility Codes	Major shifts by dual code occurred in January 2006, with many full duals moving to partial dual status. These shifts resulted in part from Medicare Part D implementation. Many duals who were able to spend down prior to 2006 as a result of prescription drug costs now went from full duals to partial dual status. In addition, FL made some policy changes in its coverage for aged and disabled individuals with income <= 88% FPL qualifying for full Medicaid benefits (see discussion of 1115 MEDS-AD waiver). The net effect was that full dual enrollment fell by about 22 percent, while partial dual enrollment increased by 81 percent. Total dual enrollment remained the same. There was, however, a major increase (46,000) in full duals reported to MASBOE 31-32 in Q4 FY08.	10/4/2011
FL	Eligibility	Managed Care	Beginning in Q1 FY03, all BHP enrollment in MSIS went to two plan IDs: 015030400 and 725000200. In addition, BHP enrollment levels were consistent between MSIS and CMS data in June 2003. Beginning in FY05, FL's Behavioral Health Plan "FL Health Partners" is reported to Plan IDs 725000200, 725000210, 7250002103, and 725000202. The last three bytes indicate different locations.	NA
FL	Eligibility	Managed Care	Between Month 1 and Month 2 of Q4 FY05, there was a large shift (90,000 enrollees) from plan type 07 (PCCM) to plan type 3 (BHP). FL corrected an error in the identification of enrollees in BHP's. FL feels that the data now better reflect PCCM and BHP enrollment. However, this correction was due to a recent program change, and the state feels that past data are also accurate. FL more recently responded that the state's Medicaid program was asked to modify its MSIS reporting to correctly report disease management organization (DMO) recipients to plan type 08 and all other Medipass recipients to plan type 08. As part of this modification (implemented in October 2006), if a recipient is enrolled in PMHP (BHP) and Medipass, the recipient is reported to plan type 03 and not dually reported in both plan type 07 and plan 03 (FL has been advised that they should be dually reported to both plan types). In Q3 FY06, FL's BHP enrollment was 185,030 while PCCM enrollment was 530,349; in Q3 FY07, FL's BHP enrollment was 546,264 while PCCM enrollment was 74,263; in Q3 FY08, FL's BHP enrollment was 548,855 while PCCM enrollment was 65,864.	NA
FL	Eligibility	Managed Care	Through Q1 FY09, FL did not correct the reporting of what appeared to be PCCM (plan type '7')-related enrollment to plan	4/22/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			type '8'. Instead, FL should have reported only those plans associated with FL's Disease Management Organization (DMO) program to managed care plan type '8' while reporting all plans related to primary care case management (PCCM) to plan type '7'.	
FL	Eligibility	Managed Care	A small number of partial duals (< 100) are reported as having managed care. FL indicated these individuals are associated with the state's Medicaid Reform waiver (waiver ID 22) and are reported to MAS 5, which focuses on moving enrollees into managed care environments, because this waiver is an eligibility expansion. These individuals are not reported with a restricted benefit flag = 3 indicating receipt of partial benefits restricted to the Medicare Savings Program.	9/23/2010
FL	Eligibility	Managed Care	Florida ceased reporting to Plan Type 8 (disease management) for administrative reasons and did not resume until July 2008, even though the program continued. Then, with the exception of one person enrolled in the third month of the quarter, disease management reporting (plan type '08' and plan IDs '758884400' [AIDS Healthcare Foundation], '912150100' [Alternative Medicine Integration], and '914746200' [Pfizer]) ended as of month 2 of Q2 FY09, despite the fact that the annual CMS June Medicaid managed care report indicated this program was still in existence. (It also cited two other small plans operating as disease management: Caremark and Hemophilia of the Sunshine State.) As of March 2011, the state has not been able to characterize whether this reporting was erroneously omitted but has instead only said that managed care reporting beginning in Q4 FY10 will be more accurate.	3/3/2011
FL	Eligibility	Managed Care	Until Q4 FY08, PCCM enrollment in MSIS was substantially undercounted because those enrolled in both a PCCM and a behavioral health plan were counted in CMS data as enrolled in both while they were only reported as belonging to a behavioral health plan in MSIS data. FL indicated that, with the exception of PCCM enrollees mistakenly assigned plan type 08, the reporting of approximately 420,000 PCCM enrollees in Q4 FY08 was otherwise correct.	3/3/2011
FL	Eligibility	Managed Care	Beginning in Q2 FY04, enrollment in several disease management organization (DMO) plans were reported to plan type 08 (Other). However, the provider ID's used in MSIS are not plan level IDs (this means many MSIS plan IDs are reported as "invalid"). In addition, a somewhat different method is used to identify DMO enrollees in MSIS than is used for the June CMS managed care report, accounting for the somewhat different results (in FY04 and FY05).	10/7/2011
FL	Eligibility	Managed Care	For many years, FL has reported about 20,000 enrollees each month in a hospital based "Provider Service Network" (PSN) as an "Other" type of managed care in the June CMS Medicaid managed care report. From the start, this entity has been reported to Plan Type 07 (PCCM), along with "Children's Medical	10/7/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			Services" (CMS) and the Statewide "Medipass" program. PSN and CMS providers are paid a capitated administrative fee, and an additional percentage of FFS claims for enrollees.	
FL	Eligibility	Managed Care	The 2009 CMS June Medicaid managed care report cited several other plans that were otherwise not reported in MSIS: two pre-paid ambulatory health plans (PAHPs) – NetPass (13,568) and Access Health Solutions (57,539) – and various long-term care plans with a combined enrollment of ~15,000.	10/18/2011
FL	Eligibility	Managed Care	Beginning in Q4 FY07, FL stopped reporting enrollees in its disease management organization (DMO) plans to plan type 08. The state resumed reporting of these enrollees to plan type 08 in Q4 FY08 (upon the implementation of a new MMIS) but indicated that it had erroneously included some PCCM providers (associated with the Children's Medical Services program) to that plan type as well. FL indicated that the DMO plan enrollees should be identifiable by their plan ID(s): Pfizer (914746200), AIDS Healthcare Foundation (758884400) and Alternative Medicine Integration (912150100). For an unknown reason, enrollment tapered off during Q1 FY09 and ended completely as of April 2009. The state was unable to explain why this occurred and whether these plans remain in place but are simply not being reported.	4/6/2012
FL	Eligibility	Managed Care	Starting in FY05, FL has a Transportation Plan for all Medicaid eligibles. FL is currently unable to report expenditures for this plan but, as of Q4 FY08, it does assign a unique waiver ID (07) in the eligibility file to those who are identified as qualified to receive services. This plan is reported in CMS' annual Medicaid managed care report.	4/6/2012
FL	Eligibility	Managed Care	In October 2009, enrollment in behavioral plans was about 614,400 and increased to a high of 682,400 in July 2010 before falling to 225,100 in September 2013. Comprehensive care enrollment increase from 993,400 in October 2009 to 1,170,000 in September 2013. The state indicated the BHO population dropped as Florida required the new Managed Care Plans to cover most, if not all Behavioral Health Services. That is, comprehensive managed care plans began providing behavioral health services during this time and are now covering individuals who were previously in behavioral managed care.	12/1/2014
FL	Eligibility	Managed Care	Dental managed care grew more than 600% between October 2009 [N = 203,200] and September 2013 [1,445,800]. The increase occurred in stages, with step-like increases in January, October, and December 2012. The increases are due to Dental managed care becoming mandatory for all children statewide. Florida's Prepaid Dental Health Plan (PDHP) became operational in Miami-Dade County in 2009 and expanded statewide in December 2012.	3/12/2015
FL	Eligibility	MASBOE	2006: In January 2006, (when Medicare Part D was implemented) some shifts by MASBOE group occurred. Enrollment in MASBOE 21-22 declined somewhat, with a	5/21/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			commensurate increase in MASBOE 31-32. This no doubt relates to changes in dual policy noted above. FL's Pharm Plus coverage also ended in January 2006. Also in 2006-2007, a small number of enrollees were reported to MASBOE 94-95 by mistake. Another mistake from Q2 FY06 - Q4 FY08 was that aged and disabled enrollees in FL's 1115 MEDS-AD waiver were reported to MASBOE 31-32 instead of MASBOE 51-52 (state codes MM SA, MM SD, MI MA, and MI MD).	
FL	Eligibility	MASBOE	2008: In Q4 FY08, FL had some major shifts in its MASBOE reporting as it changed its MMIS contractor. This resulted in part because FL began to report to MASBOE 51-52, correcting an earlier problem. However, there were other unexpected shifts in MASBOE 31-32, 41-42, and 44, which FL will need to investigate. These unexpected shifts involve aid categories MIIA, MIID, MWAA, MWAD, QMBA, QMBD, SLMBA, SLMBD, and MN. This file submission was also somewhat delayed, perhaps accounting for the overall 7 percent increase in enrollment.	10/19/2009
FL	Eligibility	MASBOE	FL acknowledged that an increase in enrollment of state assistance category 'MA U' (1931 eligible unemployed parent/child) from ~135,000 in September 2008 to ~170,000 in March 2009 was expected.	4/22/2010
FL	Eligibility	MASBOE	Children and adults in MAS/BOE 54 - 55 (state-specific group FP) only qualify for family planning benefits. Beginning in March 2007, FL's Family Planning waiver program entered its "2nd renewal phase" in which eligibility requirements were relaxed. As a result, enrollment in the program began to grow by roughly 5,000 enrollees each month. This trend continued through Q1 FY08.	3/3/2011
FL	Eligibility	MASBOE	FL reports disabled individuals who are over 65 years of age to BOE 2.	10/3/2011
FL	Eligibility	Race/Ethnicity	In FY06 and FY07 data, FL reported the ethnicity of 8-9 percent of enrollees as unknown.	9/18/2007
FL	Eligibility	Race/Ethnicity	Between Q3 - Q4 FY08, the percentage of persons reported in FL's Q4 FY08 eligibility file having an ethnicity code of '0' (not Hispanic or Latino) or '9' (unknown) shifted from about 65 and 8 percent to about 68 and 5 percent, respectively. FL indicated that this was correct and likely due to reporting improvements due to a new MMIS.	7/17/2009
FL	Eligibility	Restricted Benefits Flag	Children and adults in MAS/BOE 54- 55 (state-specific group FP) only qualify for family planning benefits (reported under the "other" code, 5). This changed in FY05 when this group was assigned RBF '6' (Family Planning Only). In addition, persons qualifying through the medically needy provisions are usually assigned the "other" restricted benefits code, including many full benefit duals. Finally, presumptively eligible women are assigned RBF '4' (restricted benefits for pregnancy-related services).	10/3/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
FL	Eligibility	Restricted Benefits Flag	FL reported a large increase in reporting to RBF 2 from September to October 2012 (from 1,600 to 4,600) before declining again to 2,800 by September 2013. The state is unaware of any programmatic changes and is not able to further investigate the data since it comes from a different agency Department of Children and Families.	5/19/2014
FL	Eligibility	TANF/1931	Florida cannot identify TANF recipients. All eligibles receive TANF = 9, indicating that their TANF status is unknown.	NA
FL	Eligibility	Waivers	Enrollment in FL's Medipass waiver (waiver ID '05', waiver type '2') declined by approximately 220,000 persons as of Q4 FY08. FL indicated that this was because many previous Medipass waiver enrollees were thenceforward distinctively reported as enrolled in the state's Medicaid Reform waiver (wavier ID '22', waiver type 1) whose enrollment had not been reported before.	7/17/2009
FL	Eligibility	Waivers	Until Q4 FY08, when it transitioned to a new MMIS, FL acknowledged under-reporting to the following waivers (identified by waiver ID): 13, 14, 15, 16, 17, and 20. It also acknowledged previous over-reporting of waiver ID '18' (FL's Statewide Inpatient Psychiatric Program).	7/24/2009
FL	Eligibility	Waivers	FL confirmed that an increase in the state's Community Supported Living waiver (waiver ID '09', waiver type '3') from ~6,000 at the end of Q4 FY08 to ~12,700 at the beginning of Q1 FY09 was expected and due to an increase in the enrollment cap on that waiver. Meanwhile, it also confirmed that an increase in the state's Nursing Home Diversion waiver (waiver ID '12', waiver type '3') from ~10,900 at the end of Q4 FY08 to ~15,300 at the end of Q2 FY09 was expected and due to an expansion within that waiver. Finally, FL acknowledged a reporting error (cause unknown) with the state's Channeling for the Frail Elderly waiver (waiver ID '11', waiver type '3'), which normally has enrollment between 1,300-1,400 people each month, but almost disappeared in February 2008 (with only 2 persons shown as enrolled in that month) before resuming its normal level of enrollment in March.	4/22/2010
FL	Eligibility	Waivers	Until Q4 FY08, when it transitioned to a new MMIS, FL acknowledged over-reporting the state's statewide Psychiatric Inpatient Program (waiver ID 18) by approximately 1,000 persons.	2/8/2011
FL	Eligibility	Waivers	2009-2010: FL continued to experience problems with its waiver reporting. Waiver ID 03 (Waiver Type 'F') suddenly declined from ~70,000 in Q1 FY09 to ~60,000 in Q2 FY09 (where enrollment remained for several quarters), and then suddenly declined to ~2,500 in month 3 of Q1 FY10. Waiver ID 11 (Waiver Type '3') transitioned from having ~1,400 enrollees in month 3 of Q1 FY09 to 2 enrollees in month 1 of Q2 FY09, before returning to ~1,400 in month 2. Subsequent quarters show a similar pattern of near-zero dips and rises. Waiver ID 13 (Waiver Type '3') experienced anomalous drops from ~2,700 in month 2 to ~1,100 in month 3 of Q2 and Q3 FY10. Waiver ID	8/11/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			14 (Waiver Type '3') suddenly increased from ~1,600 enrollees in month 2 of Q4 FY09 to ~4,300 in month 3, where enrollment since remained. Also, similar to Waiver ID 13, Waiver ID 14 experiences anomalous drops from ~4,700 to ~2,700 in month 3 of Q2 and Q3 FY10. Waiver ID 15 (Waiver Type '3') suddenly decreased from 334 in month 1 of Q2 FY10 to 275 and 268 in months 2 and 3, respectively, of the same quarter. Enrollment then increased to 336 in month 1 of Q3 FY10. Waiver ID 16 (Waiver Type '3') experienced anomalous drops in enrollment between month 1 and month 2 of Q2 and Q3 FY10 (from ~90 to ~40). Waiver ID 20 (Waiver Type '4') experienced an anomalous drop in enrolment between month 1 and month 2 of Q3 FY10 (from 244 to 4). When asked to address these shifts and to comment on whether or not they were expected, the state did not respond directly; however, it did say it believed reporting for Q4 FY10 onward would be more accurate.	
FL	Eligibility	Waivers	Enrollment in FL's Developmental Disabilities waiver (waiver ID '08', waiver type '3') declined by about 20 percent between months 1 and 2 of Q1 FY09 (from ~21,500 to ~17,000). The state indicated that this was due to the addition of two waivers (DD Waiver Tier 2 and 3) to serve individuals with developmental disabilities. We will continue to follow up with the state to ensure that these additional waivers are reported in MSIS.	4/6/2012
FL	Eligibility	Waivers	FL did not report data for any waivers in the third month of Q3 FY08. State indicated that it was in the midst of an MMIS transition and that reproducing the data would be very difficult.	4/6/2012
FL	Eligibility	Waivers	According to the CMS waiver portal, Florida's Channeling for the Frail Elderly 1915C waiver [waiver ID '11'] expired on 3/31/2014. However, the state stopped reporting to this waiver as of December 2013 and indicated the waiver ended July 2013.	12/1/2014
FL	Eligibility	Waivers	Enrollment for Waiver ID '11' [Frail Elderly Waiver] is normally around 1,200 per month, however it dropped to zero from March through June 2013. The state originally said this was because the waiver was being replaced by the LTC waiver and the drop was expected. However, it began to report enrollment again in July 2013 (~1,200), in which the state then replied enrollment was frozen from March to June and the Frail Elderly population was removed from the LTC transition.	12/1/2014
FL	Eligibility	Waivers	Florida has assigned the following four waivers to Waiver ID '08': -0010b.91.R4 [Developmental Disabilities HCBS Tier 1 1915c Waiver]; implemented on 10/01/2008 -0482.R01.00 [Developmental Disabilities HCBS Tier 2 1915c Waiver]; implemented on 10/01/2008 -0483.R01.00 [Developmental Disabilities HCBS Tier 3 1915c Waiver]; implemented on 10/01/2008 -0867.R00.00 [FL DD Individual Budgeting (iBudget) 1915c Waiver]; implemented on 3/15/2011 Beginning in Spring 2011, the state transitioned the four DD waivers (DD Tiers 1-3 and Community Supported Living DD Tier 4 [Waiver ID '09']) to	12/1/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			the iBudget Waiver. The transition was expected to be fully implemented by June 2013. During the transition, the Developmental Disabilities Waivers (Tiers 1-4) were active for reporting in 2012; but inactive for 2013. In 2013, the state reported the iBudget to Waiver ID '08' in MSIS. From the state: For waiver type '08' - Florida does not receive the data from DCF broken out as you would like. Therefore, at this time, Florida Medicaid is unable to differentiate enrollment in each unique Developmental Disabilities waiver for reporting. Florida will resolve with the second phase of T-MSIS implementation; working with our sister agency to make the modification that will allow Florida to differentiate enrollment for each DD Tier. Further, in December 2013, about 750 remaining in Waiver ID '09' [DD Tier 4]. When asked why reporting continued for this waiver, the state indicated those individuals were not disenrolled properly and is working with APD to determine why.	
FL	Eligibility	Waivers	Through Q1 FY14, Florida reports three distinct waivers to Waiver ID '07': -40205.R01.00 [Familial Dysautonomia 1915c Waiver]; implemented on 1/1/2010, expires 12/31/2014 - 0962.R00.00 [Long-term Care Managed Care 1915c Waiver]; implemented on 7/1/2013, expires 6/30/2016 -FL06 [Florida Coordinated Non-Emergency Transportation 1915(b) Waiver]; renewed for 4/1/2012 – 3/31/2014 The state said it is unable to determine enrollment based on other enrollment statuses and will not be correcting and resubmitting the affected files. Therefore we cannot distinguish individual waiver enrollment. The state plans to correct this in it Q2 FY14 submission. Specifically it plans to continue reporting the NET 1915B waiver to ID '07', and begin assigning the Familial Dysautonomia 1915c Waiver to ID '32' and the LTC waiver to ID '24'.	12/1/2014
FL	IP	Adjustments	There are a very large percentage of adjustment claims in most quarters, possibly due to frequent rate changes.	9/4/2005
FL	IP	DRG	Florida does not report DRGs.	4/19/2011
FL	IP	Revenue Code	In 2009, the percent of claims without ancillary codes is much higher than expected for Q3 & Q4.	NA
FL	IP	Revenue Code	In 2010, the percent of claims without ancillary codes is much higher than expected for Q1.	4/6/2010
FL	IP	Service Tracking Claims	Large expenditures are reported on service tracking claims - often amounting to more than is reported on FFS claims.	9/4/2005
FL	LT	Adjustments	Approximately 60 percent of LT claims are non-Original claims.	4/9/2012
FL	LT	Crossovers	FL did not report Crossover claims in the LT file in 2009, 2010, and 2011.	3/16/2012
FL	LT	Diagnosis	Diagnosis codes are missing on many claims.	4/19/2011
FL	LT	Type of Service	There aren't any claims with a Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22) as Florida does not cover these services.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
FL	OT	Managed Care Plan IDs	Starting in Q1FY2010, hundreds of managed care plans showing up in OT but not in the EL file.	4/2/2012
FL	OT	Medicaid Amount Paid Total	Q1FY2009 files show an increase of 36% in the number of claims compared with the previous quarter. Florida states that this is caused by providers not submitting claims from Q4 until transition of MMIS was complete. Unable to find corroborating information for the big increase however.	NA
FL	OT	Service Tracking Claims	Some PHP and HMO capitation payments reported as Service Tracking claims.	3/24/2006
FL	OT	Type of Service	In FY2010 and FY2011, the state reported all of its capitation payments (Type of claim=2) to Type-of-Service (TOS) =20 (Capitation payments to HMO, HIO, or PACE plans). These plans should have been reported to TOS=21 (Capitation payments to Prepaid Health Plans) or TOS=22 (Capitation payments for PCCM).	4/2/2012
FL	RX	Managed Care Encounters	Prior to Q4FY2009, the state did not report RX encounter claims to MSIS.	3/16/2012
GA	_All	MSIS ID	The state assigned new MSIS IDs, provider IDs, case numbers and provider specialty codes beginning with Q3 2003. GA replaces the new MSIS IDs with the old IDs on the MSIS files before submitting them to CMS. People who enrolled for the first time after the new MSIS ID system was implemented will only have the new IDs.	NA
GA	Claims	Medicaid Amount Paid Total	In July-Sept 2006 a new HMO started resulting in the reduction of the number of FFS claims.	3/16/2008
GA	Eligibility	1115 Waivers	CMS approved Georgia's 1115 Health Baby Family Planning waiver (Waiver ID "HB") on 29Oct2010 with an effective date of 01Jan2011. However, the state did not begin to report enrollment in the waiver until January 2012 [Q2 FY 2012]. It initially reported enrollment of 13,600 in January 2012. But this figure has increased steadily over time and averaged about 40,200 per month during Q4 FY 2013. Previously the state assigned virtually everyone in the waiver to MASBOE '35' [Poverty-related; Adult]; but it started to report them to MASBOE '55' in July 2013. Since it began reporting enrollment, Georgia has assigned virtually all of the enrollees to SSG '181', although there are a relatively small number [< 300 per month] in SSGs '180' and '182'. When it first began reporting Family Planning enrollees to MSIS, the state assigned them to RBF '1' [Full benefits]. However, in July 2013 it started to report all but 200 of them to RBF '6' [Restricted –Family Planning]. Under this Demonstration waiver, the State provides a limited Medicaid benefit package of family planning and family planning-related services to populations currently not covered under the Medicaid State plan. This includes women, ages 18- 44, with family incomes at or below 200 percent of the FPL, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP) and do not have any other health insurance.	1/31/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			The Demonstration also provides coverage for inter-pregnancy care services to women who meet the eligibility criteria cited above, and have delivered a very low birth weight baby on or after January 1, 2011. Under this Demonstration, Georgia expects to promote the following objectives: 1.) Reduce the state's low birth weight (LBW) and very low birth weight (VLBW) rates; 2.) Reduce the number of unintended pregnancies within the state; 3.) Reduce Georgia's Medicaid cost by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services; 4.) Provide access to inter-pregnancy care health services for eligible women who have previously delivered a VLBW baby; and 5.) Increase child spacing intervals through effective contraceptive use. See additional detail and update from state in Family Planning anomalies [8/11/2014]	
GA	Eligibility	CHIP	Between December 2013 and January 2014, S-CHIP (PeachCare for Kids) enrollment declined by about 5,500, (from ~220,500 to ~215,500). Between January and September, enrollment further declined by another 33,700 (to ~181,400). The overall decline between December and September, therefore, was about 29,230 [-17.78%]. According to the PeachCare for Kids website, the Affordable Care Act changed the program rules so that some families whose children were covered by PeachCare became eligible for Medicaid effective January 1, 2014. The state confirmed this policy change accounts for the decrease in S-CHIP enrollment.	3/19/2015
GA	Eligibility	Dual Eligibility Codes	GA does not automatically code dually eligible SSI recipients as QMB plus duals (code 02). Most SSI recipients are coded as dual code 08. The state has determined that it is more affordable to pay for Medicaid coverage than Medicare Part A premiums for duals who do not automatically qualify for Part A coverage. Dual SSI recipients can apply for QMB or SLMB status, but this status has no effect on the coverage/services they receive.	NA
GA	Eligibility	Family Planning	Enrollment in the state's 1115 Health Babies family planning waiver (Waiver ID 'HB') fluctuated substantially between October 2012 and December 2013. Enrollment increased 23.5% between May and July 2013; it then declined 22.7% between July and December 2013. Beginning in January of 2012, the state noted members were auto-enrolled into the Planning for Healthy Babies program. These were women being disenrolled from Medicaid after their 60 days post-delivery care and we auto-enrolled women falling off Medicaid and PeachCare for Kids. In June of 2013, GA discontinued the auto-enrollment process because the state became aware women were not completing the eligibility re-determination. Since that time, enrollment in P4HB program had been dropping precipitously to 16,000 as of around May of 2014 from a high of 41,000 in July of 2013.	8/11/2014
GA	Eligibility	Family Planning	There is a discrepancy between enrollment reported to Waiver Type 'F' [Family Planning] and enrollment reported to RBF '6'	8/11/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			[Restricted – Family Planning]. Each month the state reports about 1,000 more people to RBF '6' than it does to Waiver Type 'F'. The state indicated the MAS & BOE values are set by aid category (reported as eligibility group in the MSIS file). The restricted benefits value is set to a value of '1' (full benefits) unless a member falls into certain logic in the program. If the aid category is in the range 180-183, then the restricted benefits flag is set to '6'. There are a few members who also have a benefit plan / aid category that causes the restricted benefits flag to be set to '2' for EMA (alien) for a certain month, but this is very uncommon according to the state. The P4HB waiver is set based on the member being enrolled in the P4HB managed care plan. There are some members who have the aid category to set the MASBOE to '55' and the restricted benefits flag to '6', but they are not in the plan for the month being reported. These are the members who will not be reported as being in the Family Planning waiver. This situation seems to occur because some members are not auto-enrolled in the P4HB waiver even though they have the aid category that should have them enrolled in that waiver. In addition, some members are in the P4HB waiver but are also in another aid category that is reported at a higher rank than the one in the 180-183 range. This causes the MASBOE to be a value other than '55' and the restricted benefits flag is not '6' (usually it is '1'). Members' eligibility is determined by another eligibility source.	
GA	Eligibility	HCBS Waiver	Beginning with Q1FY 2011, GA began to report that a large number of non-HCBS enrollees were receiving HCBS-type waiver services (70% - 80% (between 16,000 and 20,000) of non-HCBS enrollees had an HCBS-type service. These individuals appear in the EL file without Waiver Type '3' (1915(c) Home and Community Based Care waiver) in one of the three waiver fields. They also have claims with a Program Type '6' ("Home and Community Based Care for Disabled Elderly and Individuals Age 65 and Older") or '7' ("Home and Community Based Care Waiver Services") in the 'OT' file. Further, the state attributed roughly 30% - 35% of its HCBS expenditures to non-HCBS enrollees. Total expenditures for the non-HCBS group were considerable; roughly $73.3 million in Q4 FY 2012 and $66.1 million in Q1 FY 2014. This issue was raised with the state to which they indicated one contributing factor may be that members are receiving claims for the SOURCE waiver, but the state was not reporting members as being in this waiver. The SOURCE waiver was combined with the HCBS Community Care Service Waiver (CCSP; Waiver number 0112.R06.00; Waiver ID "CC") in 2011. The Georgia Department of Community Health's Aging and Special Populations Unit administers SOURCE to approximately 19,000 elderly and disabled beneficiaries statewide [SOURCE: https://dch.georgia.gov/service-options-using-resources-community-environment-source], which is consistent with our findings (16K-20K per quarter with non-HCBS with HCBS-type claims). These members are not being set up with a prior authorization of 'S' for the CCSP waiver. As a result, a claims	8/11/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			that has a category of service value for the SOURCE waiver ('851' or '930') is receiving a program type of '7'. Although the state reports those COSs to the OT claims file, they indicated we will not be able to identify these members until T-MSIS is in production. Also, the member is not having the waiver type and ID assigned. This, the state claims, is accounting for a large percentage of the waiver claims each month. For October 2013, this situation accounts for 41 percent of members and 36 percent of claims where the claim has a program type of '7' and the member does not have a waiver type of '3'. GA claims if these members are reported as being in a waiver (with a waiver type of '3' in the ELIGIBLE file), then only about 0.1 percent of members and claims would have this issue. GA indicated SOURCE waiver enrollees are not assigned to a state-specific eligibility group in the Eligibility file, therefore we currently have no way of identifying them in the Eligibility file. From GA: A Customer Service Request (CSR) has been created in order to make enhancements to the MMIS necessary to accommodate these requirements for SOURCE PA Development. This will require a three phase process with a target date for when SOURCE claims will begin processing with a PA (Type SC) will be 7/2015.	
GA	Eligibility	Managed Care	According to information we received from the state, Georgia ended its ASO [Administrative Services Only] program on 31Jul2010. The data indicate that the state did not end the program all at once. The change was not reflected in the PCCM count until October 2010, when enrollment fell from 134,000 in September 2010 to 117,000 in October 2010.Enrollment remained in the 110,000 – 120,000 range until April 2011, when it again fell to about 79,000 per month. Georgia stopped reporting PCCM enrollment entirely in October 2011.	1/31/2014
GA	Eligibility	Managed Care	As of Q1 FY 2011, Georgia began to report three new comprehensive managed care plans: 1) 060442313A [AmeriGroup]; 2) 090828618A [WellCare]; and 3) 090828618A [Peach State]. CMS confirmed that the IDs assigned to them represent each as a statewide entity, rather than a regional version of the plan. Thus Peach State which was formerly assigned Plan IDs 559695479A [Atlanta], 559695479B [Central], and 559695479C [Southwest] is now assigned a single ID, 956691585A.	1/31/2014
GA	Eligibility	Managed Care	The state uses Plan Type '08' for its non-emergency transportation managed care plans [IDs: '003121981A', '003121981B', '003123028A', '003123031A', '732260632I']	11/6/2014
GA	Eligibility	Managed Care	GA reported substantial increases in Comprehensive Managed Care [PLAN-TYPE '01'] enrollment between January and September 2014. Total enrollment increased from 930,500 in January to 1,148,600 in September, or 23.44%. The increase was steady and found in each comprehensive plan (Amerigroup, WellCare, and PeachState). There were also substantial increases in Non-Emergency Transportation Managed Care	3/19/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			(NEMT) [PLAN-TYPE '08'] reporting between January and September 2014. Total enrollment increased from 1,260,000 in January to 1,500,000 in September, or 19.02% (see graph below). The increase again was steady and found in each of GA's five NEMT plans. The state indicated the increases were caused when they shifted from conducting six month [eligibility] reviews to twelve month reviews. Under the ACA the federal regulations were changed to require reviews every twelve months. There was a period of time on which reviews were not conducted in order to switch to the new annual review process. Consequently enrollment increased across the board for each plan. When GA began the reviews again, the enrollment began to decrease (although not at the rate expected). This should result in changes seen going forward.	
GA	Eligibility	MASBOE	A few substantial changes in MASBOE reporting between December 2013 and September 2014. Specifically we saw increases in child and adult enrollment during this period. Documentation on the Kaiser Family Foundation website and Medicaid.gov suggests enrollment increased in part because of new Affordable Care Act provisions (effective January 2014) requiring simplified eligibility and enrollment processes. The state agreed with this explanation when we raised this issue with it, and also stated the increase in the Federal Poverty Level have allowed more families to qualify for Medicaid.	3/19/2015
GA	Eligibility	Race/Ethnicity	Georgia does not assign anyone an old RACE-ETHNICITY-CODE of '7' [Hispanic or Latino and one or more races] or '8' [More than one race (Hispanic or Latino not indicated)].	1/31/2014
GA	Eligibility	Restricted Benefits Flag	From at least Q1 FY 2010 through Q4 FY 2013, Georgia assigned women with restricted pregnancy-related benefits [RBF '4'] to MASBOE 35 [Poverty-related/Adult] only.	1/31/2014
GA	Eligibility	Restricted Benefits Flag	Georgia assigns women in its Breast and Cervical Cancer Prevention and Treatment program to RBF '5' [Restricted – other] and MASBOE 3A [Poverty-related/BCCPTA].	1/31/2014
GA	Eligibility	Retroactive/ Correction Records	Georgia stopped reporting retroactive/correction records in Q1 FY 2009, because the systems from which its MMIS contractor [ACS] pulled the quarterly MSIS EL record had already reconciled all previous quarters. This was due in part to corrections ACS made in response to our review comments on the state's Q1 FY 2009 data. CMS and the state decided that any attempt to construct additional retro/correction records that would modify those earlier quarters would be too time-consuming and resource-intensive to pursue. Georgia resumed reporting retro/correction records in January 2012 [Q2 FY 2012]. Since that time, the state has reported about 28,000 retro records [1.1%] per quarter. Georgia also has reported about 690,000 correction records [26.3%] per quarter over the same period. As of Q4 FY 2013, we have not determined that whether the state implemented these records correctly.	1/31/2014

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
GA	Eligibility	Retroactive/ Correction Records	The number of retroactive and correction records reported in Q4 FY14 was about half of what GA normally reports. Between Q3 and Q4, the number of correction records fell from 625,300 to 272,400, while the number of retroactive records fell from 36,500 to 16,800. Typically GA's Eligible files consist of 1-2% retroactive records and 22-28% correction records. However, the Q4 FY14 file included .7% retroactive and 12% correction records. The state explained that the time period in question (2014 quarter 4) would be for data from July-Sept 2014 and its retroactive process is for the prior 4 quarters. GA's noted its member data come from various external vendors which could result in the changes we noted above. The state further suggests that shifting from 6 to 12 month eligible reviews per the ACA may have allowed for this decrease to occur.	3/19/2015
GA	Eligibility	SSN	GA indicated that its PeachCare for Kids (PCK) vendor was assigning pseudo SSNs that began with a "9" to PCK kids. This has affected data on an ongoing basis, and will continue to do so (i.e., state will not be asked to change this for now). These pseudo SSNs need to be 9-filled. GA also has historically had a few hundred SSNs that begin with an "8", which is an invalid first digit until June 2011, when SSN randomization took effect.	9/5/2012
GA	Eligibility	State-Specific Eligibility	Georgia began to assign enrollees to State Specific Group '181' in January 2011. Initial enrollment in Q2 FY 2011 was relatively low [< 250 per month]. It increased gradually between January and November 2011, when it reached 10,300. Enrollment in the group continued to increase and averaged 41,300 per month during Q4 FY 2013. Originally everyone in SSG '181' was assigned to MASBOE 35 [Poverty-related/Adult]. It is likely that many individuals in SSG '181' have been enrolled in the state's Healthy Babies 1115 Demonstration Waiver [Waiver ID 'HB'] since its beginning. But, we cannot say for sure, because Georgia did not start to report enrollment in the waiver until January 2012. So, there was an extended period when people were reported to SSG '181'; but not to a waiver. The state began to report enrollment in both SSG '181' and Waiver 'HB' in January 2012. Initially there was a substantial difference in the number of people reported to SSG '181' and the number reported to Waiver 'HB'. In March 2012, for example, there were 31,400 SSG '181'; but only 22,100 in the Family Planning Waiver. This has changed over time and now virtually everyone in SSG '181' is in Family Planning. As of July 2013, the state reported almost everyone in the waiver to MASBOE 55 [Demonstration/Adult] and RBF '6' [Restricted – Family Planning].	1/31/2014
GA	Eligibility	TANF/1931	Georgia cannot accurately identify TANF recipients. The field is 9-filled for all eligibles.	NA
GA	Eligibility	Waivers	The effective date for Georgia's 1915c Community Based Alternatives for Youth (CBAY) waiver [Waiver ID 'CB'] was 03Aug2009. However, the state did not begin to report enrollment in the waiver until May 2013. Total enrollment is	1/31/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			comparatively low and averaged about 36 individuals per month as of Q4 FY 2013.	
GA	Eligibility	Waivers	There is a serious issue with Georgia's HCBS waivers that began in FY 2011. We did not see a problem in reporting claims for individuals assigned as HCBS enrollees. Each month, about 92.0% of those individuals identified as HCBS enrollees actually have HCBS-type claims. The problem is with individuals identified as Non-HCBS enrollees. Since Q1 FY 2011, the state has reported about 84% of them each quarter with an HCBS-type claim. The expenditures associated with the Non-HCBS enrollees increased substantially between Q1 FY 2011 and Q1 FY 2013. Total expenditures were $51.9 million in Q1 FY 2011 versus $73.8 million in Q1 FY 2013. This represents an increase of 42.2% over the entire period. - See update from state under HCBS waiver anomalies [8/11/2014] Update July 2014: Beginning with Q1FY 2011, GA began to report that a large number of non-HCBS enrollees were receiving HCBS-type waiver services (70% - 80% of non-HCBS enrollees had an HCBS-type service). These individuals appear in the EL file without Waiver Type '3' (1915(c) Home and Community Based Care waiver) in one of the three waiver fields. They also have claims with a Program Type '6' ("Home and Community Based Care for Disabled Elderly and Individuals Age 65 and Older") or '7' ("Home and Community Based Care Waiver Services") in the 'OT' file. Further, the state attributed roughly 30% - 35% of its HCBS expenditures to non-HCBS enrollees. Total expenditures for the non-HCBS group were considerable; roughly $73.3 million in Q4 FY 2012 and $66.1 million in Q1 FY 2014. This issue was raised with the state to which they indicated one contributing factor may be that members are receiving claims for the SOURCE waiver, but the state was not reporting members as being in this waiver. The SOURCE waiver was combined with the HCBS Community Care Service Waiver (CCSP; Waiver number 0112.R06.00; Waiver ID "CC") in 2011. These members are not being set up with a prior authorization of 'S' for the CCSP waiver. As a result, a claims that has a category of service value for the SOURCE waiver ('851' or '930') is receiving a program type of '7'. Although the state reports those COSs to the OT claims file, they indicated we will not be able to identify these members until T-MSIS is in production. Also, the member is not having the waiver type and ID assigned. This, the state claims, is accounting for a large percentage of the waiver claims each month. For October 2013, this situation accounts for 41 percent of members and 36 percent of claims where the claim has a program type of '7' and the member does not have a waiver type of '3'. GA claims if these members are reported as being in a waiver (with a waiver type of '3' in the ELIGIBLE file), then only about 0.1 percent of members and claims would have this issue. GA indicated SOURCE waiver enrollees are not assigned to a state-specific eligibility group in the Eligibility file, therefore we currently have no way of identifying them in the Eligibility file. From GA: A	1/31/2014

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			Customer Service Request (CSR) has been created in order to make enhancements to the MMIS necessary to accommodate these requirements for SOURCE PA Development. This will require a three phase process with a target date for when SOURCE claims will begin processing with a PA (Type SC) will be 7/2015.	
GA	IP	DRG	Georgia submitted the DRGs as character instead of numeric. During the Valids edits, if the DRG is character, it is converted to 0. This was corrected starting with the 2003 files. The DRG codes are on the state backup files, just not the Valids.	3/3/2011
GA	IP	DRG	Beginning in FY2010 Q1, the state excluded DRGs in its MSIS IP file submissions.	1/10/2013
GA	IP	DRG	HP has not reported DRG since they began submitting files in 2011. DRG information will be reported it in T-MSIS.	12/22/2014
GA	IP	Family Planning	There are very few claims with a Program Type of 2 (Family Planning)	12/10/2004
GA	IP	Managed Care Encounters	GA appears to have submitted encounter claims with a Type of Service of FFS in the IP file in 2008-2009 and possibly earlier. These claims can be identified by linking the dates of service with the dates of MC enrollment in the eligibility file.	12/2/2010
GA	IP	Managed Care Encounters	GA submitted no IP Encounters for Q3 2009 through Q4 2010. The State incorrectly submitted IP encounters as FFS claims for the period. All of the claims in question should have had PLAN-ID-NUMBER = '888888888888'. They did not. Instead, they had a PLAN-ID-NUMBER = '999999999999' or some other value. These claims also had non-zero values in the Medicaid Amount Paid field. The State resubmitted all of its IP files for FY 2010. While the State corrected the problem with Plan ID, it continued to report Encounters with non-zero values in the MEDICAID-AMOUNT-PAID field. Using data from the first and second submissions, we estimate that GA overstated the Amount Paid for FFS claims by an average of $200 million per quarter during FY 2010. The State was not asked to resubmit files for Q3 2009 or Q4 2009 which exhibited the same problem. As a result, there is no way to accurately estimate the actual Amount Paid on FFS claims for those two quarters. The State corrected both issues in its Q1 and Q2 1011 submissions. All encounters had a PLAN-ID_NUMBER = '888888888888'. All Encounters had a MEDICAID-AMOUNT-PAID = $0. Without correcting for this discrepancy, researchers may grossly under estimate the cost of FFS IP claims for the period in question.	5/31/2011
GA	IP	Revenue Code	2014Q3 - The lower number of ancillary codes is due to a change the state made in May 2013. Before this change, they processed all detail records for an inpatient claim regardless of the status (paid or denied) of the detail. With that CO, the state removed denied details from being processed. Many of the ancillary codes that had been previously reported were for denied details. Once the state stopped reporting info from these	12/22/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			denied details, they suddenly had many fewer ancillary codes being reported.	
GA	LT	Crossovers	GA reported no FFS Original Crossovers in its Q1FY2011 LT submission. It had reported a substantial number in the three prior quarters (Q4FY2010 =4,800; Q3FY2010 = 7,769; Q2FY2010 = 6,006). The State has confirmed that the count for Q1FY2011 is accurate.	5/20/2011
GA	LT	Diagnosis	There are no diagnosis codes on the file prior to Q2FY2003. Most diagnosis codes in Q2 have a length of 3. This was corrected starting with Q3FY2003. Also, very few claims have Leave Days.	3/3/2011
GA	LT	NPI/Taxonomy	The percentage of FFS Non-crossover Original claims with a valid NPI declined sharply between Q4FY2010 and Q1 2011. In Q4FY2010, the State reported that all of its FFS Non-crossover Originals had an NPI. The percentage of claims with an NPI fell to 29.7% in Q1FY2011. The percentage of FFS Non-crossover Original claims with a valid PROVIDER-TAXONOMY declined substantially between Q4FY2011 and Q1FY2011. In Q4FY2010, the State reported that all of its FFS Non-crossover Originals had a Provider Taxonomy. The percentage of claims with a Taxonomy fell to 29.9% in Q1FY2011. Georgia changed its MMIS to HP (formerly EDSS) in Q1FY2011. It believes that the changes cited above are the result of that switch.	5/20/2011
GA	LT	Patient Liability	The percent of claims with Patient Liability is lower than expected.	12/10/2004
GA	LT	TPL	There is no reported Other Third Party Payment (or Third Party Liability/TPL).	12/10/2004
GA	LT	Type of Service	There are no claims with a Type of Service of "02" or "04" as Georgia does not cover either IP Psychiatric Care for those Under 22 nor IMD services for those age 65 and older.	12/10/2004
GA	OT	Managed Care Capitation	BHO capitation claims not included in the FY2009 files	NA
GA	OT	Managed Care Capitation	Capitation claims for transportation managed care are not included in the files through FY2006.	NA
GA	OT	Managed Care Capitation	The State of Georgia normally make 1.13 million cap payments for TOS 20 each month. During Q2FY2011 the State made roughly 6.7 million retroactive payments in Oct 2010. This had a substantial impact on calculating the ratio of enrollees to cap payments for the quarter.	1/5/2012
GA	OT	Managed Care Plan IDs	The Provider ID is reported in the Plan ID field until Q3FY2009.	NA
GA	OT	Managed Care Plan IDs	The Plan IDs for transportation managed care in the eligibility files do not link with the Plan IDs in the claims.	3/3/2011
GA	OT	Managed Care Plan IDs	2014Q3 - Plan ID 300040436AD is a GBHC plan, and the encounter is from July 2011. GBHC is the plan with hundreds of	12/22/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			plan IDs that were directly related to the provider. There is one encounter with this plan ID. The file has one other plan ID that is GBHC – plan ID 300023687A. There are six encounters (14 total details in the file) for one member. This one was from July 2010 and no longer an active plan ID and since we believe we didn't provide a list of providers for this plan since there were hundreds that could be associated with this plan. Any encounters with this plan should have a date of service at least two years old. There were 3,510 distinct claims (original and adjustment, not including voids) with a total of 8,279 details that were reported with a plan ID of all 9s. This can happen for one of three reasons. 1. Sometimes we process an encounter for a service date where the member is not enrolled in a plan. What can occur is that the member goes to the provider after he is no longer in that plan, and the provider submits the encounter. There are also a few cases where the beginning date of service for the first detail is not within the dates on the plan, but the DOS for another detail is within the dates. Since we use the beginning DOS on the first detail (it's almost always the only DOS for the entire claim), we miss a very few that way. This accounts for 1,292 (16%) of the encounters with plan ID of 9s. 2. If the type of service is for a transportation encounter (TOS = 21 or 26), we check to make sure the member has an NET plan. We have several cases where a member has a transportation encounter but no active NET plan. He may have another type of plan. But since there is no match on the NET plan, we don't find a plan ID for that encounter. This accounts for 5,113 (62%) of the encounters with plan ID of 9s. This is a change we made almost three years ago to correct an issue that CMS reported to us. 3. Benefit plan FCCMO – the new Foster Care plan, Members in this plan do not have a managed care plan ID assigned to them in MSIS. The earliest date for one of these plans is March 2014. This accounts for 1,874 (23%) of the encounters with plan ID of 9s.	
GA	OT	Place of Service	Over one quarter of the original, FFS claims have a Place of Service of 99 (Unknown).	12/10/2004
GA	OT	Type of Service	There aren't any claims with a Type of Service of 30 (Personal Care Services) as Georgia does not cover these services in its state plan.	12/10/2004
GA	RX	Family Planning	There aren't any Family Planning claims.	12/10/2004
HI	_All	Managed Care Plan IDs	HI reported on 8/5/14 that in January, they will switch to having two Plan IDs for all their managed care. One "regular" and one for their Aged, Blind, Disabled population. The latter will be identified with an "X" in front of the name.	8/5/2014
HI	Claims	Crossovers	There was a dramatic drop in crossover claims reported in HI's FY 2010 files (beginning in October 2009). The number of FFS crossover claims dropped substantially but there are no encounter crossovers reported therefore there is a substantial	10/20/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			net decrease in the number of crossover claims. The state asserts that the claims reported to MSIS are accurate.	
HI	Claims	ICN	Hawaii uses different ICN number lengths for claims - 12 byte for facility, 14bye for professional	9/24/2014
HI	Claims	Managed Care	The volume of encounter data fluctuates significantly quarter-over-quarter in Hawaii MSIS files. Hawaii has told Arizona (claims processor and MSIS file creators) that this is how they receive records from plans. Arizona has in turn informed CMS that it also received encounter records in "batches," often for "old" encounters. As a result, TOS categories also fluctuate quarter over quarter in encounter records.	9/24/2014
HI	Eligibility	1115 Waivers	HI's 1115 "Quest" waiver is a comprehensive demonstration that mandates managed care coverage for most child and adult Medicaid enrollees, and some non-dual aged and disabled enrollees. In addition, it expands coverage to some children, adults, and disabled enrollees. The waiver was originally implemented in 1994. Initially the waiver converted approximately 108,000 individuals from three public medical assistance programs including: AFDC individuals, General Assistance individuals (including 9,900 Medicaid eligible children) and participants in the former state funded health insurance program. In January, 2006, HI extended its 1115 program to also include children from 200-300% FPL using Title XXI funds, and childless adults up to 100% FPL. As of February 2009, HI appeared to have transitioned its aged, blind, and disabled population (including those within four of its 1915(c) waivers) into capitated managed care through the Quest Expanded comprehensive section 1115 demonstration waiver.	11/18/2010
HI	Eligibility	1115 Waivers	2009: HI has several hundred enrollees assigned to MAS 5 who otherwise do not show enrollment in the 1115 "Quest" waiver.	10/6/2011
HI	Eligibility	1115 Waivers	As of October 1, 2013, HI stopped reporting to MASBOE '52' and '54' [SSEG 'H19']. This is because under the new ACA provisions, these individuals, and the services they are entitled to, are now covered under normal Medicaid and where therefore removed from HI's 1115 demonstration waiver. Further, effective 10/1/2013, 'H19' enrollees were supposed to be moved to 'A41' [MASBOE '35'] as part of the state's new Eligibility group mapping. The state created the new group 'A41', but left it under MASBOE '55' and failed to move it to MASBOE '35'. HI is aware of the issue and plans to fix it for the next submission.	1/20/2015
HI	Eligibility	1115 Waivers	Between July 2012 and September 2013 enrollment in MASBOE '52' increased from 3,200 to 12,100. A majority of these people are assigned to State Specific Group 'H19' [QUEST-net]. HI's indicated the increase was expected and a result of typical progression of 'safety net' population.	1/20/2015
HI	Eligibility	1115 Waivers	In Q1–Q2 FY 2014, about 62,000-80,000 MAS '5' cases were not assigned to Waiver Type '1' because these individuals were removed from the state's 1115 Demonstration as the result of	1/20/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			new ACA provisions. The associated Eligibility Groups ('A21', 'A41', and 'A43') were supposed to be mapped to MASBOE '35' beginning in October 2013. However, they were incorrectly mapped to MASBOE '55'. The state is aware of this issue and is working to correct it.	
HI	Eligibility	CHIP	Hawaii has an M-CHIP program, but no S-CHIP program. The M-CHIP program did not begin enrollment until January 2000 and didn't appear in MSIS until July 2000. M-CHIP reporting in MSIS and SEDS was consistent until Q3 FY08 when SEDS counts became 18-20 percent higher. We have asked HI to explain this divergence.	9/25/2009
HI	Eligibility	CHIP	Beginning in Q2 FY10, H75 and H76 are reported to MASBOE 44 rather than 54 (because they are Title XXI Medicaid Expansion enrollees eligible under an 1115 Expansion [Quest-NET], they should ostensibly be reported [with CHIP = 2] and to MASBOE 54). The state indicated that both key codes were now part of the Medicaid State Plan, hence reporting to MASBOE 34. We will inquire again with HI to confirm this, since it affects HI's ability to report these children as M-CHIP (CHIP = 2) (i.e., at that point M-CHIP would be reported to MASBOE 34).	5/14/2012
HI	Eligibility	CHIP	Between Q1 FY10 - Q4 FY10, HI failed to accurately report individuals as having a CHIP flag = '2' -- i.e., only key codes H71, H72, and H76. However, HI did accurately report the change of CHIP status for individuals in key code H75: QUEST-Net State Employed. The state indicated that persons in this key code correctly had their CHIP flag set to = "1" through April 2010 and then switched to "2" as of May 2010.	5/14/2012
HI	Eligibility	Dual Eligibility Codes	HI did not report to dual code 04 until Q2 FY05. Prior to Q2 FY05, these enrollees were reported to dual code 08. In addition, QI recipients were reported to dual code 03 (SLMB) instead of dual code 06 until Q2 FY05.	NA
HI	Eligibility	Dual Eligibility Codes	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL, explaining the relatively small number of QMB-only duals (dual code 01).	NA
HI	Eligibility	Dual Eligibility Codes	Between Q4 FY04 and Q1 FY05, HI's full dual distribution changed. Roughly 8,000 disabled full duals in MASBOE 12 and 32 shifted from dual code 02 to dual code 08. It seems likely that most full duals in MASBOE 12 and state code H23 (Disabled SSI) should have been reported to dual code 02 instead of 08. This problem was reduced somewhat for those in MASBOE 12 in Q2 FY05, but continued to appear until Q4 FY08. The problem was eliminated for those reported to MASBOE 32 in Q2 FY05. The total number of full duals reported in MSIS has been consistent.	9/25/2009
HI	Eligibility	Dual Eligibility Codes	Until Q2 FY09, HI reported its QDWI population (linked to state-specific eligibility group H40) as dual code = 00 rather than dual code = 05. After this was fixed, it was apparent that most of the enrollees were children. The state subsequently acknowledged	10/6/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			that coding of this family was an error that was fixed in February 2010. We've asked the state to clarify whether this reporting will continue past Q1 FY10.	
HI	Eligibility	Managed Care	HI's "PACEHP" program is not a full PACE, rather it is a "Pre-PACE" program operating under a waiver, and it is not reported as managed care Plan Type 06 (PACE). It is correctly reported to managed care Plan Type 01 (HMO).	7/6/2011
HI	Eligibility	Managed Care	When asked why its behavioral managed care plan remained in MSIS despite being absent from the CMS 2009 Medicaid Managed Care report, HI indicated it was still active and that the two sources should have matched with a count of 3,641 enrollees each.	10/6/2011
HI	Eligibility	Managed Care	As of February 2009, HI's 1115 Quest waiver moved most aged, blind, and disabled eligibles (as well as/including HCBS recipients) into managed care.	12/6/2011
HI	Eligibility	Managed Care	Based on information from the administrator of the Hawaii Quest waiver, CMS indicated that two of HI's three behavioral plans switched to FFS arrangements as of October 2009 (Q1 FY10)--APSBHS and CAMHDA--and that the remaining plan--DOHEIP--did the same as of October 2010. The state responded that ongoing reporting of these plans (through Q4 FY10) was an unintentional error.	5/14/2012
HI	Eligibility	Managed Care	HI's PACE program (plan type "PACEHM"), which began in Oct. 2008, should be reported to Plan Type =06 (PACE) rather than =05 (LTC). This has been incorrect at least until Q1 FY09. This plan, which has always had a relatively small count of enrollment, declined and ultimately ended as of the second month of Q4 FY10.	5/14/2012
HI	Eligibility	Managed Care	Between August and September of 2013, enrollment in the state's Ohana Behavioral Health [Plan ID 'OHANBH'] increased from 700 to 3,900. According to documentation the plan's website, HI expanded services under this plan in early 2013. Specifically, in March of 2013, it changed its Community Care Services (CCS) program, run by Ohana Health Plan, to a Behavioral Health Organization. Then in September 2013, HI began to transition members from the Adult Mental Health Division (AMHD) to CCS, expanding eligibility and benefits. Ohana assumed some functions performed previously by AMHD. The state confirmed the increased enrollment is the result of these expansion efforts.	1/20/2015
HI	Eligibility	MASBOE	From FY02 Q1 forward, enrollment is no longer reported to MASBOE 35, since the H03 group includes both pregnant women and adults covered under the 1115 waiver. This group is now mapped to MASBOE 55.	NA
HI	Eligibility	MASBOE	Since FY 2000, Hawaii enrollment data have shown a seam effect, with enrollment the highest in month one of each quarter	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
			and the lowest in month three. Generally, enrollment rises significantly in month one of each quarter.	
HI	Eligibility	MASBOE	2009: HI was asked about anomalous patterns in MASBOE 44-45 that appeared tied to eligibility key code H44 ("Financial Disclosure"). For example, this key code had 1,785 enrollees in December 2008 and 497 in January 2009.	11/11/2011
HI	Eligibility	MASBOE	From Q1 FY03 - Present: HI has reported roughly as many as 100 individuals a month to MASBOE 99. The state describes these people as individuals who have aged out of the MASBOE group they were previously reported to, such as children turning 19. We think these individuals might still be enrolled in Medicaid, considering the time it takes to properly terminate Medicaid enrollment. We asked to state to adjust its age sort, and to continue reporting these enrollees to valid MASBOE groups. However, the state responded that it is "afraid that if we change these records to accommodate your recommendation to eliminate MASBOE 99s, we will receive a request from CMS to explain why we are assigning individuals to an eligibility code that they are not eligible for. We can use the MASBOE 99 to inform the workers to make appropriate corrections to the recipient's eligibility." Therefore, we may advise the state to treat monthly data for those assigned MASBOE 99 as not Medicaid-eligible and therefore requiring 0-filling. 8-2014 update: In Q4 FY12 - Q4 FY13 150-180 enrollees per month were assigned to MASBOE '99', a majority of which were to State Specific Group 'H72', but we believe they should be assigned MASBOE '34' (the state has not confirmed this). HI responded similarly as in the past that all of these recipients being reported under MASBOE '99' do not meet the age criteria for the eligibility group they are in. For example, H72 denotes child eligibility for children = 18 years, so those reported with MASBOE 99 were over 18 years old. The state will continue to use MASBOE 99 as long as its eligibility system continues to allow this to happen. In August 2014 the state said it was informed that its new eligibility system is working on enhancements to systematically redetermine eligibility when the recipient is reaching critical age and expect that these enhancements will be completed by the end of 2014.	12/1/2011
HI	Eligibility	MASBOE	Between September and October 2013, MASBOE '34' decreased by ~ 30,000 while MASBOE '14' increased by ~ 34,500. This is because as of 10/1/2013, children formerly in Hawaii's 1115 QUEST waiver [which were assigned to SSEG 'H03', MB '34'], were moved from the waiver and into regular Medicaid due to new ACA provisions (i.e., former 1115 services now provided under Medicaid). Those children are now reported to SSEG 'A01', MASBOE '14'.	1/20/2015
HI	Eligibility	MASBOE	Effective 10/1/2013, SSEG 'H87' should be reported to MASBOE '31'. In Q1-Q2 FY14, it was still being reported to MASBOE '41', with enrollment between 180 and 415. The state has been notified of this error.	1/20/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
HI	Eligibility	MASBOE	Effective 10/1/2014, SSEG 'A42' is being replaced by 'A44' [Low Income Adult Transition 1115 demonstration members, MASBOE '55']. The state said it had to make a rate code change, so it created 'A44' and moved all those in 'A42' to 'A44'. 'A42' should only be active in Q1-Q4 FY14.	1/20/2015
HI	Eligibility	MASBOE	In Q1-Q2 FY14 Hawaii mistakenly reported SSEG 'A32' [Adult Caretakers of 1115 demonstration enrollees] to MASBOE '15'. This group, which consists of about 560 enrollees, belongs in MASBOE '55'. The state is aware of this issue and is working to correct it for the next submission.	1/20/2015
HI	Eligibility	MASBOE	Q1 FY2014 and forward, SSEG 'A21', 'A41', 'A42', and 'A43' should not be reported to MASBOE '55'. Due to ACA provisions, those in groups 'A21', 'A41', and 'A43' are covered under normal Medicaid (no longer in 1115 waiver) and should be reported to MASBOE '35'. 'A42', meanwhile, will be replaced by 'A44' effective 10/1/2014 and should stay in MASBOE '55'. The state is aware it did not map these groups correctly in its Q1 and Q2 FY14 files ('A21', 'A41', and 'A43' are still reported to MASBOE '55'). HI plans to have it fixed for the next submission.	1/20/2015
HI	Eligibility	Race/Ethnicity	The state reports high amounts of unknown race/ethnicity (increasing from 51,626 in Q4 FY2014 to 88,038 in Q4 FY2013). The state indicated this seems to be an issue of mapping the race/ethnicity to the race codes in their new eligibility system (but indicated this is not a programming issue). Specifically, they are having a problem with correctly mapping certain race codes so instead they are defaulting to 'Unknown'. The state plans to correct mapping but does not have a time frame to complete this work. In the meantime, CMS has raised the fields' tolerance levels in order to process these files.	6/17/2014
HI	Eligibility	SSI	HI is a 209b state.	NA
HI	Eligibility	SSN	Until Q4 FY07, HI had been providing pseudo-SSNs for enrollees who did not have a legitimate SSN. The state indicated that these pseudo-SSNs could be identified by an "84" within the first two digits, followed by the seven more digits which represented the first seven digits of an ID number.	6/18/2009
HI	Eligibility	SSN	As of Q1 FY10, HI began reporting no enrollees with 9-filled SSNs. When asked whether doing so meant individuals without known SSNs could be inadvertently omitted from reporting, HI responded to CMS that the state had a project to correct all SSNs that were 9-filled because "there should not be any 9 filled SSNs." As a result, the state said, having no 9-filled SSNs should be viewed positively.	5/14/2012
HI	Eligibility	TANF/1931	Hawaii 9-fills the TANF field for all eligibles.	NA
HI	Eligibility	Waivers	As of February 2009, HI moved four of its 1915(c) waivers into its 1115 waiver. As a result, these waivers (IDs 'H3', 'H4', 'H5', and 'H6') disappear by Q3 FY09 ('H6' was missing as of Q2 FY09). The state indicated that participants utilizing services	10/6/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			previously associated with these waivers could not be tracked (using the same IDs) henceforward. Meanwhile, the sole remaining 1915(c) waiver ('H2') remains. However, its enrollment was somehow adversely affected, resulting in counts of <10 persons per month during Q2-Q4 FY09. The state indicated this waiver's enrollment should have been around 2,600 per month. As of Q1 FY10 enrollment was about 2,600 as the state indicated, but enrollment (to Waiver 'H2') dropped to zero as of Q4 FY12. 5/1/2015 update: the state corrected Waiver H2 enrollment in Q4 FY12 and forward. These files were resubmitted in late April 2015.	
HI	IP	All	Hawaii has noted that they submit encounter records to their processor (AZ) as they receive them. There is a significant lag in encounter data receipt and so MSIS quarters contain a variety of recent and "old" records. This results in a variety of anomalies, such as percentage of claims with principal procedure code, provider taxonomy variations, patient status variations, and ancillary code variation.	10/2/2014
HI	IP	DRG	The state does not report DRGs.	12/15/2004
HI	LT	Crossovers	FY2000: There are no crossover claims.	12/10/2004
HI	LT	Type of Service	In 2009 HI moved most of the LT residents into managed care having an impact on the distributions.	NA
HI	LT	Type of Service	There are no claims in the file with a Type of Service of IP Psych < 21 although the state covers that service.	12/15/2004
HI	OT	Amount Charged	Amount Charged is always missing in the FY1999 files.	12/10/2004
HI	OT	Managed Care Encounters	Q1FY2008: In Encounter claims, 8% of claims contain what looks to be CPT-4 codes but are reported as HCPCS codes.	NA
HI	OT	Managed Care Encounters	Q1FY2008: In Encounter claims, 86% of claims contain a service code of 'H' with a service flag of HCPCS.	NA
HI	OT	Managed Care Plan IDs	CAMHDA and APSBHS are both behavioral health carve outs. The State records enrollment so that it can communicate with the medical plans re coordination of care. However, Hawaii makes no capitation payments to these entities, as their services are FFS.	6/21/2011
HI	OT	Medicaid Amount Paid	In FY2003 there was a switch in reporting OPD claims. Prior to FY2003 the Medicaid Amount Paid on the header was repeated on each line item, over stating the expenditures. Beginning in FY2003, HI began submitting a header claims with the total amount paid and line item claims with services but no amount paid.	12/15/2004
HI	OT	Medicaid Amount Paid $0	Hawaii outpatient hospital claims will be handled the same way as the Arizona claims since Arizona is doing the MSIS file creation for Hawaii. That is, there will be a summary outpatient hospital claim with the total Medicaid Amount Paid for all line item services and then individual line item claims with $0 paid.	12/10/2004

State	File Type	Rec/Issue Type	Issue	Recorded
			This means that there will be a higher percent of claims with $0 paid.	
HI	OT	Service Code Flag	Q1FY2008: In FFS claims, 10% of claims contain what looks to be CPT-4 codes but are reported as HCPCS codes.	NA
HI	OT	Type of Service	Starting in Q1FY2008 most of the dental claims disappeared from the OT files. This is under investigation by HI. In December 2010, HI resubmitted Q1FY2008 file that contains dental claims, so this is no longer an issue.	NA
HI	RX	Date Prescribed	The fill date is reported in both the Fill and Prescribed Date fields. The state corrected starting with Q2FY2005.	3/3/2005
HI	RX	Managed Care	Hawaii introduced the Quest Expanded Access (QExA) Program in February 2009. The Program was designed to move the Aged, Blind and Disabled populations into managed care. As a result of Quest, there were substantial changes in the distribution of claims for pharmacy services. The total number of Original FFS Rx claims declined nearly 220,000 between Q4FY2008 and Q4FY2009. The total number of Encounters grew more than 186,000 over the same period. The largest change occurred in February 2009, as expected. The data clearly show a shift of the target populations from FFS to managed care. In Q4FY2008, more than 96% of persons in BOE 1 (Aged) and BOE 2 (Blind/Disabled) with a pharmacy claim had an FFS claim. In Q4FY2009, more than 99% of them had an Encounter.	6/14/2011
HI	RX	Medicaid Amount Paid Total	Starting in Q1FY2007 most of the RX FFS claims disappeared from the RX files.	NA
HI	RX	NDC	Hawaii does not report NDC codes on pharmacy encounter records	10/2/2014
HI	RX	Prescription Fill Date	During FY 2008, on average 10.6% of the Original FFS Rx claims had a Prescription Fill Date prior to the current reporting quarter. The comparable average for FY 2009 was 0.0%. It is highly unusual to have all claims within a quarter filled during that quarter. There are almost always some claims filled in earlier quarters. Hawaii was unable to provide a satisfactory explanation for the result. CMS accepted the files as sent.	6/16/2011
HI	RX	Provider Taxonomy	Hawaii does not appear to report any Durable Medical Equipment/Medical supplies (Type of Service = 19) in the prescription drug file. However, over 72% of records show a Provider-Taxonomy of 332B – Durable Medical Equipment/Medical Supplies.	3/24/2015
HI	RX	Taxonomy codes	FFY 2012 Q3 RX file does not report taxonomy.	4/28/2015
HI	RX	Type of Service	Less than 2% of RX claims in FFY 2012 Q1, Q2 and Q3 report TOS = 16 (DME), although around 70% of claims report provider taxonomy for DME/medical supplies. This problem was fixed in future submissions of RX claims.	4/28/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
IA	_All	Data System Change	As of early 2006, Iowa no longer has ACS as fiscal agent. Instead they have 9 separate contractors with "Neridian" as the "core contractor" doing "core functions" including claims payment. Other contractors do TPL, SURS, point-of-service pharmacy, provider services, and member services.	9/15/2009
IA	Claims	Amount Charged	The state fills in the Amount-Charged field on encounter records with the amount the service provider is charging to the HMO plan.	1/8/2014
IA	Claims	Crossovers	When states cannot distinguish Medicare deductible and coinsurance amounts on crossover claims, they are supposed to report the actual amount in the Medicare Deductible Payment field and code the Medicare Coinsurance Payment field as "99998." During Valids processing, the value "99998" in the Medicare Coinsurance Payment field is supposed to be reset to "0" so that users do not inadvertently use 99998 as a dollar quantity. However, the Valids processing does not reset "99998" to 0 in the Medicare Coinsurance Payment field.	12/10/2004
IA	Eligibility	1115 Waivers	Some Iowa Care members qualify for two or more limited benefit aid types. These persons are enrolled in "blended" aid type codes in MSIS. Members may be concurrently eligible for IowaCare and also Family Planning-only coverage, Pregnancy presumptive services, or BCCPT presumptive.	6/16/2010
IA	Eligibility	1115 Waivers	CMS first approved the Iowa Family Planning Network [IFPN] 1115 Demonstration [11-W-00188/7] in January 2004. The state implemented the waiver in February 2006 with an initial expiration date of January 2011. CMS approved waiver renewals in December 2011 and again in December 2013. The expiration date of the current renewal is 31Dec2016. The original IFPN waiver provided family planning services to: 1.] women losing Medicaid pregnancy coverage; and 2.] women of childbearing age with a family income = 300% of the FPL [who were not otherwise eligible for Medicaid, CHIP, or private health insurance]. In December 2011, Iowa amended the waiver, extending family planning and family planning-related services to: 1.] women losing Medicaid pregnancy coverage at the conclusion of a 60 day postpartum period; and 2.] men and women of childbearing age [12 – 54 yeas] who have a family income = 300% FPL, and who are not otherwise enrolled in Medicaid, CHIP, or a private health insurance plan that offers family planning services. In its second waiver renewal, CMS extended this coverage through 31Dec2013. Beginning on 01Jan2014, the second renewal also extended family planning coverage to individuals enrolled in CHIP or a private health insurance plan that already offers family planning services. For more information about this waiver, see the anomaly note for RBF '6'.	2/17/2014
IA	Eligibility	1115 Waivers	Iowa implemented a new 1115 Demonstration waiver, the Iowa Marketplace Choice Plan [11-W-00288/5] on 01Jan2014. The state began to enroll eligible individuals in the waiver on	2/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			01Oct2013, although the service effective date is 01Jan2014. The state will use premium assistance to purchase qualified health plan [QHP] coverage from the individual marketplace for uninsured Medicaid-eligible childless adults between 19 and 64 years of age with incomes = 133% of FPL. Individuals in the program are not otherwise eligible for Medicare or other comprehensive Medicaid benefits, and they do not have access to employer sponsored health coverage. Iowa will pay QHP premiums for people enrolled in the waiver. Members will be offered benefits through the QHP with wrap around provisions by the state Medicaid agency. This includes services like family planning at non-network providers; and, for individuals aged 19 and 20, early and periodic screening and diagnostic treatment [EPSDT]. The Marketplace Choice Plan does not include coverage for non-emergency medical transportation [NEMT] coverage.	
IA	Eligibility	1115 Waivers	The IowaCare 1115 Demonstration waiver expired on 31Dec2013. The state implemented the Iowa Wellness Plan [CMS ID: #11-W-00289/5] and the Iowa Marketplace Choice Plan [CMS Waiver ID: #11-W-00288/5] on 01Jan2014. It stopped reporting enrollment in IowaCare after Q1 FY 2014. It began to report enrollment in the new waivers in Q2 FY 2014 with Aid/Program Codes '501' and '531'.	2/18/2015
IA	Eligibility	CHIP	Q4 FY 2009-present: In July 2009, IA passed a bill designed to increase enrollment of children in Medicaid and CHIP. First, the state implemented a CHIP expansion for children with family income from 200 percent to 300 percent of FPL effective July 2009. At the same time, the state added coverage for legally residing immigrant children with income up to 300 percent of FPL. The bill included several additional provisions, including presumptive eligibility, simplified income verification, paperless renewals, and an individual coverage mandate, with varying implementation dates. IA implemented presumptive eligibility for children in Medicaid and CHIP on March 1, 2010. These enrollees are reported to MASBOE 34 and to aid group 884 and 885 starting in Q3 FY 2010. In Q4 FY 2010, IA started reporting enrollees in this aid category to MASBOE 64. IA confirmed that this group should be reported to MASBOE 34) Also in March 2010, IA implemented a dental-only managed care option for children who have private medical, but not dental, coverage, but this coverage is through S-CHIP and is not reported to MSIS. The state implemented express lane eligibility July 1, 2010. IA did not report any new aid categories at this time. These children were enrolled in MSIS but cannot be separately identified using state specific eligibility groups. IA plans to implement simplified income verification and paperless renewal as part of health care reform implementation. The state's individual coverage mandate will not affect Medicaid eligibility.	4/6/2012
IA	Eligibility	CHIP	Iowa has a combination Medicaid-expansion and separate Children's Health Insurance Program. Since Q1 FY 2010, the state has reported about 15,000 – 17,000 Medicaid-expansion	2/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			CHIP enrollees [CHIP-CODE '2'] per month to MSIS and the same number to SEDS. Iowa does not report separate CHIP enrollees to MSIS, although it does report them to SEDS. It reported M-CHIP enrollment of 127,700 to SEDS in Q4 FY 2013.	
IA	Eligibility	Dual Eligibility Codes	Iowa reports some full duals [= 100] to MAS 3 each month. Most of them are assigned to MASBOE 35. The state does not provide full benefits to people in MAS 3. According to the state, this assignment is the result of data entry errors, which it is trying to eliminate.	2/17/2014
IA	Eligibility	Managed Care	IA reports disabled full duals to behavioral health plans. The state's eligibility system assigns disabled full duals under 65 to Iowa Plan behavioral health plans, which include both mental health and substance abuse programs.	11/17/2010
IA	Eligibility	Managed Care	In 2003 Iowa discontinued enrollment in several HMOs and moved many [but not all] enrollees to Primary Care Case Management [PCCM]. As a result, HMO enrollment declined substantially around this time. By February 2005 the state had limited HMO enrollment to a single plan – Coventry Health Care. In February 2009 Iowa ended HMO enrollment completely and reassigned most people in Coventry to its PCCM plan called MediPass. Iowa began to report HMO enrollment again in March 2012. The state assigned ~ 900 enrollees to comprehensive managed care organization during the month. Total enrollment in comprehensive care has continued to increase since then, and reached ~ 34,500 in September 2013. From March 2012 through September 2013, Iowa added new plans [Plan IDs] virtually every month. It began with a single plan ['0208455'] in March 2012. As of September 2013, the state had 18 plans operating in the state. Through September 2013, more than 93% of the growth in comprehensive managed care has occurred in 6 of the 18 plans: '0208452' [Meridian HMO Cedar County], '0209707', '0210233' [Meridian HMO Polk County], '0208455', '0208453', and '0210234' [Meridian HMO Black Hawk County]. None of the Plan IDs noted above are in the state's crosswalk of managed care plans. We intend to ask the state for an updated crosswalk in our review of its Q4 FY 2013 file.	2/17/2014
IA	Eligibility	Managed Care	Iowa has had a PACE plan since September 2008. Originally, Siouxland PACE operated in six counties: Cherokee, Ida, Monoma, Plymouth, Sioux, and Woodbury. Since Q4 FY 2012, the state has had two separate PACE plans. Siouxland PACE operates in Cherokee, Monoma, Plymouth, and Woodbury counties. Immanuel Pathways operates in Harrison, Pottawattamie, and Mills counties. The state has two Plan IDs for Siouxland ['0701947' and '1701947] and one for Immanuel Pathways ['0703536']. As of Q4 FY 2013, average monthly enrollment in PACE was 190.	2/17/2014
IA	Eligibility	Managed Care	On 01Jul2005, Iowa implemented the IowaCare 1115 Demonstration waiver which CMS initially approved through 30Jun2010. According to the state's documentation, IowaCare is	2/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			a limited-benefit, public health insurance program for adults. One reason the state developed the program was to replace $65 million in federal matching funds lost through Intergovernmental Transfers [IGTs]. The IowaCare program covers: 1.] Adults, age 19 – 64 years with net family incomes 0% - 200% of FPL who are not eligible under the Medicaid State Plan [SSGs '60E' & '60H']; 2.] Newborns and pregnant women with incomes = 300% of FPL who have incurred medical expenses for all family members that reduce family income to 200% of FPL [SSGs '60P' & 60T]; and 3.] Children, age 0 – 18 years diagnosed with severe emotional disorders [SEDs] who would be eligible for State Plan services, it they were institutionalized. Members are required to pay a monthly sliding-scale premium, if they are above 100% of the FPL. Anyone below 100% of the FPL is not required to pay a premium. The IowaCare provider network is limited to the University of Iowa Hospitals and Clinics (UIHC) in Iowa City, and Broadlawns Hospital in DesMoines. The Iowa Care Demonstration was renewed for a period of 3.5 years on 01Sep2010. On 14Jun2013, CMS renewed the waiver again through 31Dec2013. CMS did this to extend the eligibility periods for individuals who would otherwise need redetermination in the last 6 month of the demonstration.	
IA	Eligibility	Managed Care	PCCM [Plan Type '07'] enrollment grew substantially between Q1 FY 2009 [N ˜ 149,700] and Q4 FY 2013 [N ˜ 282,000]. This represents an increase of more than 88.0% over the period in question. There was a notable increase in enrollment between September [N ˜ 189,500] and October [N ˜ 215,600] 2010. According to information the state provided previously, at that time the Iowa Care program expanded by adding local access services and implementing a Medical Home model of care. Since the start of the expansion enrollment has continued to increase, reaching 282,000 in September 2013.	2/17/2014
IA	Eligibility	Managed Care	Starting in July 2010, Iowa began to report enrollment in Plan Type '08' [Other] to MSIS. The state assigns Plan Type '08' to its Non-emergency Transportation [NEMT] plan. According to Iowa's documentation, the NEMT provider is TMS Management Group.	2/17/2014
IA	Eligibility	Managed Care	Starting in September 2012, enrollment in comprehensive managed care began to increase substantially. Enrollment grew from about 1,300 to about 9,500 between August and September 2012. Since that time, it has continued to increase and reached about 34,500 in September 2013. According to information provided previously, Iowa has a single HMO which it approves on a county by county basis. Plan IDs all represent the same HMO; but the state uses legacy IDs to specify the county in which it operates. As of September 2013, the HMO is active in 18 of the state's 99 counties. Iowa expects to continue its expansion of managed care into new counties. The state indicated that it planned to add 5 more counties during Q1 FY 2014. It is also evaluating plans proposed for several other counties.	2/17/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
IA	Eligibility	MASBOE	IA has some age-sorting issues with its child/adult categories. The state is working to improve this reporting.	3/3/2011
IA	Eligibility	MASBOE	Enrollment in MASBOE '35' increased substantially in Iowa during January 2014. It rose from 9,900 in December 2013 to ~87,400 in January 2014. Enrollment continued to increase and reached ~127,400 in June 2014. Two new SSGs, '501' and '531' accounted for all of the growth. The state confirmed that '501' and '531' include Medicaid expansion adults with full benefits [RBF '1'].	2/3/2015
IA	Eligibility	Private Health Insurance	Iowa reports that roughly 15% - 20% of its Medicaid population has private health insurance [HEALTH-INSURANCE = '2', '3', or '4']. Compared with most other states, this figure is substantially higher than average. The state assigns health insurance code '3' [state purchased insurance] to people in HIPP. It assigns health insurance code '4' [third party & state] to people who have a combination of self- and state-paid coverage. As of Q4 FY 2013, Iowa assigned ~ 1,500 people per month to health insurance code '3' and ~ 1,900 per month to health insurance Code '4'.	2/17/2014
IA	Eligibility	Race/Ethnicity	Iowa's Medicaid application indicates that individuals are not required to provide their race and/or ethnicity to be eligible for services. In addition, since 2007 the state has not required face-to-face interviews as part of the application and enrollment process. As a result, whether measured using the RACE-ETHNICITY-CODE or the five Race Codes, about 35% - 40% of all records have an 'Unknown' race.	2/17/2014
IA	Eligibility	Restricted Benefits Flag	Iowa implemented a Money Follows the Person [MFP] program in August 2008. Between August 2008 and September 2013, the number of people assigned to RBF '8' increased from 2 to 145 per month.	2/17/2014
IA	Eligibility	Restricted Benefits Flag	Iowa implemented an 1115 family planning waiver in 2006 called the Iowa Family Planning Network [IFPN]. Between Q1 FY 2009 and Q1 FY 2010, the fields RBF, MASBOE, Waiver Type, Waiver ID, and State Specific Group displayed a strong correspondence. Virtually all members enrolled in the IFPN were assigned to RBF '6', MASBOE 54 - 55, Waiver Type 'F', Waiver ID 'W1', and SSGs '86E' or '906'. The state assigned a substantial majority of enrollees each quarter [= 85%] to SSG '906'. It assigned nearly all of the rest to SSG '86E'. In the past the state indicated that individuals in SSG '86E' received 'blended coverage', although it did not define what it meant by blended. Between Q2 FY 2010 and Q1 FY 2013, the state did not report everyone in the waiver to RBF '6'. Each month it assigned 2,000 – 4,000 enrollees to the waiver; but not to RBF '6'. The data indicate that nearly everyone enrolled in the waiver, but not assigned to RBF '6', were assigned to SSG '86E'. Over the same period the state assigned everyone in SSG '906' to RBF '6' and Waiver Type 'F'. Iowa changed its family planning waiver reporting in Q2 FY 2013. As of Q2 FY 2013, the combination of RBF, MASBOE, Waiver Type, Waiver ID, and SSG	2/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			are again in agreement. Iowa reported an average of 29,600 people per month to the IFPN waiver during Q4 FY 2013.	
IA	Eligibility	Restricted Benefits Flag	Prior to Q2 FY 2011, Iowa reported a handful [= 5 per month] of people to RBF '2' and MASBOE 55. The state indicated that this was a reporting error and fixed the problem in January 2011.	2/17/2014
IA	Eligibility	Restricted Benefits Flag	Iowa assigns about 300 children per month to MASBOE '32' [poverty related – blind/disabled] and RBF '1' [Full benefits]. Nearly all of them are in SSG '647'. SSG '647' includes children in the Medicaid for Kids with Special Needs [MKSN] program. Iowa treats them as a standard Medicaid group entitled to full benefits [RBF '1'].	2/18/2015
IA	Eligibility	Restricted Benefits Flag	Iowa assigns about 300 individuals each month to RBF '1' and SSG '647'. The state has confirmed that they are children in eligibility group MKSN [Medicaid for Kids with Special Needs]. It state treats them as a standard Medicaid group entitled to full benefits.	4/28/2015
IA	Eligibility	SSI	As of Q4 FY 2013, Iowa reports nearly all of its SSI disabled enrollees = 65 years to MASBOE 11 [Cash/Aged].	2/17/2014
IA	Eligibility	State-Specific Eligibility	Iowa began to report two new SSGs, '501' and '531', in January 2014. It assigned roughly 79,500 individuals per month to '501' and MASBOE 35 in Q2 FY 2014. By Q4 FY 2014 the total had increased to 95,200. Iowa also assigned about 21,600 per month to '531' and MASBOE 35. By Q4 FY 2014 the total had grown to 28,900. Iowa indicated that these are new 1115 waiver groups. If that is accurate, then it should have assigned these beneficiaries to MASBOE 55 instead.	4/28/2015
IA	Eligibility	TANF/1931	Between Q2 FY 2009 and Q4 FY 2013, Iowa '9-filled' the TANF Flag for everyone except for people in MASBOE 00. The state assigned those people a TANF Flag of '0' ['Not eligible']. Prior to Q2 FY 2009, Iowa assigned persons with MASBOE 00 a TANF Flag of '9' ['Unknown'].	2/17/2014
IA	Eligibility	Waivers	See 1115 waiver anomaly for discussion of MSIS reporting for 1915(c) waiver related to emotionally disturbed children.	9/19/2008
IA	Eligibility	Waivers	Iowa has a 1915c HCBS waiver called the Children's Mental Health Waiver [Waiver ID '0819.R01.00]. According to the CMS website, the waiver currently is active. It was last renewed on 01Jul2013 through 30Ju2018. MPR had asked about the waiver in its review of Iowa's Q4 FY 2011 EL file. In a response dated 22May2013, the state indicated that it had assigned the waiver to Waiver Type '3'. However, in a subsequent email dated 05Nov2013, Iowa noted that it was actually reporting it to Waiver Type '1' and requested MPR's guidance. In its review of the state's Q4 FY 2013 El file, MPR will recommend that Iowa reassign the waiver to Waiver Type '3'.	2/17/2014
IA	Eligibility	Waivers	Iowa's HCBS Health & Disability Waiver [Waiver ID '4111.06.00'] targets physically disabled persons who are less than 65 years	2/17/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			old. The state reassigns enrollees who still need services on or after age 65 to its HCBS Elderly Waiver [Waiver ID '4155.R05.00]. The HCBS Health & Disability Waiver is also called the Ill & Handicapped Waiver.	
IA	Eligibility	Waivers	The Iowa Plan is a Section 1915b waiver that provides 'freedom of choice' for people receiving mental health and substance abuse services. Enrollees in the waiver are assigned to Behavioral Health Plans [BHPs]. Beginning in Q4 FY 2010, enrollment in BHPs and in the waiver itself increased considerably. The increase was primarily due to an influx of aged [BOE 1] enrollees. Starting in July 2010, the state began to report about 27,000 aged people per month to the waiver. This represents about 70% - 75% of all aged enrollees. The CMS waiver website indicates that the waiver has expired, although the expiration date is 30Jun2016 and the state continues to report enrollment in it.	2/17/2014
IA	IP	Family Planning	There are no claims with a Program Type 2 (Family Planning) because family planning is billed as on an outpatient basis on a HCFA-1500.	12/10/2004
IA	LT	Adjustments	Iowa's ICF/IID's must submit cost reports yearly. The reports are analyzed and new payment rates are set. Once a review is completed a mass adjustment to pay at the difference between the old rate and new rate need to be processed and are initiated by PCA. Since most cost reports are submitted at the end of a month, a mass adjustment is required to reprocess claims for the new effective date.	3/14/2011
IA	LT	Diagnosis	Residential Care Facilities are allowed to bill with an invalid principal diagnosis of V0001. The most common principal diagnosis code in IA's MSIS LT files is V0001. (see http://dhs.iowa.gov/sites/default/files/Creating%20Institutional%20Claims%20Nursing%20Facility%20(Instructions).pdf)	12/9/2014
IA	OT	HCBS Waiver	Iowa reports almost all of their HCBS waivers to TYPE OF SERVICE = 10 (as opposed to TOS = 12, 19, 33, or something else). This is incorrect reporting according to the TOS = 10 definition in the appendix of the data dictionary. This may resolve itself in T-MSIS but should continue to keep an eye on it.	10/6/2014
IA	OT	Managed Care Capitation	Managed care plan 2599993 represents health insurance premium payments. There are capitation claims for this plan but no eligibility enrollment or claims and this is appropriate. This program pays costs of enrolling in employer provided health insurance or individual insurance for Medicaid eligibles.	1/25/2012
IA	OT	Managed Care Capitation	State reports plan ID '0104899' in OT claims file but does not report a corresponding plan ID in the EL. According to state, "IME has the same contractor for BHIS and Mental health services: Magellan. Internally in MMIS, they look separate because in MMIS they have 2 separate provider numbers. Every member who has been enrolled with Magellan Mental health	2/22/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			provider number (0177394) is by default also enrolled with the Magellan BHIS provider number (0104899). Hence, on the EL file you will only see 0177394 provider number, but when generating capitation claims, you will see payments made to 0177394 and to 0104899."	
IA	OT	Managed Care Encounters	Between FY2010Q1 - FY2013Q3, state did not include TOS=08 (Physician services) encounter claims in its submissions because of a programming issue in setting the type-of-service code mapping.	9/24/2013
IA	OT	Type of Service	In the Q2FY2011 file the average Medicaid amount paid for TOS=10 jumped from $45 for the prior three quarters to $225. In addition the percent of claims for TOS10 jumped from 4% to 15%. There was an equivalent decrease in dollars and claims for TOS=19 (other services). Iowa states that it noticed many claims were being incorrectly reported to TOS 19 in the past and this was the first file where the state fixed this. This continued with the Q3FY2011 file.	10/26/2011
IA	OT	Type of Service	As of Q4FY2011, state reports a number of their OT claims with a TOC=2 and TOS=19.	1/24/2012
IA	RX	Adjustments	FY2012 Q4 showed an unusually high number of adjustment claims (4-times more than usual). The state reprocessed the previous 12-months of pharmacy claims because a dispensing fee increase was approved retroactive to August 2011.	11/29/2012
ID	_All	Data System Change	Idaho transitioned to a new MMIS on 7/7/2010.	NA
ID	_All	MSIS ID	ID changed the format of MSIS IDs in Q2FY10 causing claims adjudicated after Q1FY10 to not link to enrollments prior to Q2FY10.	4/19/2013
ID	Claims	All	Comments are all related to FFS claims unless specified otherwise.	NA
ID	Claims	Crossovers	The sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT is less than MEDICAID-AMOUNT-PAID on the majority of crossover claims in the Q4FY2010 LT, IP, and LT files. The sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT is greater than $0 on the majority of crossover claims with MEDICAID-AMOUNT-PAID equal to $0. MEDICAID-AMOUNT-PAID is greater than $0 on the majority of crossover claims where the sum of the sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT is equal to $0.	4/19/2013
ID	Claims	Data System Change	In May 2010 ID transitioned to a new MSIS contractor.	NA
ID	Claims	Type of Service	Type of service was assigned incorrectly on some claims after implementation of the new MMIS in Q4FY10. This may have also caused some claims to be reported in the wrong type of file. This was fixed on some claims by adjusting claims. Some claims could not be fixed. This was resolved in FY12.	4/19/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
ID	Eligibility	1115 Waivers	ID implemented an "Access Card" CHIP 1115 demonstration in 2005 that did not expand eligibility for M-CHIP and S-CHIP children, but offered them the option of premium assistance coverage (for private health insurance) instead of direct coverage. In Q1 FY07, the 1115 added coverage for S-CHIP adults as well, but this group only qualified for premium assistance. S-CHIP adults (which includes uninsured pregnant women, uninsured parents, and uninsured childless adults) were not reported in MSIS until Q2 FY10, nor were M-CHIP or S-CHIP children -- who are reported in MSIS -- identified as Access Card enrollees until Q2 FY10. ID indicated this was due to logistical reasons related to each data source being maintained in a separate system.	7/8/2011
ID	Eligibility	1115 Waivers	What previously had been two 1115 waivers that were different in terms of type of waiver (one 1115 with a waiver type of '1,' the other a HIFA waiver with a waiver type of '5') are now both regular 1115 waivers (waiver type '1'). The first 1115 waiver for premium assistance concerns two populations: (1) S-CHIP children; and (2) parent caretakers who fall between ~25 percent and 185 percent of the FPL. The second 1115 waiver is for childless adults and is now a Title XIX (rather than Title XXI) waiver. This covers childless adults with income between 0 and 185 percent of the FPL. This waiver started on January 1, 2010.	10/15/2012
ID	Eligibility	CHIP	Idaho reports its M-CHIP enrollment. Until Q1 FY07, M-CHIP covered children ages 0-5 from 133-150 percent FPL and 6-18 from 100 to 150 percent FPL (state codes 60 and 63).	3/22/2011
ID	Eligibility	CHIP	Effective July 2006, ID began implementing changes to its Medicaid program under the 2006 Deficit Reduction Act (DRA). These changes impacted ID's M-CHIP and separate CHIP program in two phases. In Phase I, effective from July 2006-September 2006, M-CHIP remained unchanged, but S-CHIP expanded its lower bound (had been 150% FPL) to cover children age 0-5, 133-185 percent FPL and children age 6-18, 100-185 percent FPL. In phase 2, effective Q1 FY07, both M-CHIP and separate CHIP coverage changed. From Q1 FY07 forward, M-CHIP covers all children to 133 percent FPL, including those 6-18 years old (a slight expansion). From Q1 FY07 forward, separate CHIP covers all children (0-18), 133-185 percent FPL, a slight contraction from phase 1.	9/22/2011
ID	Eligibility	CHIP	Effective Q1 FY05, ID's S-CHIP and M-CHIP programs include an 1115 demonstration called "Access Card" that allows eligible children to choose monthly premium assistance for a private insurance plan of their choice instead of the standard S-CHIP or M-CHIP benefit packages. Children receiving "Access Card" premium assistance were not included in ID's MSIS data until Q2 FY10. ID estimated that roughly 1,400 children participate in "Access Card" each month, which explains the difference between MSIS and SEDS S-CHIP reporting until that time. Almost no M-CHIP children participate in the "Access Card" program. Thus, S-CHIP enrollment is somewhat undercounted in	9/22/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			MSIS data from Q1 FY05 through Q1 FY10, but M-CHIP enrollment was reliable. In addition, ID has an adult S-CHIP population consisting of participants in the 1115 "Access Card" demonstration. Enrollment of these adults was not reported in MSIS until Q2 FY10, although they are found in SEDS.	
ID	Eligibility	CHIP	Effective Q4 FY04, ID began a separate CHIP program, and reports this CHIP group into MSIS. Until Q4 FY06, ID's separate CHIP program covered children 150-185 percent FPL.	9/22/2011
ID	Eligibility	County Codes	In Q2 FY10, ID reported 4,600 enrollees with county code 999, although no individuals were reported with this county code in Q1 FY10. In Q3 FY 10, 6,800 enrollees were reported with county code 999, and in Q4 FY 10, 6,300 enrollees were reported with county code 999. By Q1 FY11, about 10,000 enrollees were reported with county code 999. The state indicated that it would work on this issue.	10/5/2012
ID	Eligibility	Date of Death	The state does not submit date of death information.	NA
ID	Eligibility	Dual Eligibility Codes	The majority of ID's MASBOE 42 enrollees are children and thus we don't expect them to be Medicare-eligible.	3/3/2011
ID	Eligibility	Dual Eligibility Codes	ID has consistently reported about 1,000 fewer persons in MSIS than MMA to Dual Code 08. ID indicated that neither data are incorrect; rather, the discrepancy is due to timing issues that should be resolved once the state's eligibility system (EPICS) is linked to the MMIS on a daily, rather than monthly, basis.	9/22/2011
ID	Eligibility	Dual Eligibility Codes	ID routinely assigns a small number of enrollees dual code 99. Dual code 99 is used when there is a mismatch between Medicaid eligibility and dual eligibility. For example, if a client has Medicaid eligibility for the month but the dual eligibility code for that client is a Medicare only code (01, 03, etc.) the dual code is set to 99 because this combination does not make sense. When this happens, it is usually a timing issue where ID has not received the updated dual code yet.	9/22/2011
ID	Eligibility	Dual Eligibility Codes	Between Q1 and Q2 FY10, the number of enrollees assigned dual code 08 (other full dual) increased from approximately 4,500 to around 8,000. This resulted in a 47% difference in reporting of this enrollment between MSIS and MMA. Between Q3 and Q4 FY 10, the number of enrollees assigned dual code 08 (other full dual) decreased from 8,000 to about 6,500, resulting in a 34$ difference in reporting of this enrollment between MSIS and MMA. The state indicated that these changes occurred as a result of issues with their new MMIS.	10/5/2012
ID	Eligibility	Dual Eligibility Codes	In Q2 FY10, approximately 90 full duals (who we would expect to have restricted benefits flag 7) were reported with restricted benefits flag 3 (restricted benefits due to partial dual status), and approximately 140 partial duals (who we would expect to have restricted benefits flag 3) were reported with restricted benefits flag 7. We asked the state to review its data to ensure	10/5/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			that the dual and RBF flags are reported consistently in future files.	
ID	Eligibility	Dual Eligibility Codes	In Q1 FY12, Idaho stopped reporting dual eligible enrollees in the category "Other Full Duals" (Dual Code = 08). This change in reporting occurred due to changes in the eligibility setup with the new eligibility system. The state expects very few, if any, dual eligibles to be assigned as "Other Full Duals". As dual eligible enrollees are added to the new eligibility system, they are assigned to specific full dual codes instead of the "Other" category.	3/12/2015
ID	Eligibility	Managed Care	Effective Q3 FY07, ID will make premium payments for full benefit duals enrolled in BCBS Medicare Advantage Plan (called Medicare-Medicaid Coordinated Plan). BCBS will then be responsible for all Medicare copays and deductibles. This coverage will be reported to Plan Type 08 (Other).	9/17/2008
ID	Eligibility	Managed Care	ID began enrollment in a dental managed care plan(s) as of Q2 FY08.	5/4/2009
ID	Eligibility	Managed Care	In Q3 FY08, ID reported a small number of enrollees (about 300 each month) as enrolled in Plan Type 01 (comprehensive managed care). Because these plans had arrangements on a fee-for-service basis, ID was asked to refrain from reporting these enrollees as enrolled in managed care.	3/3/2011
ID	Eligibility	Managed Care	2008: ID indicated that the number of individuals reported as having dental coverage according to the annual Medicaid managed care report is higher than what's reported in MSIS because of overcounting (statistics for both Medicaid and CHIP were inadvertently submitted for the annual Medicaid report).	9/22/2011
ID	Eligibility	Managed Care	While having partial dual eligibles enrolled in Medicaid managed care plans is generally not expected, ID had been reporting about 100 individuals to PCCMs in month 3 of each quarter of Q2-Q3 FY08. ID indicated the error was due to timing and that the PCCM enrollment for that month should have been retroactively terminated each quarter, but could not be done before the data were submitted. This explains, however, why months 1 and 2 do not share this problem.	9/22/2011
ID	Eligibility	Managed Care	ID has inconsistently reported the plan ID for its Blue Cross Blue Shield Medicare Advantage Medicare-Medicaid coordinated plan. The plan was sometimes reported with plan ID '0050' and sometimes reported with plan ID '50.' This problem resolved in Q2 FY10 when the state implemented a new MMIS and created new plan IDs for all of its managed care plans.	10/30/2012
ID	Eligibility	Managed Care	For Q3 and Q4 of FY 2010, Idaho did not report any managed care data. The state confirmed that it still had managed care. Although this was fixed in the Q2 FY 2010 file, it will not be fixed for Q3 and Q4 FY 10.	11/7/2012
ID	Eligibility	Managed Care	Dental plan enrollment increased during the middle of 2011. We had assumed this is related to the expansion to the Idaho	9/12/2013

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			Smiles program to cover new groups of adults. There was also a larger than expected changes in PCCM enrollment during 2011. Counts started at about 160,000 in Q1 but then dropped to about 145,000 in Q2 and then increased to about 195,000 by the end of Q4. Despite our assumptions about program-related changes driving these shifts, the state has indicated that issues with the new MMIS caused these differences in the data.	
ID	Eligibility	Managed Care	ID's Access2Care plan (230,725 enrollees in FY12) is a 'transportation PAHP' that provides transportation services for Medicaid enrollees. These services started September 1, 2010, but it is not included in MSIS. It should be reported as Plan Type 08 in MSIS. We've asked the state to report it in MSIS.	11/13/2013
ID	Eligibility	MASBOE	2003-2006: In 2003-2006, ID had 20% more enrollees in MAS/BOE 11-12 than reported by SSI. This may have occurred because of SSI State Supplement enrollees. Also, State Group 54 may include some enrollees who are not SSI recipients. However, in Q4 FY06 there was a noticeable decline in MASBOE 11 enrollment. This decline was caused by changes implemented during ID's Medicaid Modernization Project, which better separated cash and non-cash aid categories. As a result of these improvements, MASBOE 11 decreased 25 percent while enrollment in MASBOE 41 increased 15 percent.	1/28/2008
ID	Eligibility	MASBOE	ID requires SSI recipients to separately apply for Medicaid. All SSI recipients who apply should qualify since the eligibility requirements do not differ.	9/1/2009
ID	Eligibility	MASBOE	ID uses the last day of the month when calculating an enrollee's age. For example, someone who turns 65 on June 25 is considered 65 for the entire month of June. Due in part to this reason, more than 1% of "aged" enrollees have previously registered as less than age 65+.	10/14/2009
ID	Eligibility	MASBOE	2006: Effective July 2006 in MSIS data, ID began to implement a Medicaid Modernization Plan, allowing the state to provide benchmark or equivalent coverage benefits to the vast majority of its Medicaid enrollees (children and their parents), as well as S-CHIP enrollees. Medicaid enrollees in these plans are assigned RBF 7. ID also modified its state specific eligibility codes for these groups (see revised crosswalk). In addition, nearly all Medicaid children began to be reported to MASBOE 34 (except foster care and disabled children) until Q2 FY10. This includes M-CHIP children. Separate CHIP children continued to be reported to MASBOE 00. Benefit changes include some copays and the use of personal health accounts. Individuals are also allowed to choose private plans (through premium assistance) instead of Medicaid.	9/22/2011
ID	Eligibility	MASBOE	2007: Enrollment shifts by MASBOE continued through Q3 FY08. Child enrollment grew somewhat, and was increasingly reported to MASBOE 34. By Q3 FY08, ID reported no one to MASBOE 14 and <10 children to MASBOE 44.	9/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
ID	Eligibility	MASBOE	When ID transitioned to a new MMIS in Q2 FY10, there were several shifts in MASBOE enrollment when compared to the Q1 FY10 file. There were decreases in MASBOE groups 12 and 35 as well as increases in MASBOE groups 3A, 42, and 55. The state also resumed reporting children in MASBOE 14 in this quarter.	10/5/2012
ID	Eligibility	MASBOE	Between Q4 FY11 and Q1 FY12, reporting to MASBOE 14 (Child receiving Cash) increased about 190% from 730 to 2,100. The state has confirmed this reporting was accurate and was intended to correct previous misreporting to MASBOE 15.	3/12/2015
ID	Eligibility	Private Health Insurance	Idaho reports that about 18 to 25 percent of eligibles have private insurance. This proportion is much higher than in other states.	12/10/2004
ID	Eligibility	Private Health Insurance	1999 - 2009: Since FY99, ID had been mistakenly reporting dual eligibles enrolled in Medicare Part A or B or receiving a Medicare supplement as having health insurance coverage purchased by a third party (health insurance code = '2'). Unfortunately, there is no way to distinguish between those duals who were legitimately assigned a '2' and those who were done so simply because they were enrolled in Medicare Part A or B or receiving a Medicare supplement. ID fixed this in Q4 FY09.	8/1/2011
ID	Eligibility	Private Health Insurance	In Q1 FY10, ID reported approximately 16,000 enrollees with health insurance flag 2. In the Q2 FY10 file, this enrollment increased to approximately 23,800 people. However, in an e-mail sent on April 20, 2012, ID indicated that there had been a decrease in private health insurance enrollment in the state during this time period. We asked the state if the Q2 FY10 reporting was accurate.	10/5/2012
ID	Eligibility	Race/Ethnicity	Between Q1 and Q2 FY10, there were several noticeable shifts in race/ethnicity reporting in ID. The number of individuals reported as Black/African American decreased from around 2,650 to around 200; the number of individuals reported as American Indian or Alaska Native decreased from about 3,850 to about 2,850; the number of individuals reported as Asian decreased from about 1,200 to about 50; the number of individuals reported as Hawaiian/Pacific Islander increased from about 750 to about 2,100, although by Q3 FY 10, the number of individuals reported as Hawaiian/Pacific Islander had decreased to 16 individuals, and the number of individuals reported as Hispanic or Latino decreased from about 9,400 to about 2,100. This followed other shifts in previous quarters. In Q1 FY11, the number of individuals reported as Black/African American, Asian, and Hispanic or Latino decreased by half again. The state has indicated that their new eligibility system does not report race and ethnicity data the same as the old system does and this accounts for the shifts in the data.	10/5/2012
ID	Eligibility	Restricted Benefits Flag	In Q4 FY06, ID began assigning restricted benefit code '7' to enrollees in its "alternative benefits" benchmark plan.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
ID	Eligibility	Restricted Benefits Flag	In response to repeated inquiries regarding the lack of RBF 2 in its MSIS data, ID indicated that the only restricted benefits flags used are 0, 1, 3, 4, and 7. The state began reporting a few people to RBF 2 in Q2 FY10.	9/22/2011
ID	Eligibility	SSN	When ID transitioned to a new MMIS in Q2 FY10, the percentage of individuals reported with SSNs increased from 96.5% in the previous quarter to over 99%.	10/5/2012
ID	Eligibility	SSN	When Idaho transition to a new MMIS in Q2 FY10, they began reporting 0-filled instead of 9-filled SSNs. We have an outstanding question to clarify this reporting to the state.	11/7/2012
ID	Eligibility	State-Specific Eligibility	In Q2 FY10, ID reported approximately 500 individuals to the wrong MAS/BOE according to the state-specific eligibility crosswalk. Most of these individuals were in state-specific groups 82 or 83 and were reported to MAS/BOE 14 in MSIS. The crosswalk indicated that these state-specific groups should be reported to MAS/BOE 15. We asked the state to review this and to either fix the MSIS reporting or the crosswalk so that the data correctly reflect the crosswalk in future files.	10/5/2012
ID	Eligibility	TANF/1931	Idaho 9-fills the TANF flag for all eligibles.	12/10/2004
ID	Eligibility	TANF/1931	From Q4 FY06 through Q1 FY08, about 75-125 persons in MASBOE 31-32 had the TANF field 0-filled. The TANF field should have been 9-filled for these individuals.	10/14/2009
ID	Eligibility	Waivers	Although it did not have any enrollees as of Q3 FY08, ID's HCBS/ISSH waiver was still a valid waiver that could be assigned to an individual through Q3 FY09.	10/7/2008
ID	Eligibility	Waivers	2006-2009: ID indicated that its Healthy Connections 1915(b) waiver (waiver ID 'H1,' waiver type '2') expired as of 9/30/06, with services now covered through the state plan. However, ID incorrectly continued reporting it as an active waiver in MSIS.	9/22/2011
ID	Eligibility	Waivers	2006-2009: ID indicated that its TBI waivers (waiver IDs '11' and '12,' waiver type '3') expired as of 9/30/06. However, ID continued reporting them as active waivers in MSIS.	9/22/2011
ID	Eligibility	Waivers	In FY 2008 and 2009, there were some minor shifts in enrollment for several Home and Community Based Services Waivers -- Waiver IDs B1, B3, and B5. Enrollment in Waiver ID 'B3' shows a 16% drop from ~ 1700 in September to ~ 1500 in October 2008. Enrollment in Waiver ID 'B1' shows a 12% drop from September to October 2008 from 33,000 to 29,000. In January 2011, we asked the state to clarify whether these enrollment changes were expected, but did not receive a response. Additionally, enrollment in the Home and Community Based Services Supportive Living Program waiver (Waiver ID 'B5') increased by 20% in 2009; the state indicated that this increase was expected.	9/22/2011
ID	IP	CHIP	In the Q4FY2010 IP, all separate CHIP claims (TYPE-OF-CLAIM = A) are reported as crossover claims (MEDICARE-	4/19/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT <> 8-fill). This is likely a reporting error.	
ID	IP	Crossovers	Over 90% of all FFS original Medicaid claims are crossover in the Q4FY2010 IP file. The total number of crossover claims in Q4FY2010 is comparable to the total number of crossover claims in Q1FY2010 but the total and average MEDICAID-AMOUNT-PAID is very high, at least four times greater compared to Q1FY2010 (before changes to MSIS reporting) and earlier quarters. The state explained that there were systems issues that caused errors that affected third party liability identification and claim processing.	4/19/2013
ID	IP	DRG	DRGs are not reported in the IP files.	8/22/2005
ID	IP	Total Non-Crossover FFS claims	Of the 1,765 records in the Q4FY2010 IP file, there are only seven that are FFS original non-crossover Medicaid claims. ID has explained that the number of claims adjudicated in FY2010 after implementation of a new MMIS was very low because of claims submission and adjudication errors that caused the state to pay many providers with lump sum payments until the issues could be resolved. Those lump sum payments are not included in MSIS.	4/19/2013
ID	IP	Type of Service	The majority of FFS original non-crossover Medicaid claims in the Q4FY2010 IP file may actually be LT claims according to the number of covered days, diagnosis codes, and a provider taxonomy indicating ICF/MI. The state has explained that an adjudication error caused some claims to be identified with the incorrect TYPE-OF-SERVICE and reported in the incorrect MSIS file.	4/19/2013
ID	LT	ICN	ICN changed from 19-digit all-numeric in 2010Q1 to 13 and 15-digit all-numeric in 2010Q2.	6/7/2012
ID	LT	Medicaid Amount Paid Avg	Between Q1FY2010 and Q2FY2010, average paid per covered day for ICF/IID claims was reduced by half and is about one-third of Idaho's published per diem rate for ICF/IID care. The previous average was about one-half the published rate.	6/7/2012
ID	LT	Total Non-Crossover FFS claims	There are only 271 FFS non-crossover original Medicaid claims in the Q4FY2010 LT file, a decrease of 99% compared to the average number of FFS non-crossover original Medicaid claims from Q2FY2009 through Q1FY2010. The number of crossover claims in Q4FY2010 decreased less than 50% compared to the average number of crossover claims from Q2FY2009 through Q1FY2010. Despite the decrease in the number of crossover claims in Q4FY2010 the total and average paid for those claims has increased by more than ten times compared to Q1FY2010 and prior quarters. Average MEDICAID-AMOUNT-PAID for FFS original crossover Medicaid claims in this submission of Q4FY2010 was about $1,067. Average MEDICAID-AMOUNT-PAID for FFS original crossover Medicaid claims in Q4FY2009 was $76. The state indicated that there were systems errors	4/19/2013

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			related to third party liability that were fixed in subsequent quarters.	
ID	LT	Type of Service	Through FY2006 about 20 percent of the claims have a Type of Service of 05 (ICF/IID), which is much higher than expected. This decreased to 17 percent in 2007, 14 percent in 2008, and eventually 7 percent in Q2FY2010.	12/10/2004
ID	LT	Type of Service	Mental Hospital for the Aged claims no longer reported in FY2010Q2 – previously represented very small part of LT file.	6/7/2012
ID	OT	CHIP	There are seven SCHIP capitation claims (TYPE-OF-CLAIM=B; six w/TYPE-OF-SERVICE=19, one w/TYPE-OF-SERVICE = 21) paid a total of ~$3 million, all with 0-filled MSIS-ID, all with dates of service in June 2010. The SCHIP PHP capitation (TOC = B/TOS = 21) was a large payment (>$2 million) with PLAN-ID-NUMBER = "DENTAL". If these are lump sum payments that cannot be attributed to an individual enrollee then they should have been reported as TYPE-OF-CLAIM = D (SCHIP Service Tracking/Gross Adjustment Claim).	4/19/2013
ID	OT	HCBS Waiver	In Q4FY10 there are 5,040 original FFS Medicaid crossover claims and 102 original FFS SCHIP non-crossover claims with TYPE-OF-SERVICE=19 and PROGRAM-TYPE = 6 or 7. It is unusual to see PROGRAM-TYPE = 6 or 7 reported on anything but FFS non-crossover Medicaid claims. ID has several approved 1915(c) waiver applications on file at CMS.	4/19/2013
ID	OT	Managed Care Capitation	Since at least 2008 ID has not reported adjustments of capitation claims. There are new original capitation claims with negative amounts that should have been reported as void or credit claims. This makes it falsely look like the state submits more capitation payments per quarter than there are person-months of enrollment.	7/8/2011
ID	OT	Managed Care Capitation	There were no Medicaid capitation claims in the Q2-4FY2010 OT file. The 2010 CMS Medicaid managed care enrollment report indicates that at least three managed care arrangements were in place.	4/19/2013
ID	OT	MSIS ID	Between Q1FY2010 and Q2FY2010 MSIS ID format changed from 9 to 10 digits but this appears to be consistent with EL.	6/7/2012
ID	OT	Place of Service	ID has indicated that PLACE-OF-SERVICE is not used to determine reimbursement on professional claims so it is not validated.	3/1/2013
ID	OT	Service Tracking Claims	Dental managed care began in 2008 but the state wasn't able to report individual capitation claims until Q1FY2008. In 2007 they were submitted as Service Tracking claims.	NA
ID	OT	Supplemental Claims	In FY2008 ID implemented a Pay for Performance program that consists of paying individual providers (physicians usually) for performing specified tests and checkup on specific patients with certain chronic diseases like asthma. These payments are reported in the Q3FY2008 OT file as HMO capitation payments.	NA

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			ID began reporting them as OT Supplemental Payments in Q1FY2009 and stopped reporting them in Q1FY2010.	
ID	OT	TPL	There are no claims with OTHER-THIRD-PARTY-PAYMENT > $0 in Q4FY2010. Prior to Q1FY2010 about 1.5% of all FFS original Medicaid non-crossover claims had a OTHER-THIRD-PARTY-PAYMENT > $0.	4/19/2013
ID	RX	Compound Drugs	Until Q2FY2010, ID reports compound drugs as "COMPOUND" in the NDC field.	6/7/2012
IL	Claims	Crossovers	There are no crossover adjustment claims due to the way the Illinois system processes crossover claims.	12/10/2004
IL	Claims	Managed Care Plan IDs	A zero must be added to position 11 of the Plan ID on capitation claims in order to link with EL. Plan ID in EL and on all encounters is 12 digits. Plan ID on capitation claims is reported with only 11 digits. The 10th and 11th positions of the plan ID should be zero on all plan IDs.	NA
IL	Claims	Total Non-Crossover FFS claims	FFS expenditures in all claims files dropped sharply from Q3FY2011 to Q4FY2011. The state explained that this was the result of expediting adjudication in Q3FY2011 to maximize ARRA enhanced federal match which expired at the end of quarter four. In Q1FY2012, expenditures were expected to increase but did not increase back to normal levels because of a spending cap needed to balance the budget in FY2012.	10/25/2012
IL	Eligibility	1115 Waivers	IL's family planning program (state groups 94FP00 and 96FP00, reported to MASBOE 55) was added in Q4 FY04 (Waiver ID A3, Waiver Type F). Enrollees in this program are assigned restricted benefits code '6' from Q1 FY06 forward.	NA
IL	Eligibility	1115 Waivers	IL's "Kidcare" 1115 HIFA waiver was implemented in Q1 FY03 (October 2002) and expired September 30, 2007 (Waiver ID= A2, waiver type = 5). The waiver uses a combination of Title XIX and Title XXI funding to expand coverage for children in families with income to 200 percent FPL and parents to 133 percent FPL. Until the waiver expired, enrollees were reported to MASBOE 54 (for children) and 55 (for parents). (State groups for MASBOE 54 have RL, RM, RN, RO, RP, or V in bytes 3-4 of the state eligibility code. State groups for MASBOE 55 have IA, ID, or IE in bytes 3-4). Much of the coverage expansion applies to S-CHIP child and adult coverage, but some limited expansion occurred in Medicaid (MASBOE 54-55) as well. Since the waiver expired as of September 30, 2007, the state was granted a Medicaid SPA to cover the former KidCare parents in Medicaid- they are mapped to MASBOE 45 beginning with the state's Q1 FY 2009 MSIS EL file submission. The children formerly covered under the waiver are now covered by state funds and as of Q1 FY 09, are no longer reported as Medicaid or SCHIP enrollees in MSIS (though the state has applied for a second SPA to expand SCHIP coverage up to 500% FPL). The state's SCHIP population that was already eligible without the waiver remains as-is.	2/14/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
IL	Eligibility	1115 Waivers	Illinois, in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS), has implemented an 1115 waiver to expand eligibility to uninsured adults with incomes at or below 133 percent FPL residing in Cook County (and is called the County Care 1115 waiver). It is expected to cover 250,000 adults with a benefit package more limited than traditional Medicaid. The state reports that the waiver was implemented in November 2011. However, waiver enrollment is first reported in MSIS in January 2013. Waiver enrollment increases sharply each quarter. We have asked the state to confirm whether this unusual enrollment pattern is expected. The state will be reporting these individuals to RBF '5'.	11/6/2012
IL	Eligibility	1115 Waivers	Each month starting in Q2 FY 2013, there is a slight (2-3 people per month) mis-alignment of reporting 1115 waiver enrollees to MAS 5, and for Family Planning 1115 waiver enrollees, reporting to RBF '6'. We have asked the state to fix this.	5/1/2014
IL	Eligibility	1115 Waivers	Each month, a handful of people are assigned to the County Care 1115 waiver, but not to MAS 5. In addition, some people are assigned to the Family Planning waiver, but not to MAS 5 or RBF '6'. The state has said that it will align its code in T-MSIS to address the issue.	6/11/2014
IL	Eligibility	All	Disease Management: YourHealthcare Plus is Illinois' disease management program for the following Medicaid enrollees: disabled adults; adults and children with asthma; and adults with frequent emergency room visits (six or more within one year). The program offers nurses and social workers to conduct counseling and provide education and information to take care of chronic health problems.	10/10/2012
IL	Eligibility	CHIP	IL reports unborn children covered by SCHIP under the pregnant mother's date of birth. As a result, these enrollees appear as adults in MSIS. This reporting is inconsistent with SEDS reporting, which classifies these enrollees as children.	10/12/2011
IL	Eligibility	Dual Eligibility Codes	IL reports a small number (1,000) of full duals in MASBOE 11-12 to dual code 08. These are individuals for whom the state does not pay for Part A Medicare. IL also reports some partial duals (01, 03, and 06) who are SSI recipients to MASBOE 11-12. These persons do not qualify for full Medicaid benefits due to IL's 209(b) rules.	3/13/2009
IL	Eligibility	Dual Eligibility Codes	IL provides full Medicaid benefits to the aged and disabled with income up to 100 percent of the federal poverty level.	3/6/2011
IL	Eligibility	Dual Eligibility Codes	FY 2009-2011: Compared to MMA, MSIS enrollment counts for Dual Codes 03 and 04 differ substantially. Beginning in Q2 FY 2011, Dual code 06 also shows a considerable discrepancy between the two data sources. The state has indicated that the MMA figures are more accurate, as the MSIS data are submitted manually. Additionally, the MSIS coding is on the state's legacy mainframe system whereas the MMA coding is on the state's	9/28/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			Data Warehouse. The state plans to convert its legacy MSIS mainframe system to use the Data Warehouse utilizing SQL in time for the FY 2012 submissions. The state believes this will bring the MSIS and MMA numbers more in line, however, these discrepancies were still present in the Q1 FY 2012 submission. Since the MSIS data show a relatively good match with EDB, it appears that the total MSIS dual count is probably quite accurate, but assignment of duals to the appropriate dual code may be the issue. The state made some coding changes to correct this issue beginning in Q1 FY 12, at which point the MMA comparison for full and partial duals was within 3-4% of MSIS.	
IL	Eligibility	Dual Eligibility Codes	Through Q4 FY 2011, many individuals have a discrepancy between their dual code and MASBOE assignments. The state believes that these individuals, assigned as partial duals with MASBOE 21-22 and 41-42, have incorrect dual assignments. This discrepancy was also seen in the RBF field, where some individuals with RBF= 3 receive inappropriate MASBOE assignments. The state believes this issue was occurring because the MSIS data were being pulled using an older legacy system. In this system, dual code was assigned independently of MASBOE and RBF. The state made some coding changes that greatly improved this issue beginning in Q1 FY12, with retro-corrections back to Q2 FY11. However, we still see a small number (500) partial duals mapped to MASBOE 25 and 45 each month.	9/28/2011
IL	Eligibility	Dual Eligibility Codes	In FY 2010: there were sizable enrollment increases in Dual Code '8'. Specifically, there was a 9% increase in enrollment in dual code '8' from September to October 2009, then a 9% increase from December 2009 to January 2010, another 9% increase from March to April 2010, an 11% increase between June and July 2010, a 9% increase from September to October 2010. Generally, these trends match what we see in the MMA data. The state did not have an explanation for this trend.	11/19/2012
IL	Eligibility	Managed Care	In June 2007 CMS managed care data, IL reports about 400,000 enrollees in a PCCM plan (Illinois Health Connect). However, MSIS has never included PCCM enrollment. The state confirmed that it implemented PCCMs in January 2007 (Q2 FY07). The state added this reporting in Q4 FY08 and submitted correction records with PCCM enrollment back to January 2007. In 2009, PCCM reporting in MSIS far exceeded what CMS reported in its managed care summary, so we asked the state to clarify the numbers several times. The June 2011 PCCM enrollment counts look much closer between the CMS and MSIS data (within 3%). The state said that between July and December 2011, PCCM enrollment increased dramatically due to the state's implementation of its Integrated Care Program.	3/26/2010
IL	Eligibility	Managed Care	Illinois reports enrollment in Plan Type 08 (Other). These plans once consisted of Primary Health Providers and Managed Care Community Care Networks (MCCN). These plans provide different services than comprehensive managed care plans.	10/13/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			Enrollment in these plans declined by about 7,000 in Q1 FY 2000 when the County Care Total Health Plan closed. These plans appear to be reported as HMOs (not PHPs) in CMS managed care data. In FY 2009 and FY 2010, all PlanType 08 enrollment was reported to PlanID 36398548001, Family Health Network. In FY 2011 (and FY 2010 via retro-correction records), IL also switched reporting of planID 363978801001 from plan type = 06 to plan type = 08 as the state has said that this is a Pre-PACE plan, rather than a PACE plan.	
IL	Eligibility	Managed Care	IL began reporting a PACE plan (planID 363978801001) in FY 2008. However, in FY 2011, the state switched reporting of this plan from plan type = 06 (PACE) to plan type = 08 (other). The state has said that this is not an actual PACE plan, but rather a pre-PACE plan. Correspondingly, the June 2010 managed care summary does not indicate that IL has a PACE plan. The state corrected this reporting via correction records for FY 10 with its Q1 FY 11 file submission.	10/19/2011
IL	Eligibility	Managed Care	Through 2010, IL consistently reported about 30-40% more individuals with PCCM enrollment in MSIS compared with the CMS managed care summary. The state has said that this is because the CMS managed care data only shows Medicaid enrollment whereas the state includes CHIP numbers as well. Approximately 100,000 CHIP enrollees were assigned to PCCM in MSIS in June 2010. Subtracting out these enrollees from the MSIS counts would still leave a 31 percent discrepancy. However, the June 2011 MSIS counts look to be consistent with the CMS managed care enrollment summary for PCCM.	11/20/2011
IL	Eligibility	Managed Care	Between July and December 2011, there was a sizeable increase in HMO enrollment from about 144,000 to 166,000 monthly. We have asked the state to verify if this increase was expected. The state did not provide a response, but it is likely that this increase is related to implementation of the state's Integrated Care Program in May 2011.	2/16/2013
IL	Eligibility	Managed Care	Illinois implemented the state’s first integrated healthcare program on May 1, 2011. The Integrated Care Program (ICP) is a program for older adults, and adults with disabilities, who are eligible for Medicaid, but not eligible for Medicare. The Integrated Care Program brings together local primary care providers (PCPs), specialists, hospitals, nursing homes and other providers to organize care around a patient’s needs. It will keep enrollees healthy through more coordinated medical care, helping prevent unnecessary healthcare costs. The Illinois Department of Healthcare and Family Services has contracted with Aetna Better Health and IlliniCare Health Plan to administer the program.	1/8/2014
IL	Eligibility	Managed Care	As of Q1 FY 2013, Illinois reassigns all HMO plans (Plan Type '1') to Plan Type '8' (Other Managed Care). The state also submitted correction records back to 2011 to make this change retroactively. This likely has to do with the state's	5/1/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			implementation of Integrated Care Plans, but the CMS managed care summary lists these plans as comprehensive managed care plans. IL's staff also confirmed that most of these plans offer a comprehensive benefit package, and as of July 1, 2014, all plans are required to offer a comprehensive benefit package. We have asked the state to switch the reporting of these plans back to HMO/comprehensive via retro/correction records to be sent with the resubmitted Q1 FY 2014 file.	
IL	Eligibility	MASBOE	Disabled individuals over the age of 65 have a choice of enrolling as either disabled or aged. Most choose to enroll as disabled because doing so makes them eligible for other services. As a result, a large percentage of individuals over age 65 are reported as disabled in IL.	NA
IL	Eligibility	MASBOE	In Q1 FY06, IL acknowledged that Medicaid enrolls fewer SSI enrollees than expected. The exact percentage is unknown. The 209(b) state rules also cause the number of persons reported into MAS/BOE 11 and 12 to be lower than ordinarily expected. Finally, the 209(b) rules cause some partial duals who are SSI recipients to be reported to MASBOE 11-12.	3/13/2009
IL	Eligibility	MASBOE	According to IL's MASBOE crosswalk, individuals in eligibility group 346901 (TANF-R-Cash) should be mapped to MASBOE= '14', and individuals in group 366901 (TANF-U-Cash) should be mapped to MASBOE= '16'. However, while most individuals in these two groups are correctly reported, several hundred per month are reported as SCHIP (CHIP code= '3', MASBOE= '00') through Q1 FY12. The state corrected this issue beginning with the Q2 FY12 submission, and has said that the correction records submitted with this file correct the issue in previous quarters.	1/28/2013
IL	Eligibility	Private Health Insurance	IL has some seam effects in its private insurance data, but this appears to be smoothed with correction records.	3/3/2011
IL	Eligibility	Race/Ethnicity	Each quarter, the percentage with an unknown race/ethnicity has been increasing slightly. By Q1 FY 2014, the percentage with an unknown race/ethnicity has crept up to 7.3 percent. The state reported that this seems reasonable due to enrollment increases.	5/1/2014
IL	Eligibility	Restricted Benefits Flag	RBF 4 is always highest in month three of each quarter and then drops abruptly in the first month of the next quarter -- an RBF "seam effect." All RBF-4 recipients are in state specific eligibility group 3460PE, which is for presumptive eligibility for pregnant women.	3/26/2010
IL	Eligibility	Restricted Benefits Flag	IL has a Money Follows the Person program (RBF= 8) and had expected to start enrolling people in July 2009, but the state began enrollment in the MSIS files in Q1 FY 2009. MFP enrollment dropped from 19 enrollees/month in Q4 FY 09 to 3/month in Q1 FY 10; however, this issue was corrected with the correction records the state submitted with its Q1 FY 2011 file. The state has told us that MFP numbers seen in the data	4/6/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			prior to FY 11 are due to testing the MFP enrollment field- they are actual MFP enrollees, but that MFP enrollment reported in the MSIS files is not accurate since it does not include all enrollees. However, the state said its MMIS system will contain automated eligibility data for MFP beginning in FY 2011 such that reporting of this field will be accurate.	
IL	Eligibility	Restricted Benefits Flag	IL reports a very small number (<100) of enrollees to restricted benefits code 2 (emergency services for aliens). IL has told us that other State programs cover these individuals. In many quarters, the number of current records with RBF= 2 are almost non-existent, but the state usually corrects this with retro/correction records included in later files.	4/6/2012
IL	Eligibility	Restricted Benefits Flag	IL will be assigning RBF '5' to 1115 county care waiver enrollees starting in January 2013. These enrollees receive a benefit package that is more limited than traditional Medicaid.	6/11/2014
IL	Eligibility	SSN	For several years in a row, IL has reported an unusually high level of SSNs with duplicate records - about 1.1% of SSNs have duplicate records and 2.2% of records are duplicates. In IL, more than one record can have the same SSN due to the state's system of assigning Medicaid ID numbers for uninsured children who are provided emergency services. These children are initially assigned temporary ID numbers; a permanent ID is assigned once they are enrolled in Medicaid for full benefits. Thus, two records may exist with the same SSN. SSN duplication can also occur when an individual's Medicaid coverage is cancelled and later renewed with a different ID number. CMS has asked the state to correct this in its FY 2012 submission. In response to the Q1FY12 review, the state responded that "this should not be an issue when the initiative to remove the SSN from medical records is implemented"; however, it does not appear that this would correct the issue, but would make it appear as if two different people were receiving the service.	12/8/2011
IL	Eligibility	SSN	Each quarter, the percentage of current records with a 9-filled SSN is rather high, above 5 percent. However, the state retroactively corrects many of these SSNs which brings the percentage down quite a bit.	5/1/2014
IL	Eligibility	State-Specific Eligibility	In October 2011, there was a shift of approximately 8,000 individuals from eligibility group '230SSI' (MASBOE 12) to eligibility group '239999' (MASBOE 22). We have asked the state about the reason for the shift, but did not receive an answer.	10/10/2012
IL	Eligibility	State-Specific Eligibility	Illinois implemented several eligibility restrictions as of July 2012, reducing the income limit for parents from 185 percent to 133 percent of FPL (affecting 28,000 individuals), and tightening the asset transfer limits for long-term care. Illinois also plans in November 2012 to add an income limit to its Medically Fragile Persons with Disabilities (MFPD or Katie Beckett) waiver at 500 percent of FPL. There is no current income limit and the new limit is expected to have a very limited impact	11/6/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
IL	Eligibility	State-Specific Eligibility	In January 2012, there was a relatively sizeable enrollment increase in state-specific eligibility group '1199A0' ('Aged-Elderly Waiver') from 14,000 in December 2011 to 18,000 in January 2012. Similarly, there was a sizeable enrollment increase in state-specific eligibility group '2399A0' ('Disabled - Elderly Waiver') from 9,500 to 14,400 between December 2011 and January 2012. Both of these groups are part of IL's 1915(c) HCBS Waiver for the Elderly (Waiver ID 'B2'). We have asked the state to verify whether these increases were expected but did not receive a response. Additionally, in April 2012, enrollment in MASBOE = '22' increases from 89,000 to 107,000 overall (including an enrollment increase in group '239999' from 50,000 to 63,000). Within MASBOE 12, there was also a decrease in group '230SSI' from 145,000 to 123,000 over this same timeframe. We have asked the state to verify whether these increases were expected but did not receive a response.	2/16/2013
IL	Eligibility	TANF/1931	IL MSIS reports increasingly higher TANF enrollment compared with ACF administrative data (24% higher in Q1 FY 2012, up from a 12% discrepancy in FY 06). IL has informed us that MSIS includes "0-Grant" enrollees excluded in the ACF counts. However, in FY 2013, this discrepancy has increased to a 160% difference. We have asked the state about this, but they did not know the reason for this difference.	2/25/2008
IL	Eligibility	Waivers	Through FY12, approximately 25% of IL's 1915c waiver enrollees do not have any HCBS waiver service use reported in the claims files. The state has said that due to spending caps, most providers were not paid from July – December 2011 (and presumably may have pulled back on offering services during this time). In addition, many non-HCBS enrollees are reported with HCBS services. Since both of these issues have been present since at least FY06, and since the MSIS waiver enrollment counts for many of the state's 1915c waivers are discrepant with external information about these waivers' enrollment caps, we have sent detailed information to the state on these discrepancies and asked them to investigate whether there is a reporting issue in MSIS.	1/28/2013
IL	IP	Covered Days	Consistently through at least Q4FY2012 less than 20 percent of IP claims have an equal number of covered days and length of stay.	2/15/2013
IL	IP	DRG	IL has been using MS-DRG Version 12 (94-95) for many years. Rather than upgrade to a new version they make manual updates identified in the data by the DRG indicator of IL99. They are pursuing a new kind DRG soon in 2011, possibly APR-DRGs.	NA
IL	IP	Procedure Code Modifier	Procedure Code Modifiers 1 through 6 are always missing, but this is reasonable since modifiers are rarely applicable for IP procedure codes.	12/10/2004
IL	LT	Crossovers	IL reported very few (<50) LT crossover claims until Q2FY2005 when LT crossover claims were no longer reported.	3/30/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
IL	LT	Medicaid Amount Paid	Through at least Q4FY2012 IL consistently reported between 10 and 40 FFS non-crossover claims with negative amount paid.	2/15/2013
IL	LT	Patient Status	Patient Status is missing on all LT claims through at least Q4FY2012.	2/15/2013
IL	LT	Provider Taxonomy	Very few LT claims have a taxonomy code through at least Q4FY2012.	2/15/2013
IL	OT	Crossovers	The percentage of crossover claims with a Medicaid paid amount of zero dollars ($0) has been above 50% consistently through Q4FY2011. All claims do have coinsurance and deductible amounts greater than zero. The majority of claims paid zero are for physician services.	12/2/2011
IL	OT	Indian Health Services	Through at least Q4FY2011, IL has not submitted any IHS claims.	7/8/2011
IL	OT	Managed Care	IL was scheduled to implement managed care for the elderly on Jan 1, 2011. Media reports indicated that the new managed care networks were having trouble finding enough providers to participate causing delayed implementation but the number of crossover claims and total crossover expenditures began to decline in the IL Q2FY2011 MSIS OT file. Enrollment in dual-eligible integrated care plans began in Q3FY2011 and a sharp increase in capitation payments occurred in Q4FY2011 as the associated capitation payments appeared at an average of $1,000 per person per month.	NA
IL	OT	Managed Care Capitation	In FY2011 IL reported plan ID 36397880101 (a pre-PACE plan) on HMO capitation claims (TOS=20) and on enrollments with plan type 08 (Other) which is usually considered a category for PHPs.	10/21/2011
IL	OT	Managed Care Capitation	IL has reported about 7,000 HMO capitation claims each month since at least the beginning of 2008 with Plan ID 36398546801; this plan was identified as a PHP in the EL file. This was resolved in Q2FY2010. In Q2FY2011 HMO capitation claims begin to appear again with this plan ID.	10/24/2012
IL	OT	Managed Care Capitation	2012Q3 Plan IDs on capitation claims are 1-digit shorter than plan IDs on enrollments and encounter claims. The number of encounters in the OT file decreased by nearly 50% between Q1FY12 and Q2FY12 and then again decreases another 74% from Q3FY12 to Q4FY12 for a total of an 87% decrease over the year. PLAN-ID 363985468001 only appears on enrollments with one plan type but is associated with two types of capitation claim. It appears in EL with PLAN-TYPE=8 and in the OT file with TYPE-OF-SERVICE=20(HMO).	3/28/2014
IL	OT	Type of Service	In FY2001, the State of Illinois began to process Delta Dental claims through the MMIS system rather than through the C-13 voucher system. In their 2002 January to March and April through June claims there will be a big increase in Type of Service 09 (Dental) claims because of the Department processing back-dated claims for Delta Dental (back to 3/99).	12/10/2004

State	File Type	Rec/Issue Type	Issue	Recorded
			These claims do not have a Diagnosis Code. After the April through June quarterly tape, the level of claims for Type of Service 09 should level off.	
IL	OT	Type of Service	In FY2009 Illinois began submitting more line item claims for some types of service resulting in a decrease in the average amount paid for some types of service.	10/25/2009
IL	OT	Type of Service	In Q3FY2010 OT there were about 50,000 debit claims and 150 credit claims reported with type of claim 9 (Unknown). IL confirmed that these represent FFS adjustments of elderly HCBS waiver claims. IL reports all HCBS waiver claims as program type 7.	6/15/2011
IL	RX	Adjustments	There are no NDC codes on credit adjustment claims, making it difficult to properly adjust the files.	12/10/2004
IN	Claims	FFS Claims	The total number of RX FFS claims drops by more than a third between 2013 Q2 and Q4. According to the state, the drop is expected and due to a change from HP to Catamaran systems. (In the Catamaran system, claims that are submitted multiple times (same RX #, provider, DOS) utilize the same RxCLAIM # (ICN/TCN) and are assigned a new sequence number. When pulling the data for the MSIS report, Catamaran pulls claims data without including multiple resubmissions. The state verifies that the actual numbers for Q4 are in line with total paid/rejected claims processed during that time frame.)	4/21/2014
IN	Eligibility	1115 Waivers	Indiana began to operate the Healthy Indiana Plan (HIP) 1115 demonstration waiver (CMS Project Number 11-W-00237/5) in January 2008. Under the waiver, the state operates two health insurance programs: 1) the Hoosier Healthwise (HHW) Program for current Medicaid-eligible individuals; and 2) the Healthy Indiana Plan (HIP) for uninsured, working adults with or without dependent children who are not currently eligible under the Medicaid State plan. The HHW portion of the waiver covers nine (9) groups: 1) Pregnant women with family incomes up to 200% FPL and no resource limits (HHW Pregnant Women); 2) Pregnant women with incomes up to the AFDC limit based on family size as described in the State Plan and a resource limit of $1,000 (HHW Caretakers); 3) Children < 1 year with family incomes up to 200% FPL and no resource limit (HHW Children); 4) Newborns born to and living with a woman who was eligible and received Medicaid on the date of the child's birth (HHW Children); 5) Children 1-5 years with family incomes up to 133% FPL and no resource limit (HHW Children); 6) Children 6-18 years with family incomes up to 100% FPL and no resource limit (HHW Children); 7) Blind or disabled children < 18 years receiving SSI and, except for receiving SSI, would be eligible for AFDC (HHW Children); 8) Custodial parents and custodial relatives of children eligible for Medicaid (HHW Caretakers); and 8) Blind or disabled adults >= 18 years receiving SSI and who, except for receiving SSI, would be eligible for AFDC (HHW Caretakers). HIP covers three eligibility groups: 1) HIP	10/28/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Caretaker Adults with resources > $1,000 and incomes up to the AFDC limit based on family size as described in the State Plan; 2) HIP Caretaker Adults with incomes greater than the AFDC limit based on family size and <= 200% FPL with no resource restrictions; and 3) uninsured childless adults (HIP Adults) with family incomes from 0% FPL up to and including 200% FPL. There are no resource limits for HIP Adults. Populations in HHW receive services through a managed care delivery system. HIP enrollees who have not been identified as high-risk also received services through managed care. HIP members who have been diagnosed with a high-risk condition receive services through the Enhanced Services Plan (ESP), which is managed by the Indiana Comprehensive Insurance Association (ICHIA), an organization that manages the State's high-risk pool. HIP includes a high-deductible health plan and a Personal Wellness and Responsibility (POWER) Account that acts like a health savings account for uninsured adults, including uninsured custodial parents of children enrolled in Medicaid or CHIP. The POWER Account includes incentives to use services in a cost-efficient way. In September 2013, CMS approved a one-year extension of the HIP demonstration. Under the extension Indiana will continue to cover beneficiaries in the plan, while it considers its coverage options going forward. The waiver will now expire on 31Dec2014. In light of new coverage options that will become available, as of January 2014 the demonstration will be limited to some adults with incomes < 100% FPL. This includes: 1) uninsured custodial parent with family incomes between 22% and 100% FPL; and 2) uninsured childless adults with family income up to 100% FPL.	
IN	Eligibility	1115 Waivers	Enrollment in the state's Healthy Indiana Plan 1115 waiver declined noticeably between January and June 2014 [-12.0%]. Enrollment in January 2013 was 739,600. The comparable figure for June 2014 was 650,700. The state did not expect a decline of this magnitude. However, a portion of it can be attributed to the state's new family planning benefit. Due to changes in eligibility for family planning, the state expected that some beneficiaries would move from the 1115 Waiver to the new Family Planning Benefit. Indiana indicated that much of the decline may be due to an improving economy. It may also be the result of timing and interactions with the federal exchange.	12/23/2014
IN	Eligibility	CHIP	Indiana's CHIP eligibility has expanded over time since the original federal legislation was passed in 1997. CHIP Package A (M-CHIP) covers uninsured children in families with incomes up to 150% FPL who are not already Medicaid-eligible. This CHIP segment began on 01Jul1998. CHIP Package C is the non-entitlement portion of CHIP. Families in Package C pay monthly premiums; those in Package A do not. In addition to income tests, children enrolled in Package C cannot have insurance coverage from another source. The first segment of Package C was introduced on 01Jan2000 and covers children in families with incomes > 150% and <= 200% FPL. The second segment	10/25/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
			of Package C was introduced on 01Oct2008 to cover children in families with incomes > 200% and <= 250% FPL. As of Q3 FY 2013, there are about 53,700 enrollees per month in Package A and 25,400 per month in Package C.	
IN	Eligibility	County Codes	IN routinely reports a small number of enrollees (10-20) each quarter to county code '990.' This is a code assigned by the state (not a FIPS code) to a small number of individuals for whom the state considers information regarding these enrollees to be sensitive.	11/22/2011
IN	Eligibility	Dual Eligibility Codes	Indiana assigns Dual Code '08' (Other Full Benefit Dual) to about 28,800 dual-eligible enrollees each month. This represents about 18.7% of the total dual population. According to the state, these enrollees have Medicare Part B, but do not fall into one of the standard (for example, QMB) dual categories.	10/25/2013
IN	Eligibility	Family Planning	Between January and December 2013 enrollment in the state's 1115 waiver declined 4.9%, from ~ 739,600 to ~ 703,200. Over the same period, enrollment in the state's family planning program increased 350%, from ~ 4,400 to ~ 19,800. The state assigned nearly all [~ 99.7%] of the family planning enrollees to MASBOE '35'. On 01Jan2013, the Indiana Family Social Services Administration [FSSA] implemented a new Medicaid Family Planning Eligibility Program, which gives qualifying men and women a package of services to prevent or delay pregnancy. Participants must meet the following eligibility requirements: 1.] they do not qualify for any other category of Medicaid; 2.] they must be a US citizen, a lawful permanent US resident, or a qualified documented alien; 3.] they are not already pregnant; 4.] they have not had a hysterectomy or sterilization procedure; and 5.] their income is =133% of the FPL. According to the state, much of the decline in 1115 enrollment was not expected. It attributes some of the decline to the new family planning benefit noted above. Due to changes in eligibility for family planning, Indiana anticipated that individuals would move from the 1115 Waiver to the new Family Planning Benefit. The state believes that much of the rest of the decline may be due to an improving economy. It may also be a result of timing and interactions with the federal exchange. According to the state, after leveling off in the December 2013 quarter, the number of family planning enrollees in MASBOE 35 fell in March 2014. The state did not provide further information on this group.	9/2/2014
IN	Eligibility	Managed Care	The ESP High Risk Capitation plan is reported in MSIS as an HMO but in the CMS June managed care report as "other." This plan is part of the HIP program. The ESP plan serves enrollees with pre-defined high risk conditions, and is delivered FFS. The other 2 HIP plans serve everyone else in the program and operate like traditional HMOs.	6/2/2011
IN	Eligibility	Managed Care	When IN transitioned to CareSelect in November 2007, almost all duals were moved to traditional Medicaid. Each month, however, several hundred duals remained in PCCMs. Duals are	6/2/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			not eligible for CareSelect, but they may be enrolled before the MMIS recognizes dual status. When a member's Medicare assignment is inserted and the system determines dual eligibility, CareSelect enrollment gets end-dated.	
IN	Eligibility	Managed Care	Care Select is an optional health care program that serves Medicaid recipients who have special health needs or who may benefit from specialized attention. Care Select enrollees pick a PCP and a health plan from one of the Care Management Organizations (CMOs) that contract with the state to coordinate care. People served by Care Select may be aged, blind, disabled, wards of the court or foster children, or children receiving adoptive services. To qualify for Care Select enrollees must also have one of the following conditions: asthma, diabetes, heart failure, congestive heart failure, hypertensive heart disease, hypertensive kidney disease, rheumatic heart illness, severe mental illness, SED (wards and foster children), or depression.	10/25/2013
IN	Eligibility	MASBOE	2008: In January 2008, Indiana started reporting to MASBOE 55. Persons in MAS 5 are HIP expansion enrollees (see 1115 HIP anom).	9/2/2008
IN	Eligibility	MASBOE	2009: In July 2009, IN implemented a presumptive eligibility program for pregnant women (state group PE, MASBOE 45, RBF 4) and started reporting these enrollees in MSIS at that time. However, this program was 100% state-funded until January 2010 and should not have been reported into MSIS until then.	9/8/2011
IN	Eligibility	MASBOE	In IN's Q2 FY 2010 eligibility file, enrollment in several MASBOE groups increased notably. In particular, enrollment in MASBOE 12 increases in Q2 and in MASBOE 34-35 increases but then declines in Q4 FY2010. These enrollment changes occurred in existing aid categories and are not driven by new enrollment groups. IN confirmed these enrollment changes.	9/8/2011
IN	Eligibility	MASBOE	IN is a 209(b) state. Also, starting in Q1 2005, IN reported SSI disabled over 65 to MASBOE 11.	11/22/2011
IN	Eligibility	MASBOE	Indiana reports an average of 5,300 enrollees per month to State Specific Groups 'DWN' and 'DWY'. Enrollees in these groups are working disabled individuals eligible for the state's Medicaid Buy-in Program called M.E.D. Works (Medicaid for Employees with Disabilities). To be eligible for the program, enrollees must be disabled and working, 16-64 years of age, and have incomes <= 350% FPL.	10/25/2013
IN	Eligibility	Private Health Insurance	From Q4 FY 2009 through Q3 FY 2013 there has been considerable variability in reporting private health insurance (Health Insurance '3') in MSIS. The state reported 80,500 enrollees with private insurance in December 2009. The count jumped to 101,500 in January 2010, fell to 90,200 in December 2010, and increased again to 113,400 in January 2013. As of June 2013, the state reported 110,900 individuals with private insurance. In the past Indiana indicated that the subcontractor responsible for capturing third party coverage accidentally	10/25/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			reported HIP pharmacy receipts as third-party coverage. It added that the problem had been corrected later in 2010. However, subsequent reporting does not support this contention. We will need to obtain a further explanation from the state.	
IN	Eligibility	Race/Ethnicity	IN has not been reporting enrollment in race codes 6, 7, or 8. The state does not have the data to report these fields.	6/14/2010
IN	Eligibility	Restricted Benefits Flag	IN reports pregnant women who receive pregnancy-related services to RBF 4. Pregnant women who receive only emergency services are reported to RBF 5. Starting in Q2 FY10, IN also reports pregnant women with presumptive eligibility to RBF 4. This group includes only about 300 people each month. Other eligibility groups reported to RBF 4 include: 'E' --extended eligibility for pregnant women and 'N' pregnancy-related coverage. In Q2 FY10, enrollment in RBF4 increased. IN confirmed this increase.	4/21/2011
IN	Eligibility	Restricted Benefits Flag	In June 2008, CMS approved a Money Follows the Person (MFP) program in IN. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. IN started transitioning clients into the program in June 2009. These enrollees were first reported in MSIS with RBF 8 in the Q3 FY 2009 file.	9/13/2011
IN	Eligibility	Restricted Benefits Flag	Indiana established a new benefit for Family Planning Services under an amendment to the State Plan. This went into effect on January 1, 2013. The state assigned these enrollees to RBF '6' (FP-only) and to MASBOE '34' or '35', depending on the beneficiary's age. As of March 2013, enrollment in the Family Planning program was about 7,500 per month.	8/27/2013
IN	Eligibility	Restricted Benefits Flag	As of Q3 FY 2013, Indiana reports about 16,000 enrollees per month to RBF '5' (Other Restricted Benefits). The state uses this flag to identify pregnant women and non-citizens eligible for emergency services only. The state previously indicated that it is unable to identify these two groups separate in its MSIS data. It cannot report them to RBFs '2' (Restricted Benefits – Alien) or RBF '4' (Restricted Benefits – Pregnancy-related).	10/25/2013
IN	Eligibility	Restricted Benefits Flag	In January 2008, Indiana implemented an 1115 waiver segment that offers POWER (Personal Wellness and Responsibility) Accounts to eligible individuals. POWER Accounts act like Health Savings Accounts. As of Q3 FY 2013, the state reports about 37,100 of these enrollees per month to RBF 'B' (HOA - Health Opportunity Account) and MASBOE '55'.	10/25/2013
IN	Eligibility	Restricted Benefits Flag	Indiana's CA-PRTF demonstration grant expired on 30Sep2012. Members in the demonstration transitioned from the CA-PRTF grant to the state's 1915c PRTF waiver on 01Oct 2012. The state no longer reports these enrollees to RBF 'A' (Psychiatric Residential Treatment Facilities Demonstration Grant Program).	10/25/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
			Instead it reports them to 1915c waiver 'PT'. As of Q3 FY 2013, the state reports about 500 enrollees per month to the waiver.	
IN	Eligibility	Restricted Benefits Flag	Enrollment in Indiana's Family Planning Eligibility Program increased sharply between January 2013 and June 2014. It was about 4,400 in January 2013. It rose to 26,700 in June 2014 [+500%]. The state assigned nearly all of these enrollees to RBF '6' and MASBOE '35' [Poverty related – Adult]. On January 1, 2013, Indiana's Family Social Services Administration [FSSA] implemented a new family planning benefit through a State Plan Amendment [SPA]. The program lets men and women receive certain family planning services and supplies for the primary purpose of preventing or delaying pregnancy. The program has several eligibility requirements. The beneficiary: 1) does not qualify for any other category of Medicaid; 2) must be a U.S. citizen, certain lawful permanent resident, or certain qualified documented alien; 3) cannot be pregnant; 4) must not have had a hysterectomy or sterilization; and 5) must have income that is at or below 133% of the federal poverty level.	12/23/2014
IN	Eligibility	SSN	In Q4 FY 2009, IN started reporting about 1,800 SSNs with duplicate records. This duplicate reporting involves pregnant women with presumptive eligibility. When a person receives presumptive eligibility, she is assigned a temporary Medicaid ID that begins with '55'. If she is found to be eligible the state assigns her to a new, permanent Medicaid ID. Starting in Q4 FY09, IN accidentally submitted files with the temporary IDs. The presumptive eligibility program did not have federal funding until Jan 2010. Starting in Q2 FY10, there were only a small number with temp (PE) IDs each month. The state should be replacing the temp ID for any individuals who were found to be eligible.	9/8/2011
IN	Eligibility	TANF/1931	Due to ongoing problems with TANF reporting, IN requested permission to 9-fill its TANF flag from CMS. This change went into effect in Q1 FY 2005.	9/13/2011
IN	Eligibility	Waivers	Indiana's CA-PRTF demonstration grant ended on September 30, 2012. It was replaced with the PRTF Transition Waiver on October 1, 2012. The state moved nearly all enrollees in the demonstration program to the new waiver. As a result, Indiana no longer reports enrollees to RBF 'A'. It reports them instead to the Transition Waiver with Waiver ID 'PT'.	8/27/2013
IN	Eligibility	Waivers	Until Q1 FY2013, Indiana reported about 550 enrollees per month to the state's Autism Waiver ('AU'). It moved most of them to the Community Integration and Habilitation Waiver ('DD') starting in August 2012. It completed the move in October 2012. The state formerly called the waiver the Developmentally Disabled Waiver. It continues to report it using Waiver ID 'DD'.	8/27/2013
IN	IP	Family Planning	There aren't any claims with a Program Type of 2 (Family Planning).	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
IN	IP	Managed Care Encounters	Between Q3 2013 and Q2 2014, the number of IP encounter claims decreased substantially (from over 116,934 claims to 17,368). The state says this is because in Q3 2014 Indiana resumed HAF payments (hospital assessment fees) and since then the method for reimbursement IP services has changed.	11/5/2014
IN	IP	Revenue Code	Around 10% of the inpatient claims do not have ancillary services.	2/11/2007
IN	LT	FFS Claims	Between Q3 2013 and Q2 2014, the number of FFS claims doubled. The state says this is because they have seen an increase in supplemental payments to nursing facilities.	11/5/2014
IN	OT	Capitation	The PCCM capitation payment records (reported to the Type of Service = 22) in the Claim OT file, include the following types of payments for the members enrolled in the Care Select program (PCCM):1. A per-member, per-month administration fee paid to the Primary Medical Providers (PMPs) enrolled in the Care Select network. 2. A per-member, per-month administration fee paid to the Care Management Organizations (CMOs) for members actively enrolled in their organization. The care management organization is an entity that is a primary care case manager. The PMPs enrolled in Care Select contract with the CMOs. This results in capitation claims being almost double the person months of enrollment for PCCM.	5/25/2013
IN	OT	FFS Claims	FFS XO claims fluctuated between 1.8 and 2.4 million between Q3 2013 and Q2 2014. The state says this is normal.	11/5/2014
IN	OT	Managed Care Capitation	In FY 07/08, providers received a bonus payment from the state. For MCOs, these bonus payments were recorded as capitation payments resulting in an apparent increase in cap payments.	NA
IN	OT	Managed Care Capitation	There is enrollment reported to one managed care plan (Plan ID: 155723420), but no capitation payments reported for that plan. IN explained that Managed Care Plan ID 155723420 pertains to members enrolled in the Healthy Indiana Plan (HIP) - Enhanced Services Plan (ESP). Members who have certain high-risk medical conditions are enrolled in the ESP Managed Care Entity (MCE). The State is paying for services provided to ESP members on a fee-for-service basis. The ESP plans do not receive a per-member-per-month capitation payment. Only the non-ESP HIP MCEs receive capitation payments.	4/6/2012
IN	OT	Managed Care Encounters	Between Q3 2013 and Q2 2014, the number of encounter claims increased from >3.7 million to >5.3 million. The state says this is because starting Q3 2013, the state changed the way encounters were processed in order to accurately report Third Party Liability. This caused mass adjustments which affects all quarters through 2014 Q3.	11/5/2014
IN	OT	Type of Service	In FY2008, state shifted a number of HCPCS codes from Rehab (TOS=33) to Physician (TOS=08). CMS chose not to ask state to	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
			resubmit FY2007 data, so this disjoint will be apparent when looking at FY2007 and FY2008 side-by-side.	
IN	OT	Type of Service	Starting in FY2008, IN moved 'Community Mental Health Services' claims, from Type of Service 08 to Type of Service 12.	NA
IN	OT	Type of Service	There is a large shift from Type of Service Rehab to Physician starting with Q1FY2008. This is the result of moving one service code in the state crosswalk.	NA
IN	RX	Adjustments	IN reported 8.06% of their voided claims with positive dollar amounts in Q4FY2011.	12/2/2011
IN	RX	CHIP	There were a small number of separate CHIP claims in the 2008 and 2009 RX file.	7/1/2011
IN	RX	Medicaid Amount Paid Total	Starting Jan 1, 2010 (2010 Q2 RX), claims volume and amount paid doubled. According to the state, 2010 pharmacy services are carved out and the Managed Care Organizations (MCO) no longer process these services. Changes were implemented to process pharmacy drug services for MCO members through the Fee-for-service delivery system and manage pharmacy services for drugs dispensed statewide.	NA
IN	RX	NDC	In Q2 2013 and before, 0% of NPIs = billing provider ID. Starting Q4 2013, Indiana began reporting the pharmacy/pharmacist's NPI as the billing provider ID.	4/7/2014
KS	_All	MSIS ID	KS erroneously included some state-only claims in their MSIS files in 1999-2006 and possibly later. These people are all enrollment in managed care. We were unable to identify those claims until the MSIS 2005 files when the state provided the Plan ID's for those state only claims. They have not been excluded from the 1999-2008 MSIS files, but can be identified as they have one of the following Plan ID's (100332630B, 100640400C, 100640410B, 200302690A).	7/23/2007
KS	Claims	Link	KS 2011 claims files were approved even though the links between MSIS IDs in the EL file and MSIS IDs in the claims files were poor. Links failed due to the EL file because Kansas only included beneficiaries in the EL file if they were still eligible on the date the MSIS EL file was created. The state was not asked to resubmit their EL files. It is not clear in which quarter the Link will approve.	8/12/2014
KS	Eligibility	1115 Waivers	Effective January 2013, Kansas has implemented a section 1115 demonstration waiver, "KanCare", which was to enroll nearly all Medicaid enrollees in managed care. The waiver does not expand Medicaid eligibility. However, this waiver was not reported in the Q2-Q4 FY 2013 MSIS EL files. Furthermore, all managed care reporting ceases as of January 2013 (except for PACE enrollment, which continues). The state confirmed that the managed care plan associated with KanCare should have been reported starting in Q2 FY 2013. The state is working to map the KanCare 1115 enrollees and the managed care	11/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			enrollment associated with the waiver and will resubmit the Q2-Q4 FY 2013 files.	
KS	Eligibility	CHIP	Kansas has a child S-CHIP program that is not reported in MSIS. KS implemented an expansion to its SCHIP program effective January 1, 2010, which increased the eligibility level from 200% to 250% of the 2009 FPL. The income limit is tied to the 2009 poverty level (250%), therefore the limit in 2011 is 241% FPL. The state does not intend to expand S-CHIP to pregnant women although earlier documentation suggested that it would. The program charges premiums to the participating families.	4/6/2012
KS	Eligibility	Data System Change	Kansas reported that its new / upgraded eligibility system is on target for implementation in October 2013.	11/6/2012
KS	Eligibility	Dual Eligibility Codes	Kansas uses the dual flag 08 for persons whose income and resources are too high to qualify for QMB plus, or SLMB plus, but who still receive full Medicaid benefits.	NA
KS	Eligibility	Dual Eligibility Codes	In FY06- Q4 FY08, when monthly dual coding was implemented, KS reported several hundred partial duals to MASBOE 41-42 (other, aged/disabled). Generally we would not expect to see partial duals in MASBOE 41-42. In Q1 FY09, KS removed almost all of the partial duals from MASBOE 41-42. However, some partial duals remained, especially in month 3 of each quarter. When KS reviewed and corrected this reporting they moved some people from MASBOE 41-42 to 31-32. At that time, enrollment in MASBOE 21-22 also declined. We asked the state if this change was related to the recoding of dual eligibles. Kansas still reports a small number of partial duals in MAS 2 and 4, and a small number of full benefit enrollees to MAS 3.	11/15/2011
KS	Eligibility	Dual Eligibility Codes	Each month through Q4 FY 12, about 3,500 non-duals are reported to MAS/BOE 31-32, all of which are assigned to eligibility groups= '21' and '22.' A comparison to the Medicare EDB for 2010 shows that the majority of these enrollees (approximately 2000) are dual eligibles according to that data source. We have asked the state to review the assignment of dual code in MSIS for these individuals.	10/14/2012
KS	Eligibility	Dual Eligibility Codes	As of July 2012, KS is developing an initiative outside the CMS duals financial alignment demonstrations to coordinate care for some or all dual eligible beneficiaries in their states, including coordination of acute care services	11/6/2012
KS	Eligibility	Managed Care	In Q2 FY07, KS managed care enrollment shifted dramatically. HMO enrollment increased from about 71,000 in December 2006 to 107,000 enrollees in January 2007. At that time, enrollment in the First Guard plan (id 100332630A) ended and two new HMOs appear (plan ids: 200403230A and 200405200A). In that same period, PCCM enrollment dropped from 72,000 in December 2006 to 22,500 in January 2007. The state contact explained that this change was expected. KS moved about 49,000 beneficiaries from the HealthConnect Kansas PCCM program into one of two new MCOs. This was a result of adding	12/15/2008

State	File Type	Rec/Issue Type	Issue	Recorded
			a second MCO to the HealthWave program and a policy change mandating that all "Temporary Assistance to Family" (TAF) and "Poverty-level Eligible" (PLE) members enroll in an MCO if multiple MCOs exist in their county.	
KS	Eligibility	Managed Care	Each month, about 3,000-4,000 partial duals are reported as enrolled in or more behavioral health plans (plan type =3). Most are enrolled in both of KS's behavioral health plans- one a PAHP, the other a PIHP. Since it is unusual for partial duals, who only receive cost-sharing Medicaid benefits, to be reported as enrolled in any type of Medicaid managed care plan, we have asked the state to clarify whether this is accurate. The state has said that these are medically needy enrollees whose spend-down was not met.	12/21/2011
KS	Eligibility	Managed Care	In July 2007, KS added 2 capitated behavioral health plans: KS Health Solutions (a mental health PAHP, ID 200425160) and Value Options (a substance abuse PIHP, ID 200426390). KS reported capitation payments for these plans in the OT files (with HMO type of service) starting in 2007 but did not report enrollment in the eligibility files until Q1 FY 2009. KS reports two different versions of each plan, with one version that has a Plan ID ending in 'A' and the other ending in 'B'. KS does not make capitation payments for people enrolled in the 'B' version of the plan. These are Medically Needy persons who have not met spenddown requirements. Beginning in Q2 FY 2010, all but about 700 behavioral health plan enrollees are reported to both of these plans. The state said that this is because one is a PAHP and one is a PIHP, and Medicaid enrollees are assigned to both of these plans. The state has also told us that enrollees in the state-funded MediKan program are assigned just to the PAHP. CMS asked the state to make sure these enrollees are not being reported in the MSIS data.	12/21/2011
KS	Eligibility	Managed Care	KS added a non-emergency transportation benefit plan (NEMT) for all persons who are not enrolled in an HMO in November 2009. The state started reporting these enrollees to Plan Type '8' and Plan ID '200617040A' in MSIS at that time. The June 2010 CMS managed care report lists this plan as a Transportation PAHP. The state confirmed that enrollment in MSIS of approximately 100,000 by early 2010 is as expected. KS reports that this plan ended on 12/31/2012.	4/4/2012
KS	Eligibility	Managed Care	Enrollment in Plan Type = '1' (HMO) increases suddenly from 137,000 to 180,000 from December 2010 to June 2011; over this same period, Plan Type = '08' enrollment drops from 150,000 to 121,000. The state has said that these changes were expected, but did not provide a reason.	4/6/2012
KS	Eligibility	Managed Care	Kansas's PCCM program ended effective 12/31/2012.	11/6/2012
KS	Eligibility	Managed Care	Beginning in January 2013, Kansas ceased reporting all managed care enrollment (Plan Types '1', '3', '7', and '8'), except for PACE enrollment (plan type '6'). However, external documentation shows that Kansas was planning to move nearly	3/13/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			all Medicaid enrollees into managed care plans effective January 2013 via the KanCare 1115 waiver. The state confirmed that enrollment in the KanCare plans (plan type '1') should have begun effective 1/1/2013. The state is working to correct this and will resubmit its Q2-Q4 FY 2013 files.	
KS	Eligibility	MASBOE	Q3 FY09: Enrollment in MASBOE 31, 32, 34, and 35 increased and MASBOE 41/42 decreased. The changes in MASBOE 31/32 and 41/42 may be related to the state's efforts to move partial duals to MAS 3. Enrollment in MASBOE 22 also increased in this quarter (driven by an increase in medically needy enrollees). We asked the state to clarify these enrollment changes but did not receive a response.	11/11/2009
KS	Eligibility	MASBOE	Starting in September 2007, KS has an approved alternative benefit plan. KS added reporting to this plan in MSIS in Q3 FY 2009. See RBF note. See dual eligibility anom re: shifts in MASBOE 21-22, 31-32 and 41-42 in Q1 FY09.	5/28/2010
KS	Eligibility	MASBOE	In Nov 2009, when KS implemented a non-emergency transportation plan, the state added a new benefit plan code: NEMT. This code is mapped to many different population codes and to a variety of MASBOE categories. MASBOE categories, however, did not shift when this plan was introduced.	11/15/2011
KS	Eligibility	MASBOE	Enrollment in MASBOE 21-22, medically needy, has declined steadily each quarter since the beginning of FY 2009. The state said that they expect a decline at the beginning of each calendar year, but not to this magnitude. The state suspects that there may have been a change in billing processes by a few key providers which would have resulted in a reduction in claims allowed against a spenddown and then a subsequent change in the number of people meeting spenddown. However, from Q1 FY 10 to Q2 FY 10, enrollment in MASBOE 22 increased substantially, by 17 percent.	4/6/2012
KS	Eligibility	Private Health Insurance	Each month, KS reports about 300 to 350 people to health insurance code 3. The state reported that these are persons enrolled in a Health Insurance Premium Payment (HIPP) program, through which Medicaid pays private health insurance premiums for qualifying individuals.	7/8/2011
KS	Eligibility	Restricted Benefits Flag	In Q4 FY08, KS started reporting enrollees to RBF 8 (MFP). KS implemented the program on July 1, 2008.	4/9/2009
KS	Eligibility	Restricted Benefits Flag	In September 2007, KS started enrolling some working disabled individuals into an approved alternative benefit plan (WORK). Working disabled individuals are in KS's "working disabled" state eligibility groups (26). It appears that only a subset of persons in this state group opt into the alternative benefit plan. Although enrollment started in 2007, KS did not report these enrollees to RBF 7 until Q1 FY 2009.	5/28/2010
KS	Eligibility	Restricted Benefits Flag	Since Q1 FY09, KS has reported PRTF grant enrollees to RBF A.	8/13/2010

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State	File Type	Rec/Issue Type	Issue	Recorded
KS	Eligibility	Retroactive/ Correction Records	Although KS has submitted retro-records in the past, the state has not used them since Q4 FY02.	3/3/2011
KS	Eligibility	State-Specific Eligibility	In 2012-2013, there are fairly sizeable enrollment fluctuations in eligibility group "MN". The state has said that this is due to eligibility worker errors, but the workers are later educated. These errors are an ongoing issue and are corrected when found.	2/15/2013
KS	Eligibility	TANF/1931	Effective FY06 Q1, the state began 9-filling the TANF field.	3/3/2011
KS	Eligibility	Waivers	From Q3 FY08 - Q4 FY08, KS reported PRTF grant enrollees to waiver ID PR (waiver type 3). In Q1 FY09, KS correctly stopped reporting enrollment to this waiver ID and started reporting these enrollees to RBF A.	5/28/2010
KS	Eligibility	Waivers	We would expect that most enrollees in the KS Physically Disabled (Waiver ID= 'PD') waivers would be assigned BOE= '2', but many enrollees in these waivers have BOE '1' even though CMS documentation indicates only adults age 16-64 are eligible. The state clarified that though initial eligibility for the waiver is age 16-64, existing enrollees are allowed to stay on the waiver past this age once enrolled.	2/15/2013
KS	Eligibility	Waivers	KS reports about 20% of 1915c waiver enrollees per quarter without any HCBS waiver claims. The state has said that this is expected and matches their internal records.	2/16/2013
KS	LT	Covered Days	The file contains mostly weekly bills.	12/10/2004
KS	LT	Covered Days	If the state does not pay for all covered days on the claim, the number of covered days is not reduced to reflect the days paid.	8/22/2005
KS	LT	Medicaid Amount Paid $0	There is a higher percent of claims with $0 Medicaid Amount Paid than expected due to the application of spend-down.	12/10/2004
KS	LT	Type of Service	In 2010, LT file shows a large percentage increase in Child IP Psych Services (TOS=04), while showing a large drop in average amount paid per claim.	3/28/2011
KS	OT	Capitation	Plan ID reporting is not consistent for managed care. PCCM person member person month does not line up with capitation for 2011 Q1/Q2/Q3.	8/11/2014
KS	OT	Diagnosis	Kansas uses some local diagnosis codes.	12/10/2004
KS	OT	Family Planning	KS stopped reporting Family Planning in FY2004 forward.	NA
KS	OT	Managed Care Capitation	120,000 HW 19 persons get three payments (one physical health, one PIHP, one PAHP. Approximately 160,000 FFS persons get 2 payments (one PIHP and one PAHP). Since MSIS counts each cap payment independently this seriously skews the numbers. For KS, the MSIS OT data file contains a record for each capitation. A high percentage of eligibles for a given quarter will have both a PAHP and PIHP capitations. This will push the KS ratio of MSIS OT capitation records to eligibles	9/24/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
			close to 2:1. The earliest capitation records for PAHP/PIHP are from 2007-09.	
KS	OT	Managed Care Capitation	Average dollars for capitation claims went from $213 to $76 from Q1FY2007 to Q2FY2009. Mental health services and substance abuse services were previously billed as FFS and were then switched to PIHP & PAHP. These have a lower dollar amount, therefore lowering the average as well.	9/25/2009
KS	OT	Managed Care Encounters	Starting in Q4FY2010, KS started reporting OT encounter claims resulting in a large increase in the total number of claims.	5/19/2011
KS	RX	Date Prescribed	The date filled is also reported in the date prescribed field.	7/11/2005
KS	RX	Managed Care Encounters	Starting in Q4FY2010, KS started reporting RX encounter claims resulting in a large increase in total number of claims.	5/19/2011
KS	RX	Type of Service	In Q2 and Q3FY2010, KS erroneously reported a few RX claims with a TOS of 15 (lab and x-ray) instead of 16 (drugs). This error is corrected in FY2011.	5/19/2011
KY	_All	MSIS ID	Starting in 2003, KY has a small percentage of claims that don't link with the MSIS eligibility file. It has not been corrected.	1/13/2008
KY	Claims	HCBS Waiver	The Program Type of Waiver was erroneously assigned to some IP and LT claims in Q3and Q4FY2008. The state corrected this beginning with Q1FY2009.	NA
KY	Claims	Managed Care Plan IDs	Some Plan IDs on encounter claims don't link with those in the eligibility file. They appear to be provider IDs.	3/3/2011
KY	Eligibility	CHIP	In Q1 FY 2011, Kentucky began to report complete separate CHIP [CHIP-CODE '3'] data to MSIS. The state reported average enrollment of 24,100 per month for the quarter. The state assigns all separate CHIP enrollees to RBF '1' [Full Benefits]. It also assigns almost all of them [99.5%] to SSG 'I P705'. Prior to 2013, about 25% of the enrollees were assigned to waiver ID 'MC', the Kentucky Health Care Partnership. The state assigned the remaining enrollees to its PCCM program. Kentucky let Waiver 'MC' expire in December 2012. Since that time, all separate CHIP enrollees have been assigned to a comprehensive managed care program.	1/9/2014
KY	Eligibility	CHIP	There is substantial month-over-month variation in the data Kentucky reports to MSIS for CHIP participants compared to what it reports to SEDS. In general, the state reports somewhat more CHIP-eligible individuals to MSIS than to MMA. The state indicated previously that the inconsistency is due to a lag in creating and submitting the two files. The state reports marginally more Other Full Duals to MSIS and marginally fewer QMB-only and QMB+ duals to MMA.	1/9/2014
KY	Eligibility	Dual Eligibility Codes	Between August and September 2012, total Other Full-benefit Duals [08] increased from about 22,700 to 146,100. The number returned to about 19,900 in October 2012. Nearly one-third of the increase [30.5%] came from children <= 20 years.	1/9/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			We did not detect a similar increase in the MMA data the state sent to CMS. As of January 2013, Kentucky has not explained this finding.	
KY	Eligibility	Dual Eligibility Codes	Since at least 2010, Kentucky has assigned about 90-100 full-duals per month to MASBOE 35. The state indicates that this group includes pregnant women with incomes <= 185% FPL who are Medicare-eligible.	1/9/2014
KY	Eligibility	Dual Eligibility Codes	Since at least Q4 FY 2011, Kentucky reports about the same aggregate number of full and partial duals to MSIS each quarter as it reports to MMA. The state tends to report somewhat more QMB+ and Other Full Duals to MSIS, however. Users should note that there is an apparent error in the count of Full Duals reported for September 2012.	1/9/2014
KY	Eligibility	Dual Eligibility Codes	Starting in Q1 FY 2009, Kentucky began to report an increasing number of QI-1 duals in MSIS. In October 2008, the state reported about 7,900 QI-1s. This grew to more than 12,700 in September 2012, an increase of 61.5%. The total has fallen slightly since then, and was about 11,800 in September 2013. The state notes that the increase is due to policy changes implemented as a result of the Medicare Improvement for Patients and Providers Act [MIPPA].	1/9/2014
KY	Eligibility	Managed Care	KY enrolls full duals in the HMO managed care plan. A reduced capitation rate is paid for the full duals. In addition, full duals receive transportation managed care benefits (Plan Type 08).	7/12/2011
KY	Eligibility	Managed Care	During Q2 - 4 FY10, PCCM enrollment among disabled enrollees (particularly among non-duals) declined. The state is reviewing this decline and believes it is probably the result of normal attrition (due to death or movement into LTC programs) and the fact that the newly Medicaid eligible disabled population is not currently being enrolled into PCCM. PCCM enrollment ended in November 2011, when KY implemented HMO coverage statewide.	4/26/2012
KY	Eligibility	Managed Care	In October 2011, Kentucky moved ˜ 550,000 enrollees from KenPAC, the state's PCCM program, into risk-bearing managed care. In December 2012, it moved another 170,000 enrollees, who had been in the Kentucky Health Care Partnership, into the statewide managed care plan. As a result, virtually all enrollees now are assigned to Plan Type '01'. They are also assigned to Plan Type '08' for non-emergency transportation services. Although KenPAC existed prior to Q1 FY 2011, it appears that the state reported Plan IDs for PCCM providers incorrectly at that time. The data indicate that Kentucky assigned PCCM providers to Plan Type '08' [Other], not Plan Type '07' [PCCM]. In the Q4 FY 2010 EL file, the state reported no providers with Plan Type '07'. It appears that the state lumped 'Other' and PCCM into a single 'Other' category. This is clear because some plans that were '08' in Q4 FY 2010 were classified as '07' in Q1 FY 2011. As of January 2013, everyone in the state is assigned to a comprehensive managed care and non-emergency	1/9/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			transportation plan. The state is reporting these individuals to the correct plan types. However, users should exercise caution when using Plan Type and Plan ID for 2010 and 2011.	
KY	Eligibility	Managed Care	In Q1 FY 2011, Kentucky began to report enrollment in a new transportation section 1915(b) waiver (Waiver ID 'NT'). Enrollment in this waiver is consistent with total transportation managed care enrollment. Kentucky confirmed that it is again using a waiver to provide transportation managed care services.	1/9/2014
KY	Eligibility	Managed Care	Kentucky stopped reporting enrollment in its Health Care Partnership 1115 waiver in January 2013. The state let the waiver expire on 31Dec2012. It appears that all enrollees in the waiver were reassigned to the state's 1915b MO waiver. MPR should validate the status of the waiver with the state. Should it be classified as an 1115 waiver?	1/9/2014
KY	Eligibility	Managed Care	Prior to 1995, Kentucky's Department of Medicaid Services [DMS] provided health services statewide through the Kentucky Patient Access and Care [KenPAC] program. The state established KenPAC as a primary care case management [PCCM] program in February 1986 under a Medicaid 1915b waiver. At the time, Kentucky decided not to implement capitated managed care, because a previous capitated arrangement [1983-84] ended amid controversy. In 1995, Kentucky began to implement a Medicaid 1115 demonstration called the Kentucky Health Partnership Program. Under the Partnership Program, DMS planned to move nearly all Medicaid beneficiaries in the state to capitated managed care. With the exception of a few "exempt" beneficiaries, all recipients would be required to enroll in a regional partnership plan. Recipients could not choose from a menu of different plans; and they could not choose to remain in Fee-for-Service care. Kentucky assigned all recipients in the demonstration to Waiver ID 'MC' and Waiver Type '1'. Until December 31, 2012, when it expired, Kentucky reported an average monthly enrollment in the waiver of 172,300. The Partnership differed substantially from demonstrations implemented by other states. Kentucky deliberately chose not to contract with existing commercial MCOs. Instead, it proposed to contract with eight regional "partnerships". Each partnership would provide its members with comprehensive health care services, except for long-term care. The state expected each partnership to be a capitated risk-bearing entity. Only two regions, Region 3 [the Louisville area] and Region 5 [the Lexington area], successfully formed managed care partnerships and eventually signed contracts with the state. For several reasons, Region 5's partnership operated at a substantial loss. After unsuccessful attempts to negotiate higher capitation rates, the partnership ended operations in November 1999. As a consequence, except for Region 3, the state reverted to a PCCM-FFS reimbursement plan under an expanded version of KenPAC. Kentucky continued to operate this way until November 2011. In November 2011, the state moved about 550,000 Medicaid beneficiaries from KenPAC, its	1/9/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			PCCM model of care, to risked-based managed care. The transition took place in seven of the state's eight Medicaid regions. Kentucky did not include Region 3 in the transition, since it had used managed care in the region continuously since 1995 through the Passport managed care plan. The state did not create "carve outs" for special populations, and it moved all beneficiaries at the same time. Initially the state automatically assigned beneficiaries to three new MCOs: Kentucky Spirit [Plan ID '7100165040'], WellCare [Plan ID '7100164990'] and Coventry Health and Life [Plan ID '7100165000']. Kentucky used an auto-assignment algorithm that took into account historical provider relationships, consistency between household membership and plans, and cross-plan load balancing. Beneficiaries were given 90 days from the initial implementation date to switch plans and many of them did. The state originally assigned about 218,200 beneficiaries to KY Spirit in November 2011. It also assigned about 211,500 to Coventry and 120,200 to WellCare. It assigned a disproportionate share of beneficiaries to Kentucky Spirit, because that MCO had the lowest overall capitation rates. Numerous beneficiaries left Kentucky Spirit, primarily as the result of network issues. By June 2012, enrollment in Kentucky Spirit had fallen to 147,000. In contrast, enrollment in WellCare had grown to 156,000 over the same period. On 05Jul2013, KY Spirit left the state's Medicaid program. Kentucky automatically reassigned its beneficiaries to WellCare [Plan ID '7100164990'] and Coventry Health & Life [Plan ID '7100165000']. The reassignment is reflected in the enrollment reported to MSIS for Q4 FY 2013. WellCare enrollment increased from 232,200 to 291,600 [+59,400/25.6%] between July and August 2013. Coventry enrollment increased from 210,600 to 275,100 [+64,500/30.6%] over the same period.	
KY	Eligibility	MASBOE	KY has a state-administered SSI supplement which may cause the number reported to MASBOE 11-12 to be slightly higher than SSA data.	NA
KY	Eligibility	MASBOE	KY reports many aged disabled in BOE 2. CMS confirmed that KY could continue doing so to avoid disrupting state comparisons with SSA data.	10/15/2010
KY	Eligibility	MASBOE	Each month, KY reports a small number of people with inconsistent MASBOE and dual codes. The state believes that this is caused by changes in eligibility status between the eligibility month and the date MSIS files were submitted. The system seems to report current status rather than status as of eligibility month. The state has made MSIS file generation logic updates that reduced the number of inconsistent dual status and MASBOE categories.	2/7/2011
KY	Eligibility	MASBOE	In FY 2009, enrollment in MASBOE 25 and 34 increased. KY explained that the growth in 34 resulted from an outreach effort that started in November 2008 to enroll uninsured children. The increase in MASBOE 25 did not result from any policy changes in	1/24/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			the state but may be an effect of improved coordination across state offices.	
KY	Eligibility	MASBOE	In Q1 FY 2009, KY remapped some enrollees to new MASBOE categories after they reviewed their crosswalk and realized it was out of date. They also submitted a new MASBOE crosswalk with the reassignments of program/status code changes. (1) They moved aged, blind, and disabled people in LTC and in managed care extended eligibility from MASBOE 21-22 to 41-42. (2) They moved spend down foster care children to MAS 2. (3) They moved children and caretaker relatives who were losing eligibility for transitional eligibility from MAS 2 to MAS 4. (4) They moved all persons in K-TAP (KY's TANF program) to MAS 1.	1/24/2012
KY	Eligibility	MASBOE	In Q1 FY 2008, Kentucky added two new codes [KW* & MW*] to its crosswalk of state aid categories. These categories are used for working disabled or blind individuals who "buy into" Medicaid through the state's Ticket to Work program. Since inception, Kentucky has never assigned anyone to aid category 'KW*'. However, it does assign a small number of enrollees each month [= 25] to state aid category 'MW*'. Kentucky also assigns these individuals to MASBOE 42 [Other Eligibles – Blind/Disabled].	1/9/2014
KY	Eligibility	Restricted Benefits Flag	Kentucky implemented a Money Follows the Person program in October 2008. From implementation through September 2010, enrollment averaged less than 100 beneficiaries per month. It peaked at 143 in December 2011 and has declined consistently since then. Average monthly MFP enrollment was about 82 during Q4 FY 2013.	1/9/2014
KY	Eligibility	Restricted Benefits Flag	Since implementing Medicaid reform in May 2006, Kentucky is an Alternative Benefit Plan state. Generally alternative benefit plan enrollment should be reported as RBF '7'. However, the state indicated previously that under its plan all Medicaid enrollees could be considered as falling under the alternative benefit plan. As a result, the state does not use RBF '7'.	1/9/2014
KY	Eligibility	SSN	In Q1 FY 2011, Kentucky began to report a 10-Character Numeric MSIS ID. As a result, it is no longer an SSN state. At the time of conversion, Kentucky submitted a cross-reference file to link the old and new MSIS IDs. As of Q4 FY 2013, the state assigned valid SSNs to about 96% of its enrollees and 9-filled about 2.0% of them.	1/9/2014
KY	Eligibility	TANF/1931	Each month Kentucky reports about 13%-18% more enrollees to the Administration for Children and Families [ACF] than it does to MSIS. The differences for December 2011 and 2012 were -13% and -18.2% respectively. A previous anomaly noted that the cause of this difference is unknown.	1/9/2014
KY	Eligibility	Waivers	The Q1/4 Waiver link reviews consistently find that KY just meets the threshold for 1915c claims and enrollment links. Until Q1 FY 2009, the state routinely reported community mental	11/8/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			health claims as Program Type 7 which led to some people being identified as having 1915c claims but no 1915c waiver enrollment. The link improved in FY09 when KY fixed this reporting.	
KY	Eligibility	Waivers	New 1915b waiver (ID MO) was reported starting Q1 FY 2012 with about 550,000 enrollees a month (see managed care anom). This new waiver is related to the state's managed care expansion at that time.	2/23/2012
KY	Eligibility	Waivers	Waiver link results show that in 2010, KY identified very few claims as HCBS claims (Program Type 6/7). This issue appears to have been corrected in 2011.	3/6/2012
KY	Eligibility	Waivers	Between Q4 FY 2012 and Q4 FY 2013, enrollment in 1915c waivers 'BL' [+27.8%], 'MP' [88.0%] and 'SC' [17.3%] increased considerably. When we previously asked about these changes, the state indicated that it represents normal enrollment fluctuation. Kentucky also noted growth in the 'Michelle P' Waiver [Waiver ID 'MP'] may be caused by individuals continuing to transition into this comparatively new program.	1/9/2014
KY	Eligibility	Waivers	In January 2013, Kentucky completed implementation of statewide managed care. The state began to report a new 1915(b) managed care waiver [Waiver ID 'MO'] in 2011. It moved about 550,000 enrollees into the waiver during September 2011. It completed the transition of all enrollees to managed care in January 2013, when it reassigned everyone in Waiver 'MC' [173,000] to Waiver 'MO'. The state allowed its 1115 Demonstration Waiver 'MC' [The Kentucky Health Partnership] to expire on 31Dec2012. During Q4 FY 2013, Kentucky assigned more than 700,000 enrollees to Waiver 'MO'.	1/9/2014
KY	Eligibility	Waivers	There are issues with Kentucky's waiver link data for Q4 FY 2012 and Q1 FY 2013. In Q4 FY 2012, there were more than 5,100 Non-HCBS waiver enrollees [23.9%] with HCBS waiver claims. In Q1 FY 2013, there were more than 7,300 Non-HCBS waiver enrollees [33.3%] with HCBS waiver claims. However, the total dollars involved were less than $100,000 in each instance.	1/9/2014
KY	Eligibility	Waivers	Through Q4 FY 2013, each month Kentucky assigned about 1,000 enrollees aged < 21 years to its HCBS Waiver [Waiver ID 'HB']. The state previously indicated that the waiver is for "disabled individuals" and "individuals >= 65 Years". The state assigns children that are disabled and in need of HCBS services to the waiver.	1/9/2014
KY	IP	Managed Care Encounters	There are no Procedure Codes on encounter records.	12/10/2004
KY	IP	Managed Care Encounters	There is only one Diagnosis Code per encounter record.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
KY	LT	Covered Days	The number of covered LT days exceeds the days of enrollment due to the inclusion of covered days on LTC services not covered by the bundled rate.	12/10/2004
KY	LT	Leave Days	The state does not pay for leave days.	8/22/2005
KY	OT	Family Planning	There are no claims with Program Type 2 (Family Planning).	12/10/2004
KY	OT	HCBS Waiver	KY reported all claims for waiver enrollees with Program Type of Waiver, including non-waiver services, until Q1FY2009.	NA
KY	OT	ICN-Line	KY has been placing the Original Line Numbers for claims in the wrong columns and these values have been showing up as 8-filled. The state will make corrections to the OT files for submissions beginning FY2011. ICN-Line was still 8-filled in Q1FY2012	3/3/2011
KY	OT	Managed Care Capitation	Capitated claims in OT vs. enrollment in EL for HMO - Q3FY2010: There were approximately 30,000 more capitated payments in the OT file than there was enrollment in the EL file. The state explained that when they generate capitation payments, they pay both current months and retroactive months. They also make adjustments to previously paid capitations as part of the monthly reconciliation process and these adjustments are for six months prior to the current month.	12/21/2010
KY	OT	Service Code	There are many claims without Service Codes as Kentucky uses the UB-92 claim form for HH, hospice, and outpatient hospital billing.	12/10/2004
KY	OT	Type of Service	Almost everyone is enrolled in transportation managed care, but there are still some FFS claims for transportation.	9/25/2007
KY	RX	Date Prescribed	2009 RX files, KY was incorrectly placing the filled date in the prescribed field. They will make corrections with FFY 2010 forward. They said that in most cases, fill and prescribe date are the same, but when it wasn't, they were defaulting to placing the fill into the prescribed field.	2/10/2011
LA	_All	MSIS ID	Louisiana converted to a new eligibility system in mid-1999. Prior to that time, SSNs were not verified and the state used a Medicaid ID numbering scheme that included county and aid code. As a result there is a mis-match between the EL and claims files. Also LA does not submit a link between the Temp ID and SSN, so there is a claims/eligibility linkage problem until 2007 Q1.	NA
LA	Claims	Managed Care	In FY12 LA transitioned from a PCCM program to MCOs (known as the Coordinated Care Network - Prepaid program) and enhanced PCCMs (known as the Coordinated Care Network - Shared Savings program). Both models are built around health homes. Managed care encounters for the MCOs first appeared in MSIS IP, LT, OT, and RX files in Q3FY12. Managed care encounters in RX appear to be only medical supplies, not prescription drugs. MCOs are responsible for providing:	11/4/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Audiology Services, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Surgical Services, Ancillary Medical Services, Lab and X-ray Services, Medical and surgical Dental Service, Diagnostic Services, Organ Transplant and Related Services, Family Planning Services, Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, Emergency Medical Services, Communicable Disease Services, Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies, Emergency Dental Services, Emergency and Non-emergency Medical Transportation, Home Health Services, Basic Behavioral Health Services, Clinic Services, Physician Services, Pregnancy-Related Services, Nurse Midwife Services, Nurse Practitioner Services, Chiropractic Services (Age 0-20), Federally Qualified Health Center (FQHC) Services (including behavioral services provided by FQHCs), Rural Health Clinic Services, Immunizations (Children and Adults), End Stage Renal Disease Services, Home Health-Extended Services (Age 0-20), Eye Care and Vision Services, Podiatry Services, Private Duty Nursing Services, Rehabilitative Services, and Therapy Services (Physical, Occupational, Speech and Respiratory).	
LA	Claims	Medicaid Amount Paid Total	FY2008 Total Medicaid Amount Paid for the state experienced a $650 million increase (15%) over FY2007. According to the state, for the period in question, the state legislature appropriated funds to increase rates for: -physicians -direct service workers -home health -nursing homes -EPSDT dental -ambulance transportation -ICF/DD -hospitals Additionally, the legislature increased substantially the number of waiver slots; funded adult immunizations and expanded coverage of physician psychiatric codes.	9/30/2009
LA	Eligibility	1115 Waivers	LA implemented a Family Planning waiver (ID FP, type cases B5/115 and B6/116) in October 2006 (Q1 FY07) and started reporting these enrollees to MASBOE 55 and restricted benefits flag 6.	11/9/2010
LA	Eligibility	1115 Waivers	In Q1 FY 2011, LA implemented a new 1115 waiver, the Greater New Orleans Community Health Connection (GNOCHC). Enrollees in this program are reported to Type Cases 102 and 103 (A2 and A3) and assigned to MASBOE 55. These enrollees were not reported as waiver enrollees in Q1-2 FY 2011, but they were reported in a new Waiver ID (with Waiver Type 1) starting in Q3 FY 2011. Through Q2 FY 2011, LA reports these individuals to RBF 1 (full benefits). Documentation for this program suggests that GNOCHC enrollees have notable benefit limitations (including no inpatient or outpatient hospital coverage). LA started reporting these enrollees to RBF 5 (Other benefit restrictions) in Q4 FY 2011. Each month through Q2 FY 2011, Louisiana reports about 150 of the 12,000 GNOCHC enrollees to PCCM plans. GNOCHC enrollees are not eligible for PCCM coverage.	4/24/2012
LA	Eligibility	1115 Waivers	LA has two 1115 waivers: (1) Louisiana Greater New Orleans Community Health Connection (GNOCHC) which covers adults	11/11/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			with income between 0 and 100 percent of the federal poverty level who reside in city of New Orleans or the four neighboring parishes (Jefferson, Orleans, St. Bernard, or Plaquemines) and who do not have any health insurance through Medicaid or private insurance may be eligible for the demonstration. Enrolls about 65,700 per month as of Q2 FY2014. (2) Louisiana Take Charge Family Planning Program which covers women, ages 19-44, with a family income at or below 200 percent of the Federal poverty level, who are not otherwise eligible for Medicaid, Medicare or the Children's Health Insurance Program (CHIP), and do not have any other health insurance coverage. Enrolls about 45,600 per month as of Q2 FY2014.	
LA	Eligibility	1115 Waivers	Between December 2013 and January 2014 enrollment in the Louisiana Greater New Orleans Community Health Connection [GNOCHC] 1115 Waiver [Waiver Type '1', Waiver ID 'GN'] declined abruptly from about 55,100 to 45,600, a drop of 17.2%. The state confirmed a decline in this group was expected as a result of the change in income standard decreasing it from 200% to 100% of the FPL effective January 1, 2014.	2/4/2015
LA	Eligibility	CHIP	In March 2008, CMS approved an expansion to LA's S-CHIP program (LA CHIP), to include children from families earning between 200-250% FPL (state groups 3D403A and 3D403C). Families pay a $50 monthly premium, and most services have 10% coinsurance. These enrollees appear in MSIS starting in Q4 FY 2008.	9/9/2011
LA	Eligibility	CHIP	In Q3 FY07, LA started reporting an S-CHIP program for the unborn children of non-citizen mothers who are ineligible for Medicaid, with family incomes of up to and including 200% of FPL (state groups 3C703A and 3C703C and mapped to MASBOE 00). Based on age sort information in Data Quality Report 28, it appears that LA reports the mothers of these unborn children in MSIS.	9/9/2011
LA	Eligibility	CHIP	LA reports its M-CHIP children in MSIS. There have been some inconsistencies with SEDS, but the state generally insists that MSIS counts are more reliable than SEDS.	9/9/2011
LA	Eligibility	CHIP	In Q3 FY11, LA added complete S-CHIP reporting. The state has reported HI, TANF=1, RBF=1, Plan Type, Waiver type for about 5,000-5,400 cases with MASBOE 00 since then.	5/8/2014
LA	Eligibility	Dual Eligibility Codes	Louisiana has a somewhat lower than expected proportion of disabled eligibles who are duals. However, this occurs in part because SSI disabled age 65 or older are reported to BOE 1 (aged).	NA
LA	Eligibility	Dual Eligibility Codes	From FY 2007 forward, LA 9-filled the dual code for about 150-200 persons a month. This issue is linked to a problem with Louisiana's data system. If a person's eligibility status changes during the month, the person will be assigned to every dual eligible code that they were eligible for in that month. For	9/9/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			example, a person may start October as a SLMB-only, but at some point during the month, the person becomes eligible as a QMB-only. LA's system marks him as both QMB-only and SLMB-only. MSIS does not recognize multiple dual assignments and these people are 9-filled. They do not believe they will be able to change the system.	
LA	Eligibility	Dual Eligibility Codes	Beginning in Q2 FY14, LA reported three of its existing plans to Plan Type '01' (which were formerly in Plan Type '08'). As a result, about 9,100 aged (MB '31') and 6,100 disabled (MB '32') in Comprehensive care are assigned as partial duals.	11/11/2014
LA	Eligibility	Managed Care	Some dual eligibles and FP-only enrollees are in PCCM plans because they are enrolled before they are found to be ineligible.	4/14/2010
LA	Eligibility	Managed Care	Starting in Q4 FY 2011 (earliest estimated implementation date), LA plans to implement 2 new managed care plans. The CCNP program operates much like a traditional HMO except that transportation services and prescription drug services will not be provided under the plan (state will pay prescription drug services separately, as FFS). The state plans to report this plan as Plan Type 08 and Plan ID CCNP. The CCNS program includes small capitation payments to an MCO for case management. The MCO will not provide medical services and most care for these individuals will be FFS. LA plans to report this program as Plan Type 07 and Plan ID CCNS.	7/8/2011
LA	Eligibility	Managed Care	In Q4 FY 2007, LA started a PACE plan. The plan operates in Baton Rouge and New Orleans. There is one plan and two providers.	9/9/2011
LA	Eligibility	Managed Care	Louisiana is ended their PCCM on May 31, 2012. A sharp decrease is expected, and should soon reach 0.	11/30/2012
LA	Eligibility	Managed Care	In Q2 FY 2014, LA changed how it reports three existing MC plans: Amerigroup RealSolutions [ID '0116251'], AmeriHealth Caritas Louisiana [ID '0116293'], and Louisiana Healthcare Connections [ID '0116284']. Prior to Q2, these plans were being reported Plan-Type '08' ['Other managed care'] in the EL file and Type-of-Service '21' [Capitated Payments to PHPs] in the OT file. Based on how these plans operate, the types of services they provide (each has a capitation payment structure and provides most, but not all, comprehensive services), and how 'other managed care' is defined, MPR advised the state to treat these as Comprehensive HMOs. As of Q2 FY2014, LA is reporting these plans to Plan Type '01' [Comprehensive Managed Care] in the EL file and TOS to '20' [Capitated payment for HMO] in the OT file. The state will not be fixing and resubmitting previous files.	11/11/2014
LA	Eligibility	Managed Care	Beginning in Q2 FY14 LA began reporting three plans (Amerigroup RealSolutions [ID '0116251'], AmeriHealth Caritas Louisiana [ID '0116293'], and Louisiana Healthcare Connections [ID '0116284']) to Plan Type '01' that were incorrectly assigned to '08' prior. As a result, about 9,100 aged (MB '31') and 6,100	1/8/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			disabled (MB '32') partial duals formerly assigned to 'other' plan type are now being assigned to Comprehensive plans.	
LA	Eligibility	MASBOE	Most poverty-related infants are reported in MAS/BOE 44 instead of MAS/BOE 34 because the state deems these newborns are covered until age 1.	NA
LA	Eligibility	MASBOE	LA has a state administered optional SSI supplement for LTC residents. It should also be noted that LA reports disabled SSI recipients age 65 and older to MASBOE 11.	1/28/2010
LA	Eligibility	MASBOE	LA confirmed that it uses type case '88' for persons eligible under Ticket to Work. They call this program the Medicaid Purchase Plan.	4/16/2010
LA	Eligibility	MASBOE	Effective October 2009, CMS approved a SPA that allows express lane eligibility in LA. In December 2009, LA started reporting enrollment in an Express Lane Eligibility group (F1, for Food stamps) in MASBOE 34 and the state confirmed that this group will likely grow throughout FY 2010. LA's MASBOE crosswalk shows a second Express Lane Eligibility group, F2 for School Lunch. No one in this group is reported in MSIS, but the state does plan to use this code if it can sort out the logistics of using school lunch information. LA plans to only use Express Lane eligibility for children.	9/9/2011
LA	Eligibility	MASBOE	In FY 2007 - Q3 FY 2009 and again in Q2 FY 2010 forward, LA reported about 20 to 30 records to MASBOE 99. The state explained that these records had clerical data-entry errors. LA maps these individuals to MASBOE 99 while they investigate the proper MASBOE assignment. They have no control of data entry so they do not think that they will be able to permanently eliminate this group.	9/9/2011
LA	Eligibility	Private Health Insurance	Through Q4 FY10 LA's health insurance reporting may be unreliable. Through Q4 FY10, LA reports about 65,000 to 80,000 persons each month to health insurance code 4, but only about 1,800 to 2,000 people each month are in LAHIPP. LA also planned to remove people in Medicare HMOs from the counts of private health insurance starting in Q3 FY10, but these counts did not shift at that time. In Q1 FY11, LA reassigned health insurance codes so that only about 3,000 people a month are in code 4 and about 73,000 people a month are in code 2. LA confirmed that these counts now appear accurate.	6/6/2011
LA	Eligibility	Race/Ethnicity	LA reports individuals with race codes 5 (Hispanic or Latino), 7 (Hispanic/Latino & 1+ races), and 8 (More than 1 race, not Hispanic/Latino) as having 0 race reported. The state is working to correct this reporting in the future. 2/2/2015 update: LA confirmed that cases reported to RACE-ETHNICITY-CODE '5' [Hispanic or Latino] have an unknown/unreported race. These individuals have an MMIS ETHNICITY-CODE equal to '5' [Hispanic or Latino Unknown] and therefore have number of races reported in MSIS = 0. Specifically LA noted "the existing code in MEDS of 1 – "Hispanic or Latino" was mapped to the	9/9/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			834 code of 5 - "Hispanic or Latino Unknown"". The state indicated the work order to capture the remaining race ethnicity codes (7 and 8) is pending prioritization.	
LA	Eligibility	Restricted Benefits Flag	LA implemented its MFP program in July 2009. They added this reporting in MSIS in August 2009 (Q4 FY 2009).	9/9/2011
LA	Eligibility	Restricted Benefits Flag	Through Q2 FY 2011, most of the enrollees assigned restricted benefits code 5 (other) are eligible through the medically needy provision. Starting in Q3 FY 2011, enrollees in LA's 1115 GNOCHC waiver are reported to RBF 5. All of the enrollees in the poverty-related pregnant women group are assigned RBF 4.	11/8/2011
LA	Eligibility	SSI	Between January and December 2013 enrollment in MASBOE '42' [other-blind/disabled] averaged about 29,900 per month. In January 2014, enrollment declined to about 21,300 [-26.2%]. A similar, though less extreme, pattern was noted in MASBOE '41' [other-aged]. Enrollment averaged about 21,900 from January through December 2013. It then fell to 20,150 in January 2014. The state confirmed a decline in this recipient group was expected given that LA eliminated optional coverage for aged and disabled individuals with incomes up to 100% FPL who are not eligible for SSI effective December 31, 2013.	2/4/2015
LA	Eligibility	TANF/1931	In FY 2007, LA began 9-filling the TANF field.	9/9/2011
LA	Eligibility	Waivers	LA started enrolling individuals in a new 1915(c) waiver (Residential Options) in 2010. These enrollees are reported to Type Case 119 (B9) or 120 (C0), but they were not identified as 1915(c) waiver enrollees until Q2 FY 2011, when they are reported to a 1915(c) waiver (ID RO).	4/24/2012
LA	Eligibility	Waivers	Louisiana has two 1915c waivers that they recently started. They are not being reported to MSIS as of Q3 FY12.	11/30/2012
LA	Eligibility	Waivers	Louisiana implemented a concurrent 1915BC waiver on 3/1/2012 (which it began reporting to MSIS in Q4 FY12) that is considered a comprehensive system for behavioral health services. The (c) component, known as the Coordinated Systems of Care waiver, provides crisis stabilization, independent living/skills building, parent support and training, short-term respite, youth support and training for individuals w/SED ages 0-17 and mental illness 18-21. The (b) component, known as the Louisiana Behavioral Health Services waiver, covers services for adults with substance use disorders and functional behavioral health needs, or who need subsequent medically necessary services for stabilization and maintenance, as well as at-risk children and youth with significant behavioral health challenges or co-occurring disorders of mental illness and substance use (COD) in, or at imminent risk of, out-of-home placement.	1/12/2015
LA	IP	Covered Days	Covered days are missing on more than 30 percent of managed care encounters beginning in Q3FY12 when LA began reporting	9/10/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			encounters for the new Bayou Health managed care program. This was resolved in Q4FY13.	
LA	IP	Crossovers	There is a large percent of crossover claims. Louisiana verifies that this is correct.	12/10/2004
LA	IP	DRG	The file does not contain DRGs. Through at least Q4FY14 LA pays a hospital-specific per diem rate for inpatient stays.	9/10/2014
LA	IP	Patient Status	There are more claims than expected with Patient Status of 30 (Still a Patient) because there are many interim bills. This is evident through at least Q4FY2012.	4/24/2013
LA	IP	Procedure Date	The Procedure Date Principal (that goes with the Procedure Code Principal) is missing.	12/10/2004
LA	IP	Provider Taxonomy	Through at least Q4FY2012 LA has not submitted provider taxonomy codes in the IP file.	4/24/2013
LA	LT	ICN	LA did not submit either adjustment ICNs or original ICNs on any claims in the LT file between Q1FY2011 and Q2FY2012. LA began reporting ICNs in the LT file in Q3FY2012.	4/24/2013
LA	LT	NPI/Taxonomy	LA did not submit NPI until Q3FY2012. LA began reporting NPI in Q3FY2012. As of Q4FY2012 they have not begun submitting provider taxonomy.	1/10/2014
LA	OT	FQHC	Beginning in 2003, the state is paying a fixed rate for FQHC/RHC visits. They will submit claims for line-item services with a Medicaid Amount Paid of $0 and a summary claim with the visit rate paid, but no services.	12/10/2004
LA	OT	HCBS Waiver	Beginning as early as FY2001, all Rehab services (TYPE-OF-SERVICE=33) are reported with PROGRAM-TYPE=6 but only about 1 percent were linked to people with an HCBS enrollment. This continues through at least Q3FY2012.	12/3/2012
LA	OT	Managed Care Plan IDs	Through at least Q4FY2012 the plan ID on PACE capitation claims does not match the plan ID in the EL file for the same enrollees. EL uses the word "PACE" as the plan ID. In the OT file there are two different all-numeric plan IDs on PACE capitation payments.	4/24/2013
LA	OT	Place of Service	Louisiana will no longer be able to report Place of Service for HH claims due to Health Insurance Portability and Accountability Act (HIPAA) form changes.	12/10/2004
LA	OT	Service Code	In Q3FY2010-forward, state reported a large increase in the number of local/state specific codes. According to state, they are associated with some Prior Authorization changes to the state's Early Steps program. It now requires PA with a local code of Z0199 along with some billing requirement changes. There were also some changes that caused a smaller increase in the number of T1019 claims.	NA
LA	OT	Type of Service	Starting with claims submitted in FY2010, dental lab services are reported to TOS=09 (Dental) instead of TOS=15 (lab&xray).	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
LA	QX Link	HCBS Waiver	The Q1 and Q4FY11 LINK reports indicate that over 40% of HCBS waiver claim recipients have no HCBS waiver enrollments. I suspect that the waiver claims for people that are not enrolled in an HCBS waiver are not really waiver claims. LA reports all Rehabilitation claims (TYPE-OF-SERVICE = 33) as HCBS waiver claims (PROGRAM-TYPE = 6 or 7) but less than 1% of recipients of rehab claims are HCBS waiver enrollees.	5/13/2013
LA	RX	ICN	LA did not submit either adjustment ICNs or original ICNs on any claims in the RX file between Q1FY2011 and Q2FY2012. LA began reporting ICNs in Q3FY2012.	4/24/2013
LA	RX	NPI/Taxonomy	LA did not submit NPI or provider taxonomy on any claims in the RX file between Q1FY2011 and Q2FY2012. LA began reporting NPI in Q3FY2012 but continues to not report provider taxonomy.	4/24/2013
MA	_All	Data System Change	MA implemented their new MMIS on 5/29/2009	NA
MA	Eligibility	1115 Waivers	The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types, and benefit levels. MA initially implemented the waiver in July 1997. It has modified it over time through various amendments and renewals to accommodate the Commonwealth's health care reform program. The program extends eligibility for MassHealth Standard to: 1) pregnant women and children < 1 year with incomes <= 200% FPL; 2) children ages 1-18 years with incomes <= 150% FPL; 3) parents of children < 19 years with incomes <= 133% FPL; 4) disabled adults ages 19-64 years with incomes <= 133% FPL; and 5) some women diagnosed with breast or cervical cancer with gross family incomes <= 250% FPL. The waiver extends eligibility for MassHealth CommonHealth to: 1) disabled children <= 18 years with incomes > 150% FPL; 2) working disabled adults with no income limit; and 3) non-working disabled adults with incomes > 133% FPL. MassHealth extends eligibility for MassHealth Basic to: 1) adults who receive Commonwealth-funded cash assistance through the Emergency Assistance to the Elderly, Disabled, and Children (EAEDC) program; and 2) unemployed clients of the Department of Mental Health whose income is <= 100% FPL. The waiver also extends eligibility in MassHealth Essential to long-term unemployed adults with incomes <= 100% FPL who are not eligible for MassHealth Basic. The waiver provides premium assistance for: 1) children ages 1-18 years with incomes between 150% and 200% FPL; 2) adults < 65 years with incomes <= 200% FPL who already have, or have access to, employer-sponsored insurance; and 3) individuals < 65 years with HIV who are not institutionalized and have incomes <= 200% FPL. MA provides MassHealth Standard to children ages 1-18 years with incomes between 150% and 200% FPL, who may or may not, have access to employer-sponsored health insurance. Undocumented non-citizens who would otherwise be eligible for MassHealth Standard are eligible for emergency services only. The waiver also offers time-limited	12/10/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			prenatal services to pregnant women whose self-declared gross family income is <= 200% FPL. MA reports the waiver using Waiver Type 1 and 11 separate waiver IDs. In some instances, the population assigned to a specific waiver is clear and unambiguous. For example, Waiver 3 includes women with breast or cervical cancer. In other cases the population assigned to a specific waiver is not clear. For example, no unique combination of SSG, RBF and BOE identifies the population assigned to MassHealth Limited. MassHealth Limited is intended for undocumented non-citizens eligible for emergency services only, who would be eligible for MassHealth Standard, except for their non-citizen status.	
MA	Eligibility	CHIP	Effective July 1, 2006 MA expanded S-CHIP eligibility to 300 percent FPL.	7/14/2009
MA	Eligibility	CHIP	MA reports enrollment in both M-CHIP [CHIP-CODE '2'] and separate CHIP [CHIP-CODE '3']. During FY 2011, the state reported about the same enrollment to MSIS as it did to SEDS. Quarterly differences in reported enrollment averaged 1.5% for M-CHIP and .7% for separate CHIP.	12/10/2013
MA	Eligibility	Data System Change	MA implemented a new MMIS. This system started producing MSIS eligibility files in Q3 FY09. The new system introduced notable shifts in MASBOE, managed care, dual coding, and waiver reporting. Retro records introduce these changes back to Q3 FY 2008. The state contacts are working to verify these changes, but they are confident that coding in the new system is more accurate than coding under the old system.	7/30/2010
MA	Eligibility	Dual Eligibility Codes	Prior to Q3 FY 2009, MA did not report QI-1 enrollees [Dual Code '06'] to MSIS. From Q3 FY 2009 through Q4 FY 2011, it reported about 6,700 - 7,700 QI-1s per month. MA assigned virtually all of them to state aid categories 'TC' [Medicare Part B Buy-in; Non-disabled Aged; Incomes 120-135% FPL] or '88' [Medicare Part A Buy-in; Incomes 120-135% FPL]. On average the state assigned about 55 – 59% of QI-1s to aid category TC. It assigned roughly 39% to aid category '88'. The rest were assigned to several aid categories and are likely incorrectly coded.	12/10/2013
MA	Eligibility	Dual Eligibility Codes	Prior to Q3 FY 2009, MA reported a monthly average of 1,800 QMB-only [Dual Code '01'] and 3,600 SLMB-only [Dual Code '03'] enrollees to MSIS. The state assigned more than 90% of the QMB-onlys to Aid Categories '2401CA', '2201CA', and '2501CA' with MBs 31-32. The state assigned more than 98% of the SLMB-onlys to Aid Categories '2401CA' and '2501CA', also with MBs 31-32. Starting in Q3 FY 2009, QMB-only and SLMB-only reporting changed substantially. First, the state began to use new Aid Categories. MA assigned all QMB-onlys to new Aid Category '220399'. It continued to report all of them to MB 31. MA assigned all SLMB-only enrollees to new Aid Categories 'VK1799', '241799', and '251799' with MBs 31-32. The average number of QMB-onlys fell to 330 per month in Q3 FY 2009. At	12/10/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			the same time, the average number of SLMB-onlys increased to about 11,000 per month. As of Q4 FY 2011, MA reports an average of 600 QMB-only and 12,900 SLMB-only enrollees each month.	
MA	Eligibility	Dual Eligibility Codes	Throughout FY 2011, differences in reporting dual-eligible enrollees to MSIS and MMA were negligible. Quarterly differences in reported enrollment averaged 1.7% for full-dual and 2.1% for partial-dual enrollees.	12/10/2013
MA	Eligibility	Managed Care	MA only pays PCCM providers the $10 fee for PCCM if they render the service. This is not exactly managed care, but there are a few other states that do it the same way.	10/2/2008
MA	Eligibility	Managed Care	According to the state, Senior Care Options [SCO]/PACE plans [Plan Type '06'] are the only managed care plans for which duals are eligible. Prior to Q3 FY 2009, the state reported about 3,000 Aged and Disabled Full Duals per month to Comprehensive [Plan Type '01'], Behavioral [Plan Type '03'], and PCCM [Plan Type '07'] managed care plans. This reporting improved substantially starting in Q3 FY 2009. As of Q4 FY 2011, MA is correctly reporting Aged Full Duals only to PACE plans. However, it continues to report some [<= 1,300] Disabled Full Duals to Comprehensive, Behavioral and PCCM plans. MA began to report about 4,600 – 5,800 Disabled Full Duals to PACE plans starting in Q1 FY 2011.	12/10/2013
MA	Eligibility	Managed Care	As of Q3 FY 2011, there continue to be substantial differences in reporting managed care enrollment to MSIS compared to the CMS Medicaid Managed Care Enrollment Report. During the quarter, MA reported roughly 150,000 more HMO enrollees to MSIS [N = 656,000] than it did to CMS [N = 510,400]. It also reported 15,000 more PACE enrollees to MSIS [N = 17,500] than it did to CMS [N = 2,700]. MA has a single behavioral health plan [Plan ID '110031899'/MA Behavioral Health Partnership] which it reports to MSIS as Plan Type '03'. It reports the same plan to CMS as a PIHP. The state reports about 66,200 more enrollees to Plan Type '03' in MSIS than it reports to PIHP in the CMS Medicaid Managed Care Enrollment Report. At this point, we cannot explain the difference.	12/10/2013
MA	Eligibility	Managed Care	As of Q4 FY 2011, MA reports about 380,000 - 390,000 enrollees per month to Plan Type '07' [PCCM]. However, it does not report any PCCM capitation payments [Service Type '22'] on its OT file for the same quarter. VB:MA reported on 10/1/14 that the PCCM enrollment reporting is for the Commonwealth's internal managed care plans and therefore there is no capitation reporting.	12/11/2013
MA	Eligibility	Managed Care Plan IDs	MA changed from a 7-character Numeric to a 9-character Numeric Plan ID in Q3 FY 2009.	12/10/2013
MA	Eligibility	MASBOE	Effective August 2009, CMS approved a SPA in MA that lifts the 5- year waiting period for immigrants.	3/9/2010

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State	File Type	Rec/Issue Type	Issue	Recorded
MA	Eligibility	MASBOE	MA is under-reporting the number of children in foster care.	5/19/2011
MA	Eligibility	MASBOE	Starting Q3 FY 2009: MA reports BCCPTA enrollment to MASBOE 3A. (Previously, these individuals were reported to MA's MassHealth waiver.)	5/2/2012
MA	Eligibility	MASBOE	MA assigned an average of 208,400 enrollees per month to MASBOE 99 in Q1 FY 2011. This was about 13.2% of the monthly Medicaid population. The state made several changes to its MASBOE/Aid Category crosswalk starting in Q2 FY 2011. As a result, the number of enrollees assigned to MASBOE 99 fell to about 1,700 per month during Q2-Q4 FY 2011. It appears that the state reassigned most, but not all, MASBOE 99 enrollees to MASBOE 55.	12/10/2013
MA	Eligibility	MASBOE	As of Q4 FY 2011, MA appears to be under-reporting the number of children in foster care to MSIS. According to a January 2011 report from the Children's Defense Fund, there were roughly 9,700 children in foster care within the state. MA reported only 2,600 per month to MB 48 [Other Eligibles/Foster Care].	12/11/2013
MA	Eligibility	MSIS ID	During Q3 FY 2009, MA began to change the format of its MSIS IDs from a 7-character Numeric field to a 12-character Numeric field. The state completed the conversion by Q1 FY 2010.	12/10/2013
MA	Eligibility	Private Health Insurance	In Q3 FY 2009, the number of enrollees with Health Insurance code 3 (state-purchased insurance) dropped sharply and the number with code 4 (combination of state-purchased and privately purchased) increased to offset this drop. We asked MA to clarify this change.	5/2/2012
MA	Eligibility	Race/Ethnicity	Starting in Q3 FY 2009, MA began to assign the great majority of its enrollees [>= 85%] ETHNIC-CODE '9' [Unknown]. It also began to assign about 4-5% ETHNIC-CODE '1' [Hispanic]. This appears to substantially under-report the Hispanic population within the Medicaid program. According to the Pew Research Hispanic Trends Project, Hispanics make up 10% of the state's overall population.	12/10/2013
MA	Eligibility	Restricted Benefits Flag	As of Q4 FY 2011, MA still assigns RBF '9' to roughly 8,700 enrollees each month. About 74% of them are in MB 41. The remaining 26% are in MB 54. We previously asked the state to review and correct this coding.	12/10/2013
MA	Eligibility	Restricted Benefits Flag	In Q3 FY 2009, the number of enrollees assigned RBF '2' increased substantially. Average monthly enrollment increased from 11,200 in Q2 FY 2009 to 62,700 in Q3 FY 2009. As of Q4 FY 2011, average enrollment in RBF '2' was 67,200.	12/10/2013
MA	Eligibility	Restricted Benefits Flag	Starting in Q3 FY 2009, MA began to assign an average of 660 enrollees per month to RBF '4' [Restricted/Pregnancy-related]. The state assigned all of these women to Aid Category '801399' [Prenatal, Presumptive Eligibility, >= 19 Years, Income <= 200% FPL] with MB 45 [Other/Adult]. As of Q4 FY 2011, MA reported average enrollment of 490 per month to RBF '4'.	12/10/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
MA	Eligibility	Restricted Benefits Flag	The number of enrollees assigned to RBF '5' increased substantially between Q2 and Q3 FY 2009. Average monthly enrollment was 54,100 in Q2 FY 2009 compared to 284,100 in Q3 FY 2009. As of Q4 FY 2011, average monthly enrollment increased again to 346,900. Nearly all enrollees with RBF '5' were in MBs 54 [1115 Demo/Child] or 55 [1115 Demo Adult], with the great majority being adults [BOE 5]. It appears that all enrollees in MB 54 were assigned to state aid category '721799'. It is harder to determine which state aid categories are in MB 55. The group appears to include state aid categories 'CN', 'CQ', 'CS', 'CU', and 'CW', which are all CommonWealth Care. However, the state aid categories for more than 100,000 enrollees remain unclear. MPR spent a substantial amount of time working with the state between 2012 and 2013 trying to decipher these codes; but was unable to complete the reconciliation.	12/10/2013
MA	Eligibility	Retroactive/ Correction Records	As of Q4 FY 2011, MA reports retroactive records. However, it indicated in its MSIS application that it would use the delayed submission option.	5/19/2011
MA	Eligibility	Retroactive/ Correction Records	Compared to other states, MA reports a high proportion of correction/update records each quarter. The average percentage of correction/update records [58.8%] for FY 2011 was abnormally high. In addition, MA submitted multiple revised files each quarter throughout the period from Q2 FY 2009 through Q2 FY 2011. In some cases, it submitted as many as 6 for the same quarter. Coupled with the change in MASBOE reporting, there is no way to accurately assess the impact this may have on overall eligibility reporting.	12/10/2013
MA	Eligibility	SSN	In Q3 FY 2009, the number of SSNs with duplicate records increased. This change occurred as a result of the new MMIS and how the system deals with duplicates. The state will work to reconcile these duplicates on an ongoing basis and fix them with correction records.	5/2/2012
MA	Eligibility	SSN	Prior to Q3 FY 2009 MA did not require enrollees to provide an SSN. As a result, about 10.0% of the Medicaid population had a 9-filled SSN. The state began to report about 5.2% of the enrollees with a 9-filled SSN starting in Q3 FY 2009.	12/10/2013
MA	Eligibility	State-Specific Eligibility	MA changes the format of its state aid categories [SSGs] substantially between Q2 and Q3 FY 2009. The state continued to report SSG as a 6-character Alpha-Numeric value. Starting in Q3 FY 2009, it began to 9-fill characters 3 – 6. However, in Q4 FY 2009 it revised the aid again by replacing characters 3-4 with values other than '99'. The first 2-characters represent specific eligibility groups; but we are not certain what character 3-6 actually represent.	12/11/2013
MA	Eligibility	Waivers	As of Q4 FY 2011, MA is still unable to report its 1915c waivers in MSIS. MA acquired a new MMIS in 2009. It believed that this reporting functionality would be built into the system. It was not. Therefore, the state stopped reporting 1915c waiver	12/10/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			enrollment in 2009. The state has confirmed that it is unable to report waiver enrollment accurately. It can only report on enrollees who actually utilize a 1915c HCBS service. Reporting this way would greatly underestimate the actual number of 1915c enrollees. The state cannot say when they will be able to report 1915c data.	
MA	IP	Crossovers	Since at least Q3FY2009 MA has reported many claims with a Medicaid-Amount-Paid of zero dollars and Medicare-Coinsurance and Deductible amount paid greater than zero dollars. MA explained that they were likely true zero-pay claims.	4/13/2012
MA	IP	DRG	MA reports a DRG-Flag of HG12 implying that CMS-DRGs from 1995 were used to adjudicate claims in through 2011. MA actually uses a much more recent versions of APR-DRGs.	4/13/2012
MA	LT	Diagnosis	There were very few Diagnosis Codes in the LT file until Q3FY2009 with the implementation of MA's new MMIS.	6/2/2011
MA	LT	Leave Days	MA did not report leave days until Q3FY2009 with the implementation of their new MMIS.	12/10/2004
MA	OT	Crossovers	Since at least Q3FY2009 MA has reported many claims with a Medicaid-Amount-Paid of zero dollars and Medicare-Coinsurance and Deductible amount paid greater than zero dollars. MA explained that they were likely true zero-pay claims.	4/13/2012
MA	OT	Diagnosis	MA reports diagnosis codes on only about 50 percent of claims in the OT file. Due to enrollment in HMOs a larger than normal proportion of FFS claims are dental, other services, and transportation, all types of service commonly reported by other states without diagnosis codes.	4/13/2012
MA	OT	EPSDT	Most services to children under age 21 have a Program Type of 1 (EPSDT) until Q3FY2009.	12/10/2004
MA	OT	FQHC	MA stopped reporting FQHC claims in Q3FY2009.	5/26/2011
MA	OT	Managed Care Capitation	PCCM payments are only made if there is actually a PCCM visit.	12/10/2004
MA	OT	Managed Care Capitation	Capitation payments to plans are made on a quarterly, not monthly, basis. Even so, there appears to still be a shortfall of capitation payment claims as there are fewer capitation claims than quarterly enrollment in managed care. They do not submit PCCM capitation claims because the rate is only paid when a case management service is performed.	10/16/2008
MA	OT	Managed Care Plan IDs	Beginning in Q3FY2009 with its new MMIS, MA began reporting new versions of plan IDs. The plan IDs in the EL file and the plan IDs in the OT file nearly all matched up except all of the plan IDs in the OT file were nine numeric digits and one letter whereas all of the plan IDs in the EL file were only nine numeric digits.	7/8/2011
MA	OT	Place of Service	About 1/3 of the original, non-crossover claims do not have a Place of Service. Most of these claims are outpatient hospital	12/15/2004

State	File Type	Rec/Issue Type	Issue	Recorded
			department claims (Type of Service 11) or Lab and X-ray (Type of Service 15) claims.	
MD	Claims	Crossovers	The number of crossover claims doubled in 2009 Q4 because the state started submitting the $0 paid line items in addition to the summary claims with expenditures.	NA
MD	Claims	Managed Care Encounters	MD reports Medicaid expenditures on encounter claims through Q1FY2004.	2/8/2011
MD	Claims	Total Non-Crossover FFS claims	Beginning in Q4FY2011 the total number of FFS non-crossover original IP claims and total expenditures for those claims decreased more than 20 percent from the average of the previous six quarters. There was also a noticeable decrease in the frequency of FFS non-crossover original IP claims with psychiatric diagnoses, claims paid less than $10,000, claims with a length of stay less than six days, and claims missing a primary procedure code. The state confirmed that the claims were reported correctly but did not provide an explanation for the changes. The state confirmed that the claims data were correct but could not explain what caused the change. OT expenditures decreased more than 30% from Q3FY2011 to Q4FY2011. HCBS expenditures decreased by over 50% between Q3FY2011 and Q4FY2011. This decrease may have been caused by expedited claim adjudication during the previous quarter when ARRA-enhanced match expired, leaving fewer claims in the backlog to process in the next quarter. Other states provided this explanation for similar decreases during the same quarter, some adding that budget restrictions in the following state fiscal year also kept expenditures down.	12/3/2012
MD	Claims	Type of Service	Nearly two-thirds of the Medicaid recipients are enrolled in the HealthChoice Program. The remaining one-third tend to be either higher risk patients (many institutionalized) or covered by Medicare. As a result, the distribution of Maryland's FFS claims may seem quite different from the distribution for other states.	12/10/2004
MD	Eligibility	1115 Waivers	In July 2006, MD implemented another expansion to its Health Choice 1115, providing limited primary care health benefits to uninsured adults (including childless adults) not otherwise eligible for Medicaid, with incomes<116% FPL (program is called PAC). This is a Medicaid expansion, but not M-CHIP. Enrollees are reported to state group 'S09'--which maps to MASBOE 55 and RBF 5. MD confirmed that it started using S09 for PAC enrollees instead of for pharmacy discount program enrollees in July 2006, when the program started. In Q3-4 FY09, we noticed that about 5,000 to 10,000 PAC enrollees are not assigned to the Health Choice waiver. Although in any month a small number of new PAC enrollees may receive fee for service coverage until they enroll in a managed care plan, the state confirmed that all PAC eligibles in state group S09 should be enrolled in the HealthChoice waiver. The state reviewed the S09 cases that were not in the waiver and identified them as retroactive eligibility cases. Through Q1 FY10 MD still did not	7/27/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			report all PAC enrollees to the HC waiver. The state corrected this reporting in the Q2 FY10 file.	
MD	Eligibility	1115 Waivers	MD has a long running section 1115 waiver program called Maryland HealthChoice. The program was first implemented in 1997. Initially, this 1115 waiver converted many enrollees to a managed care system. Since then, the program has expanded to include MD's PharmPlus program (ended in 2006), family planning, and as discussed below, limited benefits for uninsured adults (added July, 2006). Since this waiver expands coverage in managed care, not all individuals are reported to MAS 5. Family planning enrollees, however, are reported to MASBOE 55 and state eligibility groups P10 and S12.	4/6/2012
MD	Eligibility	CHIP	MD has an M-CHIP program. Effective June 2007, MD converted children whose family income is between 200-300% FPL from S-CHIP to M-CHIP (groups D01, D02, D03, and D04), eliminating MD's S-CHIP program, making MD an M-CHIP only state (other M-CHIP state groups are P11-P14). CMS SEDS data reflect this change in Q4 FY 07 but the Q1 FY08 counts include M-CHIP and S-CHIP (we asked the state about this discrepancy). MSIS data do not reflect this change until the Q1 FY 2008 files. The state corrected CHIP reporting for earlier files through correction records in the FY 2008 files. MD also covers pregnant women of any age under CHIP.	7/27/2011
MD	Eligibility	CHIP	In Q4FY13, total M-CHIP enrollment was 13% lower in MSIS than in SEDS. The state identified that the MSIS reporting logic is different from SEDS reporting logic and will fix in future files.	11/10/2014
MD	Eligibility	CHIP	Between July 2013 (Q4FY13) and December 2013 (Q1FY14), M-CHIP enrollment in MASBOE 34 increased by about 14,000 (14%), from about 97,000 to 111,000. This increase was caused by the addition of SSG F05S to CHIP=2. This eligibility group includes those with incomes 100-116% FPL as a result of increasing the FPL in 2008.	1/30/2015
MD	Eligibility	County Codes	Maryland reports eligibles with County Code = 510. These are residents of the city of Baltimore. While this FIPS code is technically correct, documentation for the Area Resource File suggests that data users might want to recode these persons into county "007."	2/8/2011
MD	Eligibility	Dual Eligibility Codes	All duals in state group L98 (medically needy, aged/disabled) are reported to dual code 08. MD does not have the income information necessary to sort them into 02, 04, and 08 in MSIS. However, MD is able to sort these duals in the monthly MMA files by income. As a result, MSIS reports more full duals to dual code 08, and fewer to 02 than MMA.	2/19/2008
MD	Eligibility	Dual Eligibility Codes	As of Q1FY14, MD reports about 4,800 adults (MASBOE 15) to dual code 02. In 2008, MD expanded FAC eligibility income levels to 116% FPL. This caused an increase in duals in F05U. The state confirmed that these individuals were not elderly but	1/30/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			were legitimately enrolled in Medicare. They are unsure who these people are but will continue to look into this issue.	
MD	Eligibility	HIC Numbers	Almost 27,000 non-duals have HIC numbers (about six percent of the non-dual population).	2/8/2011
MD	Eligibility	Managed Care	MD reported about 2,000 full duals as receiving managed care. MD explained that almost 150 full duals were enrolled in PACE/HMO plans--all other full duals were retroactively assigned Medicare eligibility.	7/9/2009
MD	Eligibility	Managed Care	The Health Choice waiver enrolls individuals in most coverage groups, but all individuals in those coverage groups are NOT automatically enrolled in Health Choice. Those eligible for Medicare, in an institution, in another waiver, receiving limited services, or spending down to eligibility are not eligible for HealthChoice. Those individuals who are determined eligible for HealthChoice may also have a lag time in which services are paid fee-for-service until they actually enroll in a managed care organization.	3/8/2010
MD	Eligibility	Managed Care	Some persons (several thousand) with managed care plan type 01 have the PLAN ID field 9-filled from FY04 through Q1 FY13. MD explained that these are people who are part of Health Choice but not yet in a managed care plan.	4/26/2010
MD	Eligibility	Managed Care	From Q4 FY07 forward, CMS MMA counts include PAC plans (see related section 1115 waiver anomaly) as PAHP plans. MD reports these plans to MSIS as HMOs (plan type 1).	2/8/2011
MD	Eligibility	Managed Care	Starting in Q1 FY11, Maryland reports about 3,000 individuals as enrolled in two HMO plans (plan type '01) in a given month. We don't expect individuals to be enrolled in more than one HMO plan, but the state explained that sometimes individuals switch plans during a month and get reported with duplicate enrollment. This reporting is adjusted through retro/correction records.	9/21/2012
MD	Eligibility	MASBOE	Maryland reports more SSI recipients (MAS/BOE 11 and 12) each month than expected, based on a comparison to federal SSI administrative data. However, the state administers a SSI supplement program.	NA
MD	Eligibility	MASBOE	MD periodically reports a small number of enrollees to MASBOE 99. These are recipients enrolled in the state's MMIS system with an invalid coverage group and coverage type. The state works these cases out manually as they are discovered, and fixes them with correction records.	2/8/2011
MD	Eligibility	MASBOE	MD reports some aged persons to BOE 2. We asked the state to review age reporting and ensure that all aged are reported to BOE 1.	2/8/2011
MD	Eligibility	MASBOE	Through Q1 FY13 MD reported refugees who receive medical assistance to MSIS (state groups G01, G02, G98, G99). This	3/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			coverage is not funded by Title XIX and they should not be reported in MSIS.	
MD	Eligibility	MASBOE	Beginning in month 3 Q1 FY12 through Q2 FY12, there is an increasing number of individuals (1,363 by month 3) reported to invalid MASBOE=99. All of these individuals are in state code=P10U, and have RBF=6 and Waiver Type=F. It appears that they should be reported to MASBOE=54 or 55. The state has agreed to make this fix starting in Q3 FY12 and to correct the issue in earlier files through retro/corr records.	9/21/2012
MD	Eligibility	MASBOE	In Q4FY13, about 180 individuals per month were assigned to MASBOE 99. These enrollees were in SSGs A02M, A03M, D02M, D04M, F05M, P07M, P13M, and S99N and assigned RBF 1 (full benefits). The state explained that these individuals were reported incorrectly due to ACA changes and will be corrected in future files.	11/10/2014
MD	Eligibility	Race/Ethnicity	MD typically reports several thousand individuals with unknown race-ethnicity (RACE-ETHNICITY-CODE = 9), about 6%. As of Q4FY13, MD said they will make necessary changes to identify more race-ethnicity on future files.	11/10/2014
MD	Eligibility	Restricted Benefits Flag	In July 2006, Maryland started assigning RBF code 5 to the expansion group of uninsured adults who receive limited primary health care benefits under MD's 1115 waiver (the PAC program).	11/6/2008
MD	Eligibility	Restricted Benefits Flag	In 2008, MD implemented a Money Follows the Person (MFP) program. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals receive enhanced FFP. MD confirmed that MFP enrollment began in 2008. The state estimated enrollment of 291 people through July 2009. In the Q4 FY 2009 file, MD added MFP enrollment. The state also submitted correction records to add this reporting from FY08 through Q3 FY09.	5/13/2010
MD	Eligibility	Restricted Benefits Flag	Women who only get family planning benefits via the section 1115 family planning waiver are assigned restricted benefits flag 6 (and denoted by state specific eligibility codes P10 and S12) effective Q1FY05.	2/8/2011
MD	Eligibility	Restricted Benefits Flag	MD implemented a PRTF grant in July 2009, and did not start enrolling children into the program until October 2009 (Q1 FY10). They did not begin reporting enrollees to RBF A until Q2 FY10. We've asked the state whether they will be able to use retro/correction records to retroactively add RBF A to PRTF participants that were enrolled prior to Q2 FY10, but it is unclear whether they have been able to do so.	7/27/2011
MD	Eligibility	Restricted Benefits Flag	From FY99 through Q3 FY05 and again from Q3 FY06 through Q4 FY09, MD reported to MSIS a small number of pregnant women and children to state groups X01P and X01R. Enrollment during this period was about 800/month in X01P and	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			3000/month in X01R. Group X01 is defined in MD's crosswalk as a "state-only" coverage group for non-qualified aliens. However, pregnant women reported to X01P are correctly included in MSIS data since their hospital deliveries qualify for Medicaid matching funds (as emergency services). The X01P group should be assigned RBF code 2. The X02 group is also reported to RBF 2. From FY99- Q3 FY05 and from Q3 FY06 through Q2 FY09, alien children reported to state code X01R should not have been included in MSIS since they are being provided full benefits by the state, not just emergency services (see MASBOE anomaly about new state plan amendment that expands coverage for immigrants starting in Q3 FY09). Thus, these children were incorrectly reported as Medicaid enrollees for purposes of MSIS. In December 2009, MD received approval for a state plan amendment to lift the waiting period for children and women subject to the 5-year ban as well as other lawfully residing immigrants/aliens. At that time, MD discontinued the XO1 state group and began mapping these persons to other state groups.	
MD	Eligibility	Restricted Benefits Flag	In Q4FY13, MD assigned RBF 3 (restricted benefits, dual eligible) to about 160 aged non-duals and 150 disabled non-duals. MD confirmed that these individuals should have RBF 3.	11/10/2014
MD	Eligibility	TANF/1931	From Q1 FY06 forward, MD 9- filled its TANF flag.	11/24/2009
MD	Eligibility	Waivers	MD continues to cover family planning - only services as part of its section 1115 waiver. Through Q1 FY07, MD did not report family planning-only enrollees to Waiver Type F. The state did not adjust this reporting in correction records.	2/8/2011
MD	Eligibility	Waivers	MD implemented its medical day care services waiver (Waiver ID 'MD') on July 1, 2008 but did not report enrollment in MSIS until Q4 FY 2009. The state added this enrollment for 2008-June 2009 with correction records.	2/8/2011
MD	Eligibility	Waivers	Waiver ID 'ND' (New Directions Waiver) expired on 6/30/13; however, about 20 individuals per month were assigned to this waiver in Q1FY14. ND enrollees moved to the Community Pathways Waiver on 7/1/13 and will be reported to waiver ID 'CP' on future files.	11/10/2014
MD	IP	DRG	Maryland does not use DRGs (there are no DRGs on the IP file). The State reimburses in state acute general hospitals using a percent of charges for rates established by the Health Services Cost Review Commission (HSCRC) under a Medicare waiver. Out-of-state hospitals are reimbursed according to the state Medicaid program's reimbursement principles. Other hospitals in the state are reimbursed on a per-diem basis and many are subject to cost settlement.	2/8/2011
MD	IP	Managed Care Encounters	The percentage of managed care encounters reported with other insurance payments, usually more than 25 percent, is much higher in MD than other states beginning with the first encounters submitted in Q4FY2009 through at least Q3FY2012.	8/24/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
MD	IP	Medicaid Amount Paid	Because nearly two-thirds of Medicaid recipients are enrolled in managed care, the fee-for-service hospital costs tend to be higher than for other states with less Medicaid managed care.	2/8/2011
MD	IP	Revenue Code	A higher than expected percentage of original, non-crossover FFS claims do not have ancillary codes in the UB-92 Revenue Code fields. This higher percentage is due to the inclusion of some per-diem hospitals for the sicker population. These hospitals only receive a room and board charge.	2/8/2011
MD	LT	Crossovers	Through at least Q3FY2012, there are no crossover LT claims.	8/24/2012
MD	LT	Diagnosis	Many FFS non-crossover LT claims did not have diagnosis codes, through Q3FY2011. After Q3FY2011 the percentage of FFS non-crossover LT claims with diagnosis codes increased. The issue appears to be resolved.	8/9/2013
MD	LT	Leave Days	Through at least Q3FY2012, Maryland does not report leave days.	8/8/2013
MD	LT	Managed Care Encounters	MD submits encounters in the LT file but only original encounters, no adjustments. A small number of original encounters have negative charges. This occurs through at least Q3FY2012. It is unknown if these are intended to be adjustments or are negative for some other reason.	8/9/2013
MD	OT	Diagnosis	Because mental health services are carved out of HMO managed care, there are many claims with mental health diagnosis codes.	2/8/2011
MD	OT	HCBS Waiver	In 2007/2008 about 40% of the FFS non-crossover claims have a Program Type of Waiver. This may be the result of line item waiver claims and/or the large number of beneficiaries enrolled in managed care.	4/8/2011
MD	OT	Managed Care	Maryland Medicaid's website indicates that there are several special payment categories for MCOs including lump sum payments for child delivery costs, enrollees under one, and enrollees with HIV/AIDS. The state has not confirmed that these exist in MSIS or whether they represent payments for a group of services provided to an individual or to a group of individuals. There are some capitation claims with paid amounts greater than $80,000.	NA
MD	OT	Managed Care	From 2009 to 2011 MD reported a small number of managed care capitation claims with TYPE-OF-SERVICE = 99 (Unknown). The state explained that these represented Medicare Advantage Plan premiums. Prior to 2009 MD reported about 10,000 encounters every quarter with a TYPE-OF-SERVICE = 99. After 2009 MD reported about 30,000 encounters each quarter with TYPE-OF-SERVICE = 99. The increase in encounters with TYPE-OF-SERVICE = 99 was caused by Medicare Advantage Plan reporting.	8/9/2013
MD	OT	Medicaid Amount Paid Total	In July 2009 dental benefits were carved out of existing managed care agreements. After July 2009 dental benefits were	8/15/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			paid on a fee-for-service basis by an administrative contractor and reported in MSIS as fee-for-service claims.	
MD	OT	Type of Service	Since 1993 Maryland has treated non-emergency medical transportation (NEMT) as an administration cost rather than a medical service therefore it is not included in MSIS. Maryland has a lower than average number of transportation claims compared to other states that provide NMET as a fee-for-service medical service.	5/16/2012
MD	RX	Adjustments	Since Q1FY2009, MD has consistently reported a small number of debit claims in the RX file, all with a paid amount of zero. This occurs through at least Q3FY2012.	8/24/2012
MD	RX	Family Planning	There are no family planning RX claims until Q2FY2009.	4/18/2011
MD	RX	Managed Care Encounters	Amount charged is missing or 9-filled on nearly all RX managed care encounters through at least Q3FY2012.	8/24/2012
MD	RX	Managed Care Encounters	NPI and taxonomy are missing on all RX managed care encounters through at least Q3FY2012.	8/24/2012
MD	RX	NPI	Through at least Q3FY2012 MD does not store NPI for RX encounters.	8/24/2012
MD	RX	Provider Taxonomy	Through at least Q3FY2012 MD does not store provider taxonomy for RX claims or encounters.	8/24/2012
ME	Claims	Data System Change	Maine has not had a functioning MMIS from Q2FY2005 until FY2010. They have only been able to submit complete high quality RX files during that time. In 2009 they began submitting IP/LT/OT claims files for Q2FY2005 forward, but due to system constraints, they are not high quality and in some cases incomplete. They are being officially 'approved' so they can be loaded into the CMS database as that is the best the state can do until their new MMIS is up and running sometime in 2010.	3/3/2011
ME	Claims	NPI/Taxonomy	Maine has reported that it cannot report taxonomy correctly in MSIS from FY 2011 Q1 through T-MSIS implementation.	11/15/2014
ME	Eligibility	1115 Waivers	Each month, ME reports about 200 people in dual code 08 to MASBOE 55. These enrollees are mapped to the HIFA and HIV/AIDS waivers. The state explained that these enrollees are Medicare eligible but not otherwise income-eligible for Maine Care.	8/31/2010
ME	Eligibility	1115 Waivers	Maine implemented an 1115 HIFA waiver [Waiver Type '5' / Waiver ID '11'/ CMS Waiver ID '11-W-00158/1'] called MaineCare for Childless Adults in October 2002. The waiver extended Medicaid to childless adults with incomes = 100% FPL. The state assigned all waiver enrollees to Eligibility Group '5C' and MASBOE '55'. Through Q2 FY 2009, Maine incorrectly reported these enrollees to waiver type '1'. Starting in Q3 FY 2009, it corrected the error and reassigned them to Waiver Type '5'. Enrollment increased markedly between January and September 2010. In January 2010 it was ~ 11,000. It increased	9/18/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			to ~ 17,800 in September 2010. Average enrollment for Q4 2011 was about 16,000 per month. The state indicated that most of the increase came from adding members who had been wait-listed. Members can be added anytime; but they only become members, when the program decides it can add them. For this reason, enrollment in the waiver fluctuates periodically. During SFYs 2010 and 2011, Maine added a large number of wait-listed members. This waiver was set to expire on 31Dec2013. After this point, the state believes that these enrollees will be covered under the ACA.	
ME	Eligibility	1115 Waivers	Since 2000 Maine has had an HIV/AIDS 1115 expansion waiver [Waiver Type '1' / MSIS Waiver ID '10' / CMS Waiver ID '11-W-00128/1']. The demonstration expands access to certain individuals with HIV/AIDS without health insurance and allows them to become eligible for a targeted benefits package through the demonstration without having to spend down income or resources. It includes two groups: "Members" who are MaineCare eligibles identified as HIV-positive who meet the social security definition of "totally disabled" and are below 100 percent of federal poverty level (FPL); and, "Enrollees" who do not meet the eligibility requirements of MaineCare, but who are HIV-positive with incomes = 250% FPL. The state assigns all enrollees to Eligibility Group '5B' and MASBOE '54' or '55' [nearly all are in MASBOE '55']. The waiver was set to expire on 31Dec2013. To avoid disruption of coverage as the state considers other coverage options under the ACA, CMS temporarily extended the waiver through 31Dec2014.	9/18/2014
ME	Eligibility	1115 Waivers	Enrollment in the MaineCare Waiver for Childless Adults [Waiver Type '5' / Waiver ID '11' / CMS Waiver ID# '11-W-00158/1'] fell more than 35% between Q1 and Q4 FY 2013. It was 11,500 in October 2012 and 8,200 in September 2013. The waiver ended on 31Dec2013. The state confirmed that enrollment declined prior to its expiration date.	12/22/2014
ME	Eligibility	CHIP	Maine has both M-CHIP (state code 3P) and S-CHIP (state code 000000) programs, and both are reported into MSIS.	8/11/2011
ME	Eligibility	CHIP	Separate CHIP [S-CHIP] enrollment increased substantially between Q3 FY 2012 and Q1 FY 2014. Maine reported about 530 S-CHIP enrollees per month during Q3 FY 2012. It reported about 4,800 per month during Q1 FY 2014. Kristen Cowing, the state's MSIS liaison, confirmed that the number reported for Q1 FY 2014 is correct. Total separate CHIP enrollment averages about 5,000 per month.	7/28/2014
ME	Eligibility	CHIP	There was a marked decline in M-CHIP enrollment between October 2012 and September 2013. Enrollment fell from 10,400 in October 2012 to 5,800 in September 2013 [-44.2%]. The state confirmed that enrollment in Rate Code 3P declined; but it cannot account for the change.	12/22/2014
ME	Eligibility	County Codes	Starting with Q4 FY 2010, county code is no longer a required reporting element in ME's data system. The state expects that	8/11/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			the number of individuals with unknown county codes will be higher than in previous files.	
ME	Eligibility	Date of Death	Dates of death are 8-filled for all eligibles.	NA
ME	Eligibility	Dual Eligibility Codes	All years: Maine extends full Medicaid benefits to the aged and disabled with income<100% FPL, accounting for the somewhat lower than expected proportion of QMB only dual eligibles.	8/5/2008
ME	Eligibility	Dual Eligibility Codes	Starting in Q2 FY10, ME reported an increase in partial dual eligibles. The state confirmed that these increases were correct and that they did not appear in MMA due to the timing of file submission. Although there were no policy changes that would lead to higher partial dual enrollment at this time, starting in January 2010 Maine receives Part D low-income subsidy applications from SSA to use for the Medicare Savings Program. The state contact believes that this may have led to a slight increase in the number of partial duals identified by the state and that small enrollment increases may continue in future files.	11/16/2010
ME	Eligibility	Dual Eligibility Codes	Part A coverage: FY03 Q1. There is a persistent problem that a small percent of dual code 02s do not have Medicare Part A coverage. The state believes that all of these duals should and do have Part A coverage, but because of coordination issues, these individuals may get their Part A coverage retroactively. The state confirmed this in telephone call on 9/22/04.	3/3/2011
ME	Eligibility	Dual Eligibility Codes	In Q4 FY 2010, ME dramatically undercounted the number of dual eligibles. The state identified an error and believes reporting should be corrected (with possibly an increase in the number of duals) when the file is resubmitted.	8/11/2011
ME	Eligibility	Dual Eligibility Codes	Maine reported about the same total number of QMB-plus duals (Dual Code = '02') and Other duals (Dual Code = '08) in Q4 2010 (Avg = 50,800 per month) as it did in Q3 2010 (Avg = 49,200 per month). However, many enrollees changed their Dual Code status from QMB-plus to Other Duals. In Q3 2010, the state reported an average of 42,800 QMB-plus duals per month. The average fell to 29,500 during Q4 2010. The state also reported 6,400 Other duals per month in Q3 2010. The average increased to 21,000 per month during Q4 2010. Maine indicated that there were some issues with its MMA files and there are differences in the way it counts duals for MMA versus MSIS. This does not seem to explain the result. The state has been asked to provide more details on the subject.	5/29/2013
ME	Eligibility	Dual Eligibility Codes	Maine normally reports ˜ 15,000 more Other Full Duals [Dual Code '08'] to MSIS than it does to MMA. It also reports ˜ 15,000 more QMB Plus Duals [Dual Code '02'] to MMA than it reports to MSIS. To more accurately capture information about these duals Truven revised the MSIS assignment logic. As a result, in future submissions the enrollment counts in MSIS should align more closely with those reported to MMA.	7/23/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
ME	Eligibility	Dual Eligibility Codes	Maine reports ˜ 15,000 more Other Full Duals [Dual Code '08'] to MSIS than it does to MMA. The state also reports ˜ 15,000 more QMB Plus Duals [Dual Code '02'] to MMA than it reports to MSIS. To more accurately capture information about duals the state has revised its MSIS assignment logic. As a result, in future submissions the enrollment counts reported to MSIS and MMA should align more closely.	7/28/2014
ME	Eligibility	Dual Eligibility Codes	Maine submitted EL files for Q1 FY 20111 in May 2013 and again in September 2014. CMS approved the file submitted in May. Subsequently, Maine submitted a revised file in September 2014. The state moved about 5,000 individuals previously assigned to SSG '010000' from Other Full Duals [Dual Code '08] to QMB Plus [Dual Code '02']. The May 2013 file included ˜29,800 QMB Plus and ˜21,300 Other Full Duals for December 2010. The September 2014 file included ˜34,900 QMB Plus and ˜16,400 Other Full Duals for the same period. Maine submitted its Q2 – Q4 FY 2011 files on 07May2013. It did not resubmit files for these quarters. As a result, it did not incorporate these changes into its Q2 – Q4 FY 2011 files.	2/2/2015
ME	Eligibility	Dual Eligibility Codes	Maine has a Drugs for the Elderly and Disabled [DEL] program that is entirely state-funded. Since DEL receives no federal funds, the state should not report it to MSIS, although it does. Maine began to assign DEL enrollees to Dual Code '09' in December 2011 [Q1 FY 2012], when enrollment was about 1,400. Average monthly enrollment grew to ˜1,700 in Q3 FY 2012. It further increased to ˜2,900 in Q4 FY 2013 and to ˜3,300 in Q1 FY 2014. Prior to Q4 FY 2012, the state assigned beneficiaries in DEL to MASBOE '99'. In Q4 FY 2012, it began to report them to MASBOEs '51' and '52'. Maine assigns all enrollees in the program to state specific group 'CB0000'. Author's note: This anomaly replaces all notes regarding Maine's Drugs for the Elderly and Disabled [DEL] program input before 24Feb2015.	2/24/2015
ME	Eligibility	Managed Care	PCCM enrollment of disabled persons grew in Q1-2 FY 2009. Maine adapted PCCM coverage in August 2008 to cover more disabled adults. Specifically, PCCM eligibility was expanded to include persons with SSI and not eligible for Medicare.	8/17/2009
ME	Eligibility	Managed Care	PCCM [Plan Type '07'] enrollment reported to MSIS declined substantially between Q3 FY 2012 and Q4 FY 2012. Enrollment fell from 389,800 to 161,200 [-58.6%] between June and July 2012. It has remained roughly the same through Q4 FY 2013. The state informed us that its count of PCCM enrollees was inaccurate prior to July 2012. It did not count unique enrollees. Maine corrected the error in July 2012. According to data the state submitted separately, between January and December 2012 average monthly enrollment was about 168,000. Average enrollment was about 162,000 between October 2013 and September 2014.	12/22/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
ME	Eligibility	Managed Care NEMT	Maine implemented its Section 113 Transportation Waiver [CMS Waiver ID# ME-01] in August 2013. As a 1915b, the waiver lets the state provide non-emergency transportation [NEMT] services under mandatory managed care. The waiver operates concurrently with waivers '19' [Disabled and Elderly 19], '21' [ID/DD Autism Comprehensive 21], and '29' [ID/Autism Support Waiver 29]. When asked about reporting enrollment in the waiver, the state indicated that nothing in its claims payment system (MIHMS) identifies a member as eligible for the waiver. It is done outside of the system. Maine will not be able to identify eligible individuals in its MSIS files. It does not expect to report enrollment in the waiver, when it first transitions to T-MSIS.	12/22/2014
ME	Eligibility	Managed Care Plan IDs	There was a marked decline in reported PCCM enrollment between June 2010 (N = 189,600) and September 2010 (159,900). The decline actually began in July 2010 (N = 162,00). According to the state, "This was not an expected decline in PCCM population numbers …" Due to a system conversion in September 2010, PCCM managed care enrollment activity fell. The state continues to research, identify and corrects issues with the data. As it corrects defects in the data, it estimates the enrollment numbers will increase.	5/29/2013
ME	Eligibility	MASBOE	All years: ME has a state-administered SSI supplement, which causes the counts of SSI recipients in MASBOE 11-12 to be higher than those reported in SSI administrative data. In addition, beginning in 2003, most SSI disabled age 65 and older are reported to MASBOE 11 (cash, aged).	3/18/2008
ME	Eligibility	MASBOE	All years after 2003: Almost no children are reported to MASBOE 14. Instead, ME primarily relies on the poverty-related group for child coverage (MASBOE 34). This shift began in FY03.	8/5/2008
ME	Eligibility	MASBOE	All years: The state provides full Medicaid benefits for the aged and disabled up to 100% FPL.	8/5/2008
ME	Eligibility	MASBOE	2007: In April 2007, MASBOE 31-32 increased sharply due to increases in QMB-only enrollees. ME confirmed that the increased enrollment was a result of Maine's increased income disregards.	5/18/2010
ME	Eligibility	MASBOE	Effective July 2009, CMS approved a SPA in ME that lifts the 5-year waiting period for immigrants. The state implemented this coverage effective 9/1/2010. All claims for this coverage are state-funded except for children under age 21, pregnant women, and individuals eligible for emergency services only. Our state contact is unsure what state specific eligibility group will be used to report enrollees covered using federal funds. We are also not sure whether the state will use Title XIX or Title XXI funds for this coverage.	11/16/2010
ME	Eligibility	MASBOE	Starting in Q3 FY10, Maine reported a new state group (96). This group is identified as "illegal aliens/medically indigent." The state contact explained that these enrollees are illegal aliens	11/16/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			who have met their spend-down and are eligible for emergency services only.	
ME	Eligibility	MASBOE	In Q4 2010 only, Maine inadvertently reported a substantial number of enrollees to MASBOE '51' (Avg = 4,500 per month) and MASBOE 52 (Avg = 38,200 per month). The state assigned these enrollees SSGs '3X0000' (Healthy Maine Prescriptions) and '3Y0000' (Drugs for the Elderly). These are "state only" programs and enrollment should not be reported to MSIS. Maine has removed them from its FY 2011 EL files.	5/29/2013
ME	Eligibility	MASBOE	From Q1 - Q4 2011, ME reported an average of 280 enrollees per month with CHIP-CODE = '1' and MASBOE = '00'. (High Value = 796 [July 2011] / Low Value =208 [December 2010]). The state has been asked to provide more information on this group.	6/25/2013
ME	Eligibility	MASBOE	The total number of aged and disabled enrollees in MAS '5' [1115 Demo] declined substantially between Q3 and Q4 FY2012. Combined enrollment in MASBOEs '51' – '52' fell from 52,200 to 1,800 between June and July 2012. Enrollment in MASBOE '51' alone went from 4,300 to 1,300; enrollment in MASBOE '52' fell from 48,000 to 600. As of Q4 FY 2013, it has not rebounded. The state indicated that it revised the logic it uses to report MASBOE for its 2014 extract. The data submitted in May 2013 for Q3 FY 2012 used older logic. Based on the new logic the corrected numbers for June 2012 are 1,200 for MASBOE '51' and 600 for MASBOE '52'. The aged and disabled enrollees still assigned to MASBOEs '51' – '52' in September 2013 [N = 2,950] are in state-specific eligibility groups 'CB0000' and '3X0000'. Since they were assigned to MAS '5', we expected that they would be enrolled in one of the state's 1115 demonstration waivers [MSIS Waiver ID '10' or '11']. However, they were not. Maine used the following logic to assign beneficiaries to Waiver IDs '10' and '11': 1) If any rate code = '5B' or any coverage code = 'ME00003', then Waiver ID '10'; 2) If any rate code = '5C' or any coverage code = 'ME00005', then Waiver ID '11'. The state indicated that the changes in extract logic did not impact the beneficiaries in 'CB0000' or '3X0000'. The state ran a report on the 2,500 individuals still assigned MASBOE 51-52, showing their coverage and rate codes for the quarter. Based on these codes, the associated Waiver ID is defined as 'not applicable; individual is eligible for Medicaid, but is not enrolled in a waiver this month.'	12/22/2014
ME	Eligibility	Private Health Insurance	In the Q4 FY09 file, ME submitted correction records back to Q1 FY08 that added many people (up to 13,000 people in some months) to health insurance code 2. The state moved to a better source for health insurance data and anticipated this change.	5/18/2010
ME	Eligibility	Restricted Benefits Flag	ME uses restricted benefits flag 4 for presumptively eligible pregnant women. Maine stopped assigning this RBF in the Q4	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			FY10 eligibility file. This was an error and should be corrected in the file resubmission.	
ME	Eligibility	Restricted Benefits Flag	Maine implemented a Money Follows the Person program on 01Oct2012. The first MFP enrollee transitioned into the community on 17Nov2012. However, the state did not add MFP to its MIHMS until February 2014. As a result, there should be no MFP enrollees in any file prior to Q2 FY 2014 [Jan – Mar 2014]. As of July 2014, Maine does not plan to submit MSIS EL files after Q1 FY 2014. Instead it will submit them to T-MSIS beginning with Q2 FY 2014.	7/28/2014
ME	Eligibility	Retroactive/ Correction Records	Starting Q4 FY 2010, ME has a new MMIS and contractor. After that time, the state is unable to submit retroactive and correction records.	8/11/2011
ME	Eligibility	SSN	ME routinely reports SSNs for close to 99 percent of enrollees. ME has assured us that they only report valid SSNs in the SSN field, and that they do verify SSNs with SSA. The SSN high group test data for Q3 FY06 MSIS data confirmed that only about 1.5 percent of SSNs were 9-filled, and that most of the remaining SSNs appeared valid.	6/18/2008
ME	Eligibility	TANF/1931	TANF was 9 filled beginning in FY03 Q1.	NA
ME	Eligibility	Waivers	In January 2008 (Q2 FY08), ME implemented a new IID/Autism waiver. This waiver was not reported to MSIS until Q4 FY09 (waiver type 3, waiver ID '29'). The state also added this reporting back to January 2008 with correction records. This waiver is approved to cover adults.	5/18/2010
ME	Eligibility	Waivers	Starting in Q4 FY08, issues were identified with the link between claims and eligibility records related to 1915(c) waivers. ME reports HCBS claims for persons who are not enrolled in 1915(c) waivers. The state believes the poor linkage occurred because Maine was reporting claims but not enrollment in its autism waiver (corrected with correction records). Also, the database with waiver information was out of sync from the MMIS. The state believes that this linkage will improve.	3/3/2011
ME	Eligibility	Waivers	According to the state, Section 32 CMS Waiver ID 0864.R00.00 (ME Services for Children with ID and/or Pervasive Development Disorders) had an original effective date of 01Feb2011. The state amended the start date to 01Jul2011, and amended it again to 01Jan2013. As of 29May2013, there are no children enrolled in the waiver and the state has plans to amend the start date yet again. The new start date currently is unknown. As of May 2013, there is no data to report for this waiver.	5/29/2013
ME	Eligibility	Waivers	Maine expects to report a few enrollees in the Adults with Other Related Conditions waiver [CMS Waiver ID# ME.0995.R00.00] to MSIS during Q1 FY 2014. It will report enrollment in T-MSIS starting with Q2 FY 2014.	7/23/2014
ME	Eligibility	Waivers	Maine will not be reporting enrollment in its Services for Children with ID and/or Pervasive Development Disorders 1915c	7/23/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			waiver [CMS Waiver ID# ME.0864.R00.00] to MSIS. Instead it will report enrollment in T-MSIS beginning in Q2 FY 2014.	
ME	Eligibility	Waivers	On 01Aug2013 the state's Section 19, 21, 29, and 32 waivers became combination 1915bc waivers. Maine's Section 18 and 20 waivers are also combination 1915bc waivers. Maine's Section 22 waiver is still a 1915c waiver.	7/23/2014
ME	Eligibility	Waivers	On 05Jun2014, CMS approved a temporary extension of Maine's Consumer Directed Personal Assistance Services 1915c waiver [CMS Waiver ID# ME.0127.R05.00] through 28Sep2014. The state uses Waiver ID '22' for MSIS reporting purposes.	7/23/2014
ME	Eligibility	Waivers	On 05Jun2014, CMS approved a temporary extension of Maine's Consumer Directed Personal Assistance Services 1915c waiver [CMS Waiver ID# ME.0127.R05.00] through 28Sep2014. The state uses MSIS ID '22', when it reports the waiver. Maine does not plan to report enrollment in the Services for Children with ID and/or Pervasive Development Disorders 1915c waiver [CMS Waiver ID# ME.0864.R00.00] to MSIS. Instead it will report enrollment to T-MSIS beginning in Q2 FY 2014. Maine expects to report a few enrollees in the Adults with Other Related Conditions waiver [CMS Waiver ID# ME.0995.R00.00] to MSIS during Q1 FY 2014. It will report enrollment to T-MSIS starting with Q2 FY 2014. On 01Aug2013 Maine's Section 19, 21, 29, and 32 waivers became combination 1915bc waivers. The state's Section 18 and 20 waivers are also combination 1915bc waivers. Its Section 22 waiver is still a 1915c waiver.	7/28/2014
ME	Eligibility	Waivers	Maine submitted EL files for Q1 FY 2011 in May 2013 and again in September 2014. There were a number of changes in waiver reporting between the two of them. The state moved ~1,000 beneficiaries from Waiver ID '20' [HCBS for Adults with Other Related Conditions/CMS ID #0276.R04.00] to Waiver ID '19' [Elderly and Adults with Disabilities/CMS ID #0995.R00.01]. Nearly all of the beneficiaries it moved were in SSGs '010000', '030000', and '280000'. Since Maine did not resubmit Q2 – Q4 FY 2011 files in September 2014, these changes are not included in these files. The state reported new Waiver ID '19' as a 1915bc waiver. It also reclassified Waiver IDs '21' and '29' as 1915bc waivers [Waiver Type '4'] from 1915c only [Waiver Type '3'] as of Q1 FY 2011. The state's Section 113 Transportation Waiver is a 1915b waiver that requires beneficiaries to receive Non-emergency Transportation through managed care. It operates concurrently with Waivers 19, 21 and 29. Maine did not implement the NEMT waiver until 2012. As a result, the change in reporting [from 1915c to 1915bc] was premature.	2/2/2015
ME	IP	Adjustments	There are very few adjustment claims on the files and they do not conform to the MSIS specifications. Maine has indicated that the number of adjustment claims is accurate.	12/10/2004
ME	IP	Crossovers	Maine stopped paying Medicare coinsurance and deductibles as part of an agreement with the hospital association, so there are very few crossover claims in the IP file in FY2005-2009.	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
ME	IP	DRG	There are no DRGs in the IP file.	12/10/2004
ME	IP	Family Planning	Family Planning and TPL are not reported 2005-2009.	8/22/2005
ME	IP	Medicaid Amount Paid Avg	From 2005-2009 the average Medicaid Amount Paid was incorrect (extremely low). There was some improvement in 2008.	NA
ME	LT	Leave Days	The state doesn't report leave days.	12/10/2004
ME	OT	Medicaid Amount Paid	Maine creates a summary bill on outpatient department claims with separate line items. Each line item should be included as a separate claim without the TPL, and then an additional claim should be included that has only the TPL amount. The TPL amount would be a negative dollar value matching the positive value in the Other Third Party Payment field. As a result, there are original and resubmittal claims with a negative Medicaid Amount Paid.	12/10/2004
ME	OT	Service Code Flag	Some of the Service Code Indicators do not match the format of the Service Codes.	12/10/2004
ME	RX	Adjustments	There are no adjustment claims on the file. Maine has indicated that this is OK, because drug claims are Point of Service.	12/10/2004
MI	Claims	Data System Change	Q4FY2009 - no claims were processed in the final two weeks of September as the state made the switch to their new system called "CHAMPS." State says Q4FY2009 numbers will be lower than expected and Q1FY2010 will be higher than expected. Additionally, the NPI and taxonomy fields were still blank, but MI expects to have this resolved in its next submission.	3/3/2011
MI	Claims	Data System Change	MI instituted a new MMIS - the first MSIS submission out of the new MMIS was Q1FY2010.	7/8/2011
MI	Claims	Managed Care Encounters	MI is submitting line item claims and often each line has the same diagnosis code. Michigan thought that the diagnosis code probably applied to all lines, but were concerned that if there were, for example, 11 line items for an abortion all with an abortion diagnosis, it would be counted as 11 abortions.	3/3/2011
MI	Claims	TPL	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.	12/10/2004
MI	Eligibility	1115 Waivers	MI's HIFA waiver expired December 31, 2009. After that point, MI covers HIFA enrollees under a new 1115 for childless adults (Waiver ID AB, Waiver Type 1) These enrollees are no longer covered with CHIP funds and are assigned to CHIP code 1 (Medicaid, no CHIP). These waiver enrollees only qualified for a limited benefit package that does not include inpatient hospital coverage and are assigned to RBF 5. MI manages this waiver to meet an annual appropriations limit so enrollment fluctuates regularly. Enrollees with access to employer-sponsored insurance (ESI) receive a voucher to purchase ESI. (It is unclear whether these enrollees receive wraparound benefits and whether they can be separately identified in MSIS data.)	4/2/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
MI	Eligibility	1115 Waivers	CMS approved an 1115 Family Planning waiver (Plan First! Family Planning Demonstration; Waiver Type 'F'; Waiver ID 'FP') on 01Mar2006. However, the state did not begin reporting enrollment in this program until 01Jul2006. FP enrollees are assigned to SSG L1Y with MASBOE 55 and Restricted Benefits Code (RBF) '6'. The state began to run this program under a temporary extension in 2012, while it decides whether to move this coverage to the statewide plan.	4/25/2013
MI	Eligibility	CHIP	MI has both M-CHIP and S-CHIP programs. The M-CHIP program covers children ages 15-18 up to 150 percent FPL. From January 2004 through December 2009, MI had a HIFA waiver that used Title XXI funds to cover childless adults in MSIS. That waiver expired January 1, 2010 and at that time a new 1115 waiver started that used Title XIX funds to cover these adults. MI's S-CHIP program was not reported to MSIS until January 2010 (Q2 FY 2010). The S-CHIP program covers two groups: (1) children ages 15 to 18 from 150-200 percent FPL (MIChild), and (2) since 2003, unborn children of noncitizen mothers from 133-185 percent FPL (MOMS). Starting Q2 FY 2010, MI reports MOMS enrollees in MSIS. MI started reporting MIChild enrollees in Q3 FY 2010.	11/1/2011
MI	Eligibility	CHIP	MI added full S-CHIP reporting in Q2 FY 2010 for enrollees in its MOMS program. These enrollees are reported to MASBOE 00 and a variety of state specific eligibility groups. Almost all enrollees are age 19 and older. All are assigned Restricted Benefits Flag 4. Most S-CHIP enrollees are in Behavioral Health Plans (the state is confirming that this is correct). Most have SSN 9-filled. Starting Q3 FY 2010, MI added full S-CHIP reporting for its MIChild enrollees. These enrollees are reported to Restricted Benefits Flag 1 and most are in managed care. MI does not have third party liability information for these enrollees so Health Insurance codes are 9-filled. MI plans to add this information in the new CHAMPS system, which will take place in February 2012.	4/6/2012
MI	Eligibility	Date of Death	Starting in Q4 FY 2009, MI reports some dates of death. There is often a lag between the date of death and the date that MI receives this information in the MMIS. The later a file is submitted to CMS, the more complete date of death information will be.	4/13/2011
MI	Eligibility	Dual Eligibility Codes	MI provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.	6/24/2011
MI	Eligibility	Dual Eligibility Codes	Beginning in Q2 FY 2010, MI erroneously reported about 1,250 'spend down' duals per month who did not meet their spend down limits (SSG Char 3 = 'Z') to MMA. This problem does not exist in MSIS. This resulted in an inconsistency between the MSIS and MMA totals. Michigan will continue to report this group to MMA until it reviews the implications of excluding it.	9/14/2011
MI	Eligibility	Dual Eligibility Codes	A large proportion of MI's dual eligible population are reported with dual code 08 each quarter (dual code 09 before Q1 FY03).	2/29/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			Also, MI reports relatively few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL.	
MI	Eligibility	Managed Care	In Q4 FY 2009, Michigan reports an increased number of full duals with HMOs, particularly disabled enrollees. MI explained that this increase was caused by improved dual identification processes. The state contact estimates that this will increase to a peak of more than 8,000 duals in HMOs in March 2010 and then decline to a new equilibrium of about 1,000 people in May 2010. This fluctuation is caused by the state identifying these individuals as duals and then removing their HMO enrollment.	9/14/2011
MI	Eligibility	Managed Care	Beginning in Q3 FY 2000, the state reports enrollment in a dental managed care plan. Dental plan enrollment is not included in the CMS managed care report for MI. In Q4 FY08, Dental plan enrollment increased considerably when MI expanded the program to two new, large urban areas in MI. MI terminated adult dental coverage after June 2009. Many of the adults who remain enrolled in these plans through Q4 FY09, are actually children ages 13-20. (Note: In October 2010, MI re-opened dental, vision, and podiatric care for Medicaid enrollees through November 2010. These services had been frozen since July 2009.) When MI transitioned to a new reporting system in Q4 FY09, enrollment reported in dental managed care plans became more accurate. Before this, MI had been reporting all children who resided in covered counties as dental managed care enrollees. Starting in Q4 FY09, MSIS includes only children who are actually enrolled in dental managed care. So, although it appears that dental managed care enrollment among children drops in Q4 FY09, this is actually just an improvement in reporting. (Dental managed care enrollment before this period may be over-counted.)	2/29/2012
MI	Eligibility	Managed Care	MI reports a large number of enrollees (about 1.5 million in Q1 FY 2009) to behavioral health plans (Plan Type 3). Starting in Q4 FY 2009, MI reports HIFA waiver enrollees (Waiver ID AB) to behavioral health plans. The state has offered BHO coverage to these enrollees and paid capitated rates to BHOs for these enrollees since the program started in 2004, but didn't report this enrollment in MSIS until Q4 FY 2009. (Capitation payments were included in OT claims files.) Starting in the Q1 FY 2010 file, MI reported all full-benefit Medicaid and Adult HIFA waiver enrollees to BHOs because all of these individuals are eligible for these services. Only PACE enrollees will be excluded.	4/2/2012
MI	Eligibility	Managed Care	Through Q3 FY 2010, MI reports about 65,000 persons a month to a behavioral health organization in more than 1 Plan Type and Plan ID slot, causing duplicate reporting. MI found that this duplication was caused by individuals moving between counties. In Q1 FY 2011, this issue appeared again for about 200-400 S-CHIP enrollees a month in multiple HMO plans. MI confirmed that this duplication occurred when children switched plans	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			during the month. MI will correct this reporting for the Q2 FY 2011 file.	
MI	Eligibility	Managed Care	Plan ID "2304993" is the state's identifier for LogistiCare, a contractor that provides non-emergency transportation services (NEMT) to Medicaid recipients in Southeast Michigan. The state compensates LogistiCare via capitation payments. Through February 2012, Michigan submitted these payments to MSIS as gross adjustments. In March 2012, the state began to pay LogistiCare using its CHAMPS contract management system. This is consistent with payments to the state's other managed care entities. MSIS payments made prior to March 1st are reported as gross adjustments for TOS 26 (Transportation Services). Payments made after March 1st are reported as capitation payments for TOS 21 (Prepaid Health Plan [PHP]).	10/9/2013
MI	Eligibility	MASBOE	In Q4 FY 2010, enrollment in MASBOE 34 increased by about 50,000 children. No new state specific eligibility groups were reported. MI confirmed this increase.	3/21/2012
MI	Eligibility	MASBOE	MI has confirmed that coverage codes 'D' (Freedom to Work) and 'K' (Freedom to Work/Premium Required) are Medicaid Buy-in programs. Individuals enrolled in MBI should be assigned Aid Categories (State Specific Groups) 'P1D*' and 'P1K*. The data indicate that there were no enrollees in 'P1K* for the period Q4 2011 through Q1 2012.All of the Medicaid Buy-in enrollees were assigned to SSG 'P1D*'. MI moved all Freedom to Work enrollees to MASBOE '42', starting in Q2 FY 2010. Michigan reports about 7,500 enrollees per month to this group.	4/25/2013
MI	Eligibility	MSIS ID	In January 2008 MI started reporting some records to 10-byte MSIS IDs. Only new enrollees will receive 10-byte IDs. Existing enrollees retain their 8-byte MSIS IDs.	9/14/2011
MI	Eligibility	Private Health Insurance	MI does not have private insurance information for enrollees in the MiChild S-CHIP program. Program documentation shows that these enrollees are not eligible if they have additional coverage but MI is unsure about the reliability of private health insurance documentation in this population. MI is reporting these enrollees (about 34,000 a month) to unknown insurance status while they add this reporting to the MMIS record for these enrollees.	1/18/2012
MI	Eligibility	Restricted Benefits Flag	In July 2008, MI implemented a Money Follows the Person (MFP) program. Enrollment in the MFP program appears in MSIS in Q4 FY 2008. These enrollees are assigned RBF code 8 in MSIS.	11/18/2009
MI	Eligibility	Restricted Benefits Flag	Starting Q2 FY 2010, enrollees in MI's S-CHIP program for unborn children of noncitizen mothers (MOMS) are reported to Restricted Benefits Flag 4.	9/14/2011
MI	Eligibility	Restricted Benefits Flag	MI assigns Restricted Benefits Flag 5 to childless adults covered under the state's 1115 waiver (HIFA waiver through December 2009).	1/18/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
MI	Eligibility	Restricted Benefits Flag	In Q4 FY 2006, MI began reporting enrollment in its 1115 Family Planning waiver. These enrollees are reported to MASBOE 55 and Restricted Benefit Flag 6.	4/2/2012
MI	Eligibility	TANF/1931	MI is unable to code the TANF flag for its Medicaid population. All eligibles receive a TANF code of 9, indicating their TANF status is unknown.	11/1/2011
MI	Eligibility	Waivers	MI has a long-standing waiver-claims link issue where many HCBS claims are paid to non-HCBS waiver enrollees. The state investigated and found that many of the non-HCBS waiver enrollees with HCBS waiver service claims are enrolled in Section 1915(b/c) waivers (Type 4).	2/29/2012
MI	Eligibility	Waivers	According to CMS, MI operates its Specialty Services and Supports Waiver (Waiver ID MH) under 1915(b) (c) authority. It operates its Habilitation Supports Waiver (Waiver ID HS) under 1915(c). The waiver crosswalk maintained by Mathematica shows just the opposite with its 'MH' waiver reported to waiver type 2 and its 'HS' waiver mapped to waiver type 4. These two programs are linked so individuals will only be reported to one group. Any HS enrollees (receiving 1915(b) (c) services through the program) will not be reported to MH as well (receiving 1915(b) services only) since that would overstate the size of the 1915(b) population.	3/25/2013
MI	IP	Managed Care Encounters	The procedure code is missing on 95 percent of the claims.	12/10/2004
MI	IP	MSIS ID	Q1FY2010 IP S2 file: DQ and Validation check found that: about 23.8% of claims have an MSIS ID length = 10-numeric. The rest are 8-numeric. Previously 10-numeric accounted for between 2 and 7% of claims. - We understand that new enrollees are assigned 10-numeric IDs, however, no other files have such a significant jump in claims for Q1. State responded: 1) Our new eligibles system, Bridges, was being rolled out by major population centers or county groupings between March 2009 and September 2009. When Bridges was implemented in a geographic area, all new enrollees were assigned an ID number beginning with "10". When we looked at inpatient claims on a monthly basis BY DATE OF SERVICE, we observed that the percent of "10" IDs to the total IP claim IDs increased by about 3% per month during the March 2009 to September 2009 period compared to about 1/2% per month subsequent to September 2009. The 1/2% per month is more reflective of our total Medicaid membership growth on an ongoing basis. 2) Given these findings, we would have expected CMS to first notice this jump with our Q3 or Q4FY2009 Claims IP submissions. But we were undergoing MMIS conversion during an overlapping period here with our legacy MMIS completely shut off the final two weeks of September 2009 and our new MMIS starting October 1, 2009. We studied inpatient claims and discovered an unusually large lag in inpatient claim payment during this period. Since MSIS reporting is based on date-of-	5/19/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			payment, there was a disproportionate impact of these "10" claims in the Q1, FY10 submission as these earlier months claims were pushed into a later quarter than would normally have been the case if no MMIS conversion were occurring. You should observe more moderate increases in later FY10 quarters as the post-Bridges equilibrium will have been reached on a date-of-payment basis as well as a date-of-service basis. We believe the reason this same phenomenon was not noted by CMS with other claim types is that inpatient claims have very long payment lags compared to other claim types and that a more orderly increase in "10" claims for other claim types would have been observed in the two quarters prior to Q1FY2010. CMS requested approval of the file and anomaly documentation.	
MI	IP	Service Tracking Claims	Large expenditures are reported on service tracking claims.	NA
MI	IP	Service Tracking Claims	More expenditures are reported on IP service tracking claims than on individual claims due to the method of hospital reimbursement.	10/12/2006
MI	IP	TPL	TPL is not reported on IP claims.	6/9/2009
MI	LT	Crossovers	In 2008 Q2/3 expenditures on crossover claims are incorrectly reported.	NA
MI	LT	Leave Days	Neither TPL nor Leave Days are reported in the LT files.	6/9/2009
MI	LT	Managed Care Encounters	75 percent of the claims have only one covered day.	12/10/2004
MI	LT	Service Tracking Claims	The large number of service tracking claims represents gross adjustment payments known as QAS (Quality Assurance Supplement). It is related to the provider tax program. Prior to Oct 2003, these payments were part of the NF per diem. After that, the payments were pulled off of the per diem and paid as gross adjustments. Due to a delay in the approval of the new state plan, a 9 month catchup payment was made in Q3FY2004. Normally the payments are monthly.	12/10/2004
MI	LT	Type of Service	In the Q2FY2010 LT file: 1. there was a large increase in the number of crossover claims and 2. There was a large increase in average amount paid per day for TOS=05 (ICF/IID). The state attributes these jumps to the change in the new system and the fact that LT claims were "held" and not approved for some time. The claim numbers should even back out over the next several quarters.	9/20/2011
MI	OT	Adjustments	In MI's 2010 Q4 OT S1 file, the number of adjusted capitation claims (Type of Claim = 2, voided/credited) went from close to 900,000 in the prior quarter to over 14 million. The state explained that FY10 was their first year with the new CHAMPS MMIS system. There were a number of issues with the Medicaid Health Plan capitation rates for the October 2009 through June 2010 service months which forced MI to completely reverse and repay a number of those months and those reversals and	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			repayments all occurred during the July through September 2010 period. In total, nine months of payments were reversed and repaid (although not all nine months were affected, October 2009, for example, was completely reversed and repaid twice for two different reasons).	
MI	OT	Crossovers	In Q1FY2010, the number of Original, FFS, crossover claims dropped to about 170,000 from over 400,000. State Explanation: This result is an MMIS conversion anomaly related to date-of-payment. This situation will correct itself with abnormally high result in our Q2FY2010 submission.	6/30/2011
MI	OT	HCBS Waiver	Medicaid, FFS, non-crossover claims with a program type=7: home care waiver went from 991,000 to 76,000 in Q1FY2010 file. State Response: Our Elderly and Disabled Waiver Agents (the providers of those services) encountered challenges when converting to our new MMIS which went live Q1FY2010. Many claims were not finally paid until late calendar year 2010. Therefore, CMS will observe anomalous readings culminating in huge bulges in Q4FY2010 and Q1FY2011. This problem affects all Home Care Waiver claims, not just the non-crossover claims. Non-crossover claims represent a fairly steady 10-11% of all Home Care Waiver claims whether looking at date of service or date of payment.	6/30/2011
MI	OT	Managed Care Capitation	The BHO capitation claims are reported as service tracking claims in the 1999 to 2002 OT files and then switched to individual claim reporting through 2007. In 2008-2009 they again are reported as Service Tracking. Starting in Q1FY2010 the state will be able to report them as individual claims.	12/10/2004
MI	OT	Managed Care Capitation	There are no PCCM capitation claims as case management services are only paid when the service is rendered.	10/16/2008
MI	OT	Managed Care Capitation	Cap payments with program type=6: home care 65+ went from zero to 1,511 in Q1FY2010. State Response: These represent our PACE clients, the only capitation payments we make that seem to fall into this program type.	6/30/2011
MI	OT	Managed Care Capitation	Maximum Capitated payments went from a range of around $7,000 to $14,476 in Q1FY2010 file. State Response: Capitations for our HAB Supports Waiver now include very high capitation payments for clients who were de-institutionalized when our last ICF/IID was closed. These capitation payments were accurate.	6/30/2011
MI	OT	Managed Care Capitation	Capitated payments with TOS=21: PHP went from over 900,000 to over 6 million in Q1FY2010 file. State Response: In a general sense, this represents our conversion of our mental health capitation payments to an on-line payment process and a new ability to associate these payments with individual clients. Previously, these payments were made by means of large gross adjustments and CMS commented many times on this problem in the past. These new results are appropriate.	7/8/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
MI	OT	Managed Care Capitation	Capitation payments with program type=0: no special program went from 4.2 million to over 9 million in Q1FY2010. State Response: Capitation payments for clients with program type = 0 include our Medicaid Health Plan payments (about 3.4 million per quarter) and our Mental Health capitation payments (about 5.6 million per quarter) arriving at our new equilibrium of about 9 million per quarter.	7/8/2011
MI	OT	Managed Care Encounters	Michigan will not be able to assign Type of Service for many encounter records because the plans often do not submit the information needed for Type of Service classification and use plan-specific provider types, making it impossible for the state to identify the type of provider. The claims have some non-specific types of service like "critical care."	12/10/2004
MI	OT	Managed Care Encounters	The billing provider ID is not always included on encounter claims and the servicing provider ID may be the provider tax ID or the provider ID assigned by the plan.	12/10/2004
MI	OT	Managed Care Encounters	The state can't distinguish between FQHC and RHC claims in its managed care data.	3/3/2011
MI	OT	Medicaid Amount Paid	The following anomaly is a result of MI's new MMIS system and the first MSIS submission from this MMIS for Q1FY2010: Maximum amount paid for FFS, Original, Crossover claims went from a range of $4,000 to $216,906. The state responded as follows: No Change Necessary: These results were real on a date-of-payment basis. Investigating these particular claims, we found that they were reversed in a subsequent quarter. So we do not plan to correct this item.	6/30/2011
MI	OT	Medicaid Amount Paid	The following anomaly is a result of MI's new MMIS system and the first MSIS submission from this MMIS for Q1FY2010: Maximum amount paid for Original, FFS, non-crossover claims went up from a range of $19,-37,000 to $466,277. The state responded: This variance is due to the impact of a change in the method used to process payments for School Based Services (SBS) which was implemented during Q1FY2010. Prior to this SBS was paid on the basis of service claims. During Q1FY2010 this procedure was changed to one whereby each Intermediate School District (ISD) is provided monthly interim payments through gross adjustment with final payment determined via cost settlement at year end. Each ISD's interim payment is based on the prior year amount and distributed based on reported claims in the current year. Each monthly payment reflects the "seasonality" of claims for the same period in the prior year as compared to the total for the year. So long as monthly "seasonality" in the current year reflect that for the same month in the prior year then a proportional payment is made. To the extent that it does not, other adjustments are made to the gross adjustment amount to reflect this situation. The intent here is to avoid large payments for periods when schools are closed (i.e., the summer). This new method builds into our MSIS reporting the likely event of large swings in each	7/8/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			quarterly payment per claim since current payments are based on prior year performance, exacerbated by the fact that we continually experience large swings in the number of reported claims, month-to-month, from our ISD's in the current year. In quarters where few claims are reported by a particular ISD, there will be extremely large costs per claim reported CMS advised the state to leave the current reporting procedure in place, recognizing this will create an inherent weakness in the variance analysis of this file.	
MI	OT	Medicaid Amount Paid	The following anomaly is a result of MI's new MMIS system and the first MSIS submission from this MMIS for Q1FY2010: The total amount paid for the HCBS program went from over $32.3 million to $15.8 million. The state says that the MMIS conversion will result in several consecutive anomalous "date-of-payment" quarters until sometime in FY2011 when the situation should restabilize.	7/8/2011
MI	OT	Type of Service	TOS=34: PT/OT/sT accounts for 178,526 claims in Q1 2010 file, up from over 47,000 claims. MI told us : The vast majority of school-based services are for therapies and we are now correctly assigning them to TOS 34 for the first time. This increase is attributable to this logic and we believe it to be appropriate and this range of results should represent a new equilibrium in subsequent quarters.	7/8/2011
MN	_All	NPI	Through at least FFY2013 MN reported provider ID values that are not National Provider Identifiers as National Provider Identifiers. Those invalid NPI values represent a 'Unique Minnesota Provider Identifier' (UMPI) assigned to certain atypical providers who are not eligible for an NPI. These could be case managers, personal care assistants, transportation, etc. UMPI's start with the letter A or M followed by 9 numbers.	2/27/2015
MN	Claims	Adjustments	Since at least Q3FY2009 MN has not reported Original ICNs or Adjustment ICNs on Credit or Debit adjustments of either FFS claims or encounters. Of all adjustment claims, MN only reports Original and Adjustment ICNs on Void and Resubmittal types of adjustments.	7/12/2011
MN	Claims	Amount Charged	Through at least FFY2013, amount Charged is zero ($0) on all managed care encounters reported by MN in MSIS. MN expects to submit the amount paid by MCOs to providers in T-MSIS data.	2/27/2015
MN	Claims	CHIP	MN began reporting separate CHIP FFS claims, capitation claims, and managed care encounters in Q1FY11.	5/7/2013
MN	Claims	ICN	In adjustment situations, there are instances where an original ICN is not available in the state's system. In those instances that state reports ICN as 9-filled in MSIS.	2/27/2015
MN	Claims	Managed Care	Some HMO services are included for people enrolled in LT managed care.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
MN	Claims	Managed Care Plan IDs	In order to link the Plan IDs in the eligibility file with the capitation claims, the leading 0 in the EL Plan ID needs to be dropped. Does not appear to be a problem after 2007 though a specific resolution date has not been confirmed.	NA
MN	Claims	Taxonomy codes	Minnesota uses internal specialty codes and does not enforce the collection of taxonomy codes. There are no plans to include taxonomy in MSIS at this time.	2/27/2015
MN	Eligibility	1115 Waivers	2012: Each month about 50 people are assigned to the family planning-only waiver and to PMAP+. Individuals should not be enrolled in both concurrently but there are some accidental overlaps in the system.	9/1/2011
MN	Eligibility	1115 Waivers	Through Q4 2009, MN reported about 1,500 persons a month with RBF 2 to its PMAP+ waiver. None of these persons are in MAS 5, so we expected that these persons are being reported to managed care plans through the waiver. The state explained, however, that these are people covered under the S-CHIP prenatal program (in the state plan) and that they should not have been reported to the section 1115 waiver. From Q3 FY 2009 forward, MN corrected most of this reporting, but in the first month of each quarter of Q3 FY2009 - Q1 FY2010, MN still reported a small number of people (70-150) with RBF 2 to the PMAP+ waiver. MN corrected this in the Q2 FY 2010 file (which may have resulted in the considerable decline in RBF 2 starting that quarter).	9/1/2011
MN	Eligibility	1115 Waivers	Until January 31, 2009 MN's 1115 S-CHIP waiver secured enhanced matching funds for some adults who were originally enrolled in the state's PMAP+ 1115 waiver, but were then moved into a separate CHIP program. Basically, these were parents of S-CHIP and Medicaid children with family income up to 200 percent FPL. The waiver for enhanced federal match expired on January 31, 2009.	9/1/2011
MN	Eligibility	1115 Waivers	MN operates an 1115 waiver demonstration called the MN Prepaid Medical Assistance Project Plus (PMAP+, waiver ID B1, type 1) (originally approved in 1995). The program provides services through prepaid managed care plans to "MinnesotaCare" enrollees, including pregnant women, children, parents and adult caretakers with income to 275 percent FPL (childless adults are not covered under this waiver). Parents and caretakers receive a limited benefits package. In February 2009 (Q2 FY09), S-CHIP coverage for adults expired. At that time, MN moved adults who had previously received coverage under the S-CHIP program to MN Care. The adult enrollees were reported to state groups A4 and M4 under S-CHIP. As they moved to MN Care, these enrollees were transferred to groups A2 and M2. In FY 2009, income eligibility standards changed for MN's MN Care program. In April 2009, the M2 group went from 175% - 275% FGP to > 200% - 275% FPG in April 2009, and from there to > 215% - 275% FPG in July 2009. Some enrollment fluctuation in these groups occurred at this time. See MN Care program	5/1/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			descriptions in MN documentation folder for more details about MN Care program. In August 2011(Q4 FY11), the PMAP+ waiver expanded to cover childless adults with income between 75 and 250 percent FPL. This group is mapped to MASBOE 55 and to State Specific Eligibility Group M52955. Some PMAP+ expansion enrollees, including MinnesotaCare Caretaker adults and adults without children receive limited Medicaid benefits. These benefits have limits on inpatient hospital coverage and exclude several other services, including many long-term care services. These enrollees should be mapped to Restricted Benefits Flag 5 (Other benefit restrictions) starting with the Q4 FY 2011 MSIS eligibility file. However, they are not. In our review for Q1 FY 2012, we asked the state to provide us with an update on this issue.	
MN	Eligibility	1115 Waivers	Enrollment in Minnesota's 1115 Waiver increased by more than 30,000 between March and December 2011. Minnesota was one of two states to implement early Medicaid expansion under the Affordable Care Act as of March 1, 2011. The expansion group included adults ages 21 - 65 with incomes <= 75% FPL.	6/7/2013
MN	Eligibility	1115 Waivers	CMS approved the Minnesota Reform 2020 Waiver on 18Oct2013. Reform 2020 is an 1115 Demonstration that provides authority for the state's Alternative Care [AC] and Community First Services and Supports [CFSS] programs. CMS approved the waiver through 30Jun2018. The waiver covers three populations: 1) Alternative Care; 2) 1915(k)-like; and 1915(i)-like. Alternative Care includes people = 65 years who are enrolled in Minnesota's Alternative Care program. AC is for seniors who need an institutional level of care, but have incomes and/or assets above Medicaid levels. This program provides a package of home and community based services to prevent premature entry into nursing facilities and to prevent or delay people from spending-down to Medicaid income levels. The 1915(k)-like portion of the Reform 2020 Waiver will extend the number of people receiving CFSS services. If people choose to use CFSS and not Minnesota's Elderly Waiver, the authority for this waiver lets the state use eligibility standards in place for the Elderly Waiver. It will not be implemented until the state receives approval of its SPA for Community First Services and Supports. The 1915(i)-like portion of Reform 2020 will also extend the number of people receiving CFSS services. Current federal regulations limit 1915(i) services to individuals with incomes = 150% FPL, if the individual does not require an institutional level of care. This waiver authority allows the state to provide these people with CFSS services if they have an assessed need, even if they do not require institutional care and have incomes > 150% FPL. Minnesota will not implement this program until the state receives approval of its State Plan Amendment [SPA] for CFSS.	12/19/2014
MN	Eligibility	CHIP	MN's S-CHIP covers unborn children (state group PC9900). SEDS-MSIS comparisons are difficult for this group because	9/1/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			individuals in the unborn S-CHIP groups are reported as children in SEDS, but have their mother's date of birth in MSIS.	
MN	Eligibility	CHIP	MN has a very small M-CHIP program reported to MASBOE 34 that covers only infants with income from 275 to 280 percent FPL. MN will add these enrollees to the PMAP+ waiver if they are enrolled in managed care through that waiver.	4/6/2012
MN	Eligibility	CHIP	From Q2 FY 2011 through Q1 FY 2012, MN erroneously reported its separate CHIP (CHIP-CODE = '3') population to Waiver ID = 'B2'. The state began to report these enrollees correctly to Waiver Type = '88' and Waiver ID = '8' in Q2 FY 2012.	5/17/2013
MN	Eligibility	CHIP	MN's separate CHIP program [CHIP-CODE '3'] covers about 2,000 unborn children each month. The state assigns all of them to SSG 'PC9900' and correctly reports them to MASBOE '00'. It also should 0-fill values for the following fields: 1] HEALTH-INSURANCE; 2] TANF-CASH-FLAG; 3] RESTRICTED-BENEFITS-FLAG; 4] PLAN-TYPE-1 thru PLAN-TYPE-4; and 5] WAIVER-TYPE-1 thru WAIVER-TYPE-3. However, the state only 0-fills the field TANF-CASH-FLAG. MN clearly assigns all of the separate CHIP enrollees to RBF '1', which is incorrect. It is not clear what values the state reports for the other fields.	5/7/2014
MN	Eligibility	Dual Eligibility Codes	MN's MSIS dual reporting and MMA monthly dual distribution have been inconsistent. From January 2006 forward, MMA reporting showed more partial duals than MSIS, but fewer full duals than MSIS. The state believes that the timing of the MMA files results in higher levels of partial duals relative to MSIS, and expects retroactive records to eventually make the comparison more even.	9/1/2011
MN	Eligibility	Managed Care	The new Medical Assistance (MA) program enrollees (effective March 2011) were enrolled in managed care and get the standard MA benefit package. Eventually, they look like most other PMAP groups in that a new enrollee gets a month or so of coverage under FFS, and then is enrolled in managed care. There were increases in managed care enrollment in MSIS from March 2011 to approximately August or September 2011, as the state manually converted enrollees from the state-only programs (General Assistance Medical Care and MinnesotaCare) who met MA expansion eligibility requirements into the new MA expansion eligibility category.	2/7/2013
MN	Eligibility	Managed Care Plan IDs	MSIS data element Plan-ID is an alphanumeric field and should always be left-justified and space-filled to the right. MN reports PLAN-ID right-justified which causes the spaces to fill the left side of the plan-ID. Because the first character of the Plan ID in EL is a space and the first character of a Plan ID on claims is actually the beginning of the plan ID, it may be difficult to link enrollments to claims using the Plan ID.	5/16/2012
MN	Eligibility	MASBOE	MN is a 209 (b) state, causing the number of SSI recipients in MAS/BOE 11-12 to differ somewhat from SSI enrollment data.	3/25/2010

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State	File Type	Rec/Issue Type	Issue	Recorded
			In addition, most disabled SSI enrollees age 65 and older appear to be reported to MAS/BOE 11.	
MN	Eligibility	MASBOE	In early 2007, the 125,000 MN residents who purchased Long Term Care insurance became eligible for Medicaid before spending down. The partnership affects only asset eligibility (and not income eligibility). The state has confirmed this policy change, which was not fully implemented as of November, 2007. The state expected to see its first recipients eligible under the partnership in State FY 2010 (starts in July), when they project 20 eligibles. The state does not project that the count will reach 100 eligibles until State FY 2013.	2/2/2011
MN	Eligibility	MASBOE	MN added coverage for lawfully-residing immigrant children and pregnant women within the 5-year waiting period in 2010. They are reported to the MASBOE categories and state specific eligibility groups under which they are eligible for Medicaid. They cannot be identified separately.	8/2/2011
MN	Eligibility	MASBOE	MN extends "access" services to aged persons whose eligibility is not yet fully established. These persons are in state group UN28 and receive RBF 5. Many of these individuals are subsequently enrolled in other state groups in MN's Medicaid program. However, MN is uncertain that Title XIX eligibility requirements are verified for enrollees in this group, considering that "access" services are used to determine eligibility for Title XIX.	8/2/2011
MN	Eligibility	MASBOE	MN ended its General Assistance Medical Care (GAMC) program, a state-funded medical assistance program (eligibility types GF and GS) for low income adults aged 21-64 who do not qualify for federally funded health care programs, on March 1,2011. All GAMC enrollees were moved automatically to MN's new Medical Assistance program on March 1. The new program covers adults without children who have incomes equal to or less than 75 percent of FPL. These enrollees (state-specific group 'AX') caused a large increase in reporting to MASBOE 45 in MSIS.	4/6/2012
MN	Eligibility	Private Health Insurance	MN reports 12,000 to 16,000 persons a month to health insurance code 4. The state confirmed that the people who receive this code have private third party insurance that is purchased by the state. (Prior to Q1 FY11, these persons had been reported with health insurance code 3.)	6/22/2011
MN	Eligibility	Restricted Benefits Flag	A small number of people receive RBF 4. The state confirmed that these are non-citizen pregnant women. Our state contact researched some of these cases and is unsure why they were identified as emergency medical assistance cases, because they appear to be eligible as non-citizen pregnant women (for prenatal and post-partum care).	5/17/2010
MN	Eligibility	Restricted Benefits Flag	MN reports several state specific groups to RBF '5' [restricted benefits – other]. These enrollees receive a 'less rich' benefits package: 1) MinnesotaCare Caretaker Adults [SSG 'A2']; 2) MinnesotaCare Childless Adults [SSG 'M2']; and 3)	11/14/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			MinnesotaCare Caretaker Adults [SSG 'M5']. The state began to report about 74,100 of these enrollees per month in Q2 FY 2012. MN also assigns two other SSGs to RBF '5'. Enrollees in 'UN2854' and 'UN2814' receive 'access' services only, since their eligibility has not been fully established. The state has reported 3,500 – 4,100 of these enrollees per month since at least Q1 FY 2010.	
MN	Eligibility	Restricted Benefits Flag	In 2011, MN received a $187.4 million MFP Rebalancing Demonstration grant. Total funding for the first year was $13.4 million. The state did not implement its MFP program until 2013. We expect MN to report RBF '8' enrollment for Q2 FY 2013.	5/7/2014
MN	Eligibility	TANF/1931	MN 9-fills the TANF field.	3/13/2013
MN	Eligibility	Waivers	MN's Consolidated Chemical Dependency Treatment Fund waiver uses 1915(b) authority to assign individuals to county-provided case managers. This waiver does not place enrollees into formal managed care organizations and services for these enrollees are FFS.	10/24/2011
MN	Eligibility	Waivers	Minnesota has several waiver programs for seniors and persons with disabilities. Reporting for these programs has been refined over time. First, MN has a voluntary managed care/HCBS program that is integrated with Medicare for seniors (MSHO) and for persons with disabilities (MDHO). After 2006, this program operates through contracts with Medicare special needs plans. (The MDHO program ended 12/31/10.) The MSHO/MDHO programs operate under 1915(a) authority in Medicaid and individuals in this program who do NOT receive HCBS should not be reported to MSIS. (Before Q3 FY09, MN incorrectly reported these enrollees to waiver ID M1.) Individuals in MSHO/MDHO who do receive HCBS are reported to the individual 1915(c) waivers that provide these services (including the Elderly, CADI, TBI, and DD waivers). Seniors who do not choose to enroll in MSHO are required to enroll in the Senior Care Plus program (waiver ID SC, waiver type 4). (There is no corresponding required managed care program for individuals with disabilities.) This program includes Medicaid managed care and HCBS. As of Q1 FY09, people in Senior Care who do NOT receive HCBS are reported to the Elderly Basic waiver (Waiver ID EB, Waiver Type 2). (Before Q1 FY09, all Senior Care plus enrollees were reported to waiver ID SC, regardless of whether they received HCBS.) Through Q4 FY 2009 MN reported almost all Senior Care enrollees to the 1915c Elderly waiver. The state confirmed that this is duplicate reporting (because Senior Care provides all the same services as the Elderly waiver through capitation). Starting Q1 FY10 the state reported only Senior Care enrollment and the state removed duplicate reporting (~4,000 individuals) back to Q1 FY09 through correction records. MDHO ended 12/31/10. The state anticipates that this will have a limited impact on MSIS eligibility reporting. First, most MnDHO enrollees will continue to receive 1915c services via FFS waivers. When MN renewed its	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			CADI and TBI waivers, the state ran ad hocs on encounter data to see what types of services this population will end up receiving on the FFS side. They found that, by and large, they resemble the "average" FFS enrollee, so MN will more or less spread them out proportionally across the FFS waiver services. MN expect that this change will only be noticeable for CADI, as roughly 1000 enrollees will go from PHP to FFS. TBI has a handful of MnDHO folks. In January 2009, MN expanded the Senior Care program and enrollment increased at that time. Through Q4 FY 2009, MN reported most Senior Care Plus enrollees to the Elderly 1915c waiver as well (Waiver ID M2, Waiver Type 3). Since individuals in the Senior Care plus waiver ID should already be receiving HCBS, this reporting could be unnecessary duplication. The state agreed that services in the FFS Elderly basic waiver should already be covered under Senior Care. Duplicate reporting to the Senior Care+ and 1915(c) waivers dramatically improved in Q1 FY10. Some enrollees in the EB waiver do also receive FFS HCBS through the CADI and DD waivers. These services are not covered under capitation and the state makes separate payments for these programs. Each month a couple hundred individuals are reported to both the EB waiver and the Elderly Waiver--the state contact investigated this and found that this was caused by individuals moving in and out of capitated coverage.	
MN	Eligibility	Waivers	CMS approved an extension of Minnesota's Community Alternative Care Waiver [MSIS ID 'H2'/CMS ID 4128.R06.00] with an effective data of 27Feb2014. The new expiration data is 31Mar2018.	3/31/2014
MN	Eligibility	Waivers	Enrollment in waiver 'F1' [The Consolidated Chemical Dependency Treatment Fund] declined noticeably from Q1 to Q4 FY 2012. Between Oct 2011 and Sep 2012 average monthly enrollment fell from 3,000 to 2,500, a decline of 17.7%. The state informed us that the expansion of its disabled population into managed care accounted for the decline.	3/31/2014
MN	Eligibility	Waivers	MN assigns about 85 enrollees per month to Waiver Type 'F' [Family Planning], but not to MB 54 - 55 and RBF '6' [Restricted benefits – family planning].	5/7/2014
MN	Eligibility	Waivers	CMS approved Minnesota's 1915b Case Management Waiver [CMS ID# MN-03] in February 2013. According to the state, everyone who gets "case management" under the Case Management Waiver is in one of the state's 1915c HCBS waivers.	12/19/2014
MN	Eligibility	Waivers	According to CMS, Minnesota's Community Alternatives for Disabled Individuals [CADI] (MSIS Waiver ID 'M3' / CMS Waiver ID# '0166.R05.00') and Traumatic Brain Injury [TBI] (MSIS Waiver ID 'M4' / CMS Waiver ID# '4169.R04.00') waivers are mainly for people ages 0 – 64 years. The state's waiver applications indicate that people already in them may remain in them, when they turn 65 years old. Our DQ reports [See Q4 FY	12/23/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			2013] indicate that about 7.0% [Avg ˜ 1,200] of those in CADI and 5.2% [Avg ˜ 70] of those in TBI are = 65 years. The state says that these numbers are in line with its expectations. Participants enrolled in the waivers prior to age 65 may remain enrolled after age 65. However, people who are 65 at the time of the waiver application are not eligible.	
MN	IP	Family Planning	There aren't any family planning claims. The state said none meet the definition. The professional component is billed in the OT file.	12/10/2004
MN	IP	ICN	Through at least FFY2013 MN reports ICNs on very few managed care encounters. MN does not have the ability to adjust managed care encounter data. The managed care plans are expected to void/resubmit or replace data when errors are being corrected. The ability to do internal adjustments at both individual level and mass adjustment level are under development.	2/27/2015
MN	IP	Service Tracking Claims	Through at least FFY2013 DSH payments are not processed as lump sum payments as is common in other states. DSH payments are calculated on each individual claim.	2/27/2015
MN	LT	0-filling	The state explained that end date of service is 0-filled in MSIS when the variable supplied by the managed care plan is blank, starting in 2012Q4 on about 45% of claims.	9/16/2014
MN	LT	Diagnosis	The diagnosis code is "00000" on most claims from Q1FY1999 through FY2004 and on some claims after that. In FY 2011 up to 20 percent of FFS Medicaid claims had a diagnosis code of "00000".	2/15/2013
MN	LT	Type of Service	Starting in Q3FY2001 Minnesota moved its chemical dependency claims from IP to LT.	3/3/2011
MN	LT	Type of Service	Through at least Q1FY2012, the percent of ICF/IID claims is greater than expected in part because some nursing facility services are covered by managed care but mostly because MN reports day training and habilitation of ICF/IID patients as separate ICF/IID claims with no covered days in the LT file.	2/15/2015
MN	OT	Crossovers	Beginning in Q4FY2009 MN began reporting some crossover claims with program type code 6 or 7. It appears as though this is valid because MN has a 1915c waiver for dual eligibles that enrolls them in Medicare Advantage Special Needs Plans (SNP) and then the waiver pays for the balance for waiver services not paid in full by the Medicare SNP.	NA
MN	OT	FFS Claims	The FFY2013Q3 had a decrease in fee-for-service and capitation claims due to a delay in reporting. Pursuant to Laws of Minnesota for 2009, Ch. 79, Art. 13, Sec 3, Subd.6, paragraph (c), payments for warrant June 18, 2013, must be delayed, until first warrant in July 2013, under certain conditions. This includes hospital and certain non-hospital acute care services.	2/27/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
MN	OT	HCBS Waiver	Through at least FFY2013 about 30% of the MSIS IDs in the EL file with HCBS waiver enrollment do not have any FFS (TYPE-OF-CLAIM = 1) or managed care encounter (TYPE-OF-CLAIM = 3) HCBS waiver claims (PROGRAM-TYPE = 6 or 7) in the corresponding OT file each quarter.	2/27/2015
MN	OT	ICN	Through at least FFY2013 MN reports ICNs on very few managed care encounters. MN does not have the ability to adjust managed care encounter data. The managed care plans are expected to void/resubmit or replace data when errors are being corrected. The ability to do internal adjustments at both individual level and mass adjustment level are under development.	2/27/2015
MN	OT	Managed Care Capitation	Due to the warrant schedule, member months may be out of proportion to capitation claims and vice versa.	2/9/2011
MN	OT	Managed Care Capitation	There was a substantial reduction in managed care capitation payments in FFY2013Q3 that was the result of two legislatively mandated payment delays. The first delayed all June 2013 service month capitation payments to the first warrant in July 2013. The second was an additional delay of $270 million ($135 million state share) in managed care capitation payments from April or May 2013 to the first warrant in July 2013.	2/27/2015
MN	OT	Service Tracking Claims	Through at least FFY2013 DSH payments are not processed as lump sum payments as is common in other states. DSH payments are calculated on each individual claim.	2/27/2015
MN	OT	Specialty Code	Specialty Code is missing on most physician claims until Q3FY2008.	5/11/2012
MN	OT	Specialty Code	Specialty code DS (Dialysis Supplier) was being assigned inappropriately in MSIS prior to Q2FY12. Also, in Q2FY12 Medicare stopped accepting end stage renal disease dialysis claims billed directly by dialysis suppliers. After January 1, 2012 Medicare only accepted end stage renal disease dialysis claims from dialysis facilities.	8/26/2013
MN	OT	Type of Service	The distribution of OT claims paid each month is uneven.	12/15/2004
MN	RX	Adjustments	The NDC is not reported on credit & debit adjustment claims, but there are very few of those types of adjustments.	7/30/2006
MN	RX	Date Prescribed	Date Prescribed is not reported by MN.	2/15/2013
MN	RX	FFS Claims	The FFY2013Q3 had a decrease in fee-for-service and capitation claims due to a delay in reporting. Pursuant to Laws of Minnesota for 2009, Ch. 79, Art. 13, Sec 3, Subd.6, paragraph (c), payments for warrant June 18, 2013, must be delayed, until first warrant in July 2013, under certain conditions. This includes hospital and certain non-hospital acute care services.	2/27/2015
MN	RX	FQHC	Through at least FY2012Q1, MN reports Program Types of Family Planning (PT=2), Federally Qualified Health Center (PT=4), and Indian Health Services (PT=5) in the RX file. It is	2/15/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			unusual but not inappropriate for a state to report FQHC and IHS program types in the RX file.	
MN	RX	Medicaid Amount Paid	The distribution of RX claims paid each month is often uneven through at least Q1FY2012.	2/15/2013
MO	Claims	Provider Taxonomy	Taxonomy codes are missing on most RX and LT claims and on 20-35% of OT and IP claims. The state does not require the taxonomy code on a claim unless the provider is considered to be a 'one to many' provider in which the code is then used to 'break the tie' in determining which legacy provider number to assign to the claim. (A 'one to many' provider is a provider with one NPI to many legacy provider numbers. There are no immediate plans to require taxonomy on all claims.	2/1/2010
MO	Eligibility	1115 Waivers	Through FY07, MO had Family Planning only coverage as part of the larger 1115 waiver. Family planning enrollees were mapped to MASBOE 55, RBF 6, and reported as part of the larger section 1115 waiver with Waiver ID 'A1' and Waiver Type '1' (1115). In October 2007 (Q1 FY08), FP coverage became a separate waiver; however, these enrollees continued to be reported as part of the larger 1115 waiver. Since this waiver was new, it should have been reported with a new Waiver ID. In Q1 FY 2009, the state corrected this reporting by assigning these enrollees to Waiver ID 'D1' and Waiver Type 'F'. The state also corrected this back to Q2 FY 08 via correction records submitted with the Q1 FY 09 file.	9/21/2011
MO	Eligibility	1115 Waivers	MO acknowledged problems with reporting to its Family Planning Waiver (Waiver ID= D1, ME codes 80 and 89) through Q4 FY 09. Approximately 16,000 to 19,000 individuals are reported to the Family Planning Waiver each month, whereas the state confirmed that approximately 90,000 are currently enrolled in this waiver. The state suspects that the 16,000 - 19,000 may be the number utilizing services, rather than the number enrolled. We see nearly all of these 16,000 - 19,000 Family Planning Waiver enrollees reported to eligibility group 80 (which the state confirmed as correct enrollment for this group), whereas there were only a small handful of people reported to group 89 (whereas the state expects enrollment in group 89 to be closer to 70,000). MO has been working on reporting correct enrollment to both groups, particularly group 89. Enrollment counts improve markedly starting in Q4 FY 11 (with retro-correction records back to Q1 FY 2011), with about 66,000 FP enrollees, but counts are still lower than expected.	4/6/2012
MO	Eligibility	1115 Waivers	MO's section 1115 waiver program, implemented in 1998, extended Medicaid coverage to several groups, beginning with M-CHIP children with income to 300% FPL and postpartum women (for family planning only services). In 1999, coverage was also extended to various groups of working parents with income to 100% FPL. However, cutbacks for parents occurred in 2002 and then full benefit parental coverage seems to have completely stopped in Q4FY05. Only family planning adults	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			remained in the 1115 waiver in FY06. MO's 1115 waiver expired in October 2007 and the postpartum women transitioned into a separate, stand-alone section 1115 family planning demonstration. When the 1115 expired, some M-CHIP children shifted to MASBOE 34 while others shifted to the new separate CHIP (S-CHIP) coverage.	
MO	Eligibility	1115 Waivers	In July 2012, Missouri has implemented an 1115 waiver (called "Gateway to Better Health") to expand eligibility to childless adults who would otherwise become eligible for Medicaid in 2014 under the ACA. The state has said that enrollees will be assigned ME Codes 91, 92, or 93. The state has said that it would report the waiver starting in Q1 FY 2015, but it did not report the waiver or the enrollees (ME codes 91, 92, and 93 are missing from the file, as is the waiver). According to the state, this issue was caused by missing eligibility info for duals. The state plans to correct this in Q2 FY 2015.	11/6/2012
MO	Eligibility	CHIP	MO has an M-CHIP program and (since October 2007) an S-CHIP program. M-CHIP are assigned to eligibility groups 71-72, while S-CHIP are assigned to eligibility groups 73-75 through Q4 FY 09. The M-CHIP data differ from SEDS in some quarters through FY06, but the state insists their MSIS data are correct. Though the state's S-CHIP program began in October 2007, reporting of SCHIP enrollment didn't begin until Q1 FY 09. S-CHIP covers infants with family income from 185-300% FPL and children ages 2-18 years with family income from 150-300% FPL. Prior to the implementation of S-CHIP, the M-CHIP program covered all children to 300% FPL. As shown in SEDS, some former M-CHIP enrollees shifted into this new S-CHIP program; however, the MSIS data did not correctly report this shift and all M-CHIP(groups 71-72) and S-CHIP continued to be reported as M-CHIP (CHIP Code= '2') through Q4 FY08. This issue was corrected in Q1FY09 when the state began reporting S-CHIP correctly to CHIP CODE= '3', though (incorrectly) to MASBOE '34' in Q1-Q4 FY09. SCHIP enrollees were correctly remapped to MASBOE '00' starting in Q1 FY 10. However, also at this time, S-CHIP were incorrectly re-mapped from eligibility groups 73-75 to state-specific eligibility group '000000'. The state corrected this issue effective Q2 FY 2014. Finally, in Q1FY11, the state ceased reporting S-CHIP to CHIP-CODE '3', though this issue was corrected via correction records and enrollment to CHIP Code '3' resumes in Q2 FY11.	4/6/2012
MO	Eligibility	County Codes	Missouri reports eligibles with County Code = 510. These are residents of the city of St. Louis. Documentation for the Area Resource File suggests that prior to 2009, residents of St. Louis county are recoded to '191' in the area resource file. Therefore, researchers may want to recode these persons into county "191" for years prior to 2009.	NA
MO	Eligibility	County Codes	Missouri reports some individuals to county code 999. This code is used for confidential enrollees, welfare investigation cases, etc.	9/26/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
MO	Eligibility	County Codes	Through FY02, MO used improper FIPS code 193 for Ste. Genevieve county. It should have used code 186 (even though it is an even number not typically used for a FIPS code). The state corrected this problem for most (but not all) enrollees beginning in Q1 FY03.	4/6/2012
MO	Eligibility	Dual Eligibility Codes	Missouri differs from most other states in its dual eligibles policies. About 45 percent of the total dual population (61,000 persons) are assigned dual code 08.	NA
MO	Eligibility	Dual Eligibility Codes	MO showed a large decline in dual code reporting from September to October 2005. Legislation passed in 2005 reduced eligibility for the elderly and disabled causing some duals to lose their eligibility completely or now only qualify through spend down. However, MO's total aged and disabled enrollment did not drop in October 2005--only the dual code counts. It looks as if total aged/disabled enrollment did not drop noticeably until CY 2006. We asked the state to clarify how they are reporting duals and individuals who have not yet spent down in the MSIS enrollment data, but have not been able to get any information.	NA
MO	Eligibility	Dual Eligibility Codes	In FY07 and Q1 FY08, MO had about 60 partial duals incorrectly reported to MASBOE 11-12 and 200 to MASBOE 41-42.	3/24/2011
MO	Eligibility	Dual Eligibility Codes	In Q2 and Q3 FY 2009, SLMB (dual code 3, eligibility group ‘AALN00’) and QI-1 (dual code 6 eligibility group 'BBLN00’) enrollment fluctuates substantially. SLMB enrollment shifts between 3,400 and 300 enrollees while QI-1 enrollment shifts between 200 and 40 enrollees. The state did not know the reason for this shift. This issue occurs again in Q1FY11 and Q4FY12 for QI-1s.	9/21/2011
MO	Eligibility	Dual Eligibility Codes	MO shows large differences in dual code counts in MSIS compared to MMA, especially with the counts of dual codes 01, 03, and 06. In Q1 FY06, the total count of duals was similar to the January 2006 MMA counts, but the counts of full and partial duals were different. In FY07, FY08, and FY09, the full dual counts were close, but MSIS data showed only about half as many partial duals. The state has made changes to MMA coding in the summer of 2011 and they are now quite confident with the numbers reported in MMA. The state has said that it will correct this issue in its next file submission (Q2 FY 2015).	4/6/2012
MO	Eligibility	Dual Eligibility Codes	Through FY 13, Missouri reports more than half of all individuals assigned to MASBOE 31-32 with full benefits (Dual Codes '2', '4', or '8' and RBF '1'). Missouri has said that it does extend full benefits to individuals with incomes up to 85% FPL. MHABD (MO HealthNet for the Aged, Blind and Disabled) non-Spenddown participants are approved at 85% of FPL or lower, which would fall into the category. The eligibility codes that reference this benefit include 11 (MO HealthNet – Old Age Assistance), 12 (MO HealthNet – Aid to the Blind) and 13 (Permanently and Totally Disabled (PTD)). Therefore, some reporting of full duals to MASBOE 31/32 is expected; however, prior to Q3 FY 2014, the majority of these assignments were in	8/29/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			error. Starting in Q3 FY 2014, Missouri made a coding fix that significantly reduced the number of full duals assigned to MASBOE 31/32 (it is not immediately apparent whether the state re-assigned the dual code or the MASBOE for these individuals). The state has said that the reporting is now correct. It appears that the original coding problem may have been due a discrepancy in mapping of ME code '55' (reported as eligibility group '55Q 00' in MSIS) to the Dual Code field. ME code '55' is labeled 'QMB' in MO's crosswalk. As such, individuals with a ME code '55' ('QMB') should also be assigned a 'QMB' dual code (dual code 01) and vice versa. Instead, individuals with ME code 55 are assigned to a variety of dual codes in MSIS. It is unclear if the ME code or the Dual Code assignment was incorrect for these individuals. The state greatly improved this issue beginning in Q3 FY 2014.	
MO	Eligibility	Dual Eligibility Codes	Enrollment reported to dual code '3' (SLMB-only) fell from 5,000/month in Q2 FY2013 to 1,800/month in Q3 FY2013 and to 700/month in Q4 FY 2013. The state said that a coding change was made that caused this decline and it has now been corrected. However, this does not appear to be accurate as SLMB enrollment continues to decline further through Q1 FY 2015. We asked the state to send correction records with its Q1 FY 2015 file to correct this issue, but it did not.	7/23/2014
MO	Eligibility	Dual Eligibility Codes	Between Q1 FY 2014 and Q4 FY 2014, the assignment of individuals to Dual Codes '01', '02', '04', and '08' (QMB, QMB plus, SLMB Plus, and Other Full Dual) fluctuated markedly. The state purchased a new eligibility system in 2013 and started programming the system to recognize MAGI participants from Non-MAGI participants. The state had issues with the system incorrectly enrolling participants which is the cause of the fluctuations.	3/11/2015
MO	Eligibility	Managed Care	Medicaid enrollees residing in the 57 counties next to the I-70 corridor are enrolled in a Managed Care Plan. Medicaid enrollees residing in all other counties (which are more sparsely populated) receive services on an FFS basis.	9/26/2011
MO	Eligibility	Managed Care	Through Q1 FY 2015, Missouri has been reporting enrollment to an HMO (Plan ID 818888888) which is not a real HMO, but a pseudo-ID. The state should not be reporting to this ID. We have asked the state to cease reporting enrollment to this Plan ID, but the issue remains unresolved.	9/26/2011
MO	Eligibility	Managed Care	MO's Non-Emergency Transportation (NEMT) managed care plan is not reported in the state's MSIS eligibility files, although MO submits transportation MC capitation claims in MSIS. The state clarified that only non-SCHIP Fee-For-Service enrollees are included in the NMET plan (a capitated, non-emergency transportation plan). The state has said that it bases its cap payments for NEMT on ME code and whether or not they are in a health plan. The information for MSIS reporting comes out of the state system rather than the MMIS, so the state would have	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			to make additional programming changes to be able to report a plan type and ID on the EL file. We have asked the state if there is programming logic that could be added such that if the individual is in the designated health plan and has a qualifying ME code, then they would be assigned to Plan Type 8.	
MO	Eligibility	Managed Care	Effective October 1, 2009, outpatient pharmacy services were carved out of the Managed Care Program, switching to FFS coverage. As a result, FFS pharmacy claims and expenditures (and percentage of enrollees with any FFS claims) increased substantially.	3/12/2013
MO	Eligibility	MASBOE	All Years: Missouri is a 209(b) state. This explains why the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by Social Security Administration.	NA
MO	Eligibility	MASBOE	All Years: TMA enrollees are included in the 1931 group mapped to MASBOE 14-15.	NA
MO	Eligibility	MASBOE	2009: In 10/08, MO expects to implement a new Transitional program that will provide some benefits to individuals whose Medicaid eligibility has been closed (due to earned income with a certain number of work hours per week) for an additional 6 months. These enrollees will be mapped to MAS 4 and are expected to show up in Q2 FY09.	7/23/2008
MO	Eligibility	MASBOE	2007: Effective 7/1/07, MO started covering a new group of foster care children in the state's Medicaid program. They were assigned to state-specific eligibility code "38" which is defined as "Independent Foster Care Children ages 18-21" and mapped to MASBOE 48.	12/10/2008
MO	Eligibility	MASBOE	2008: In Q1-4 FY08, MO continued to have M-CHIP children reported to MASBOE 54 even though its section 1115 waiver had expired. They should have been reported to MASBOE 34. The state corrected this reporting in Q1 FY 09, with retro-correction records applying back to Q2 FY 08. Additionally, the new S-CHIP group (state eligibility groups 73-75) should have been reported to MASBOE 00, Chip Code= 3 but were reported to MASBOE = '34' in Q1-Q4 FY09. This was corrected in Q1 FY10 (unclear if retro-correction records have corrected this issue back to FY 09).	7/8/2011
MO	Eligibility	MASBOE	2003: Towards the end of Q1 FY03, MO added Medicaid Buy-In coverage for the working disabled (MAWD - Medical Assistance for Workers with disabilities), resulting in increased enrollment in MASBOE 42. These enrollees are in state groups 85M + 86M. Missouri discontinued this program in August 2005, then reinstituted the program under different eligibility rules in 2007. The program is now called "Ticket to Work".	9/26/2011
MO	Eligibility	MASBOE	In Q4 FY 2013, there was a jump in the percentage of foster care children (BOE = '8') that are age 21 or older, from less than 1 percent in Q3 FY 2013 to over 6 percent in Q4 FY 2013.	7/23/2014

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			The state said that this is because the Age limit for foster children increased from 21 to 26 in Q4 FY 2013.	
MO	Eligibility	MASBOE	Starting in Q2 FY 2014, the number of individuals assigned to MASBOE 31 or 32 fell by about 50%. Also, the percent of restricted duals (those with RBF= '3') that are properly assigned to MASBOE 31-32 fell from 93 percent in Q3 FY 2014 to less than 48% in month 1 of Q4 FY 2014. The percentage returns to normal (95%) in Month 2 of Q4 FY 2014. Missouri purchased a new eligibility system in 2013 and started programing the system to recognize MAGI participants from Non-MAGI participants. The state had issues with the system incorrectly enrolling participants which it said was responsible for these fluctuations.	3/11/2015
MO	Eligibility	Private Health Insurance	MO had an error in its system that caused the number of enrollees reported to Health Insurance flag "2" (receiving 3rd party insurance) to incorrectly increase from about 50,000 enrollees per month at the end of Q4 FY05 to about 81,000 enrollees per month at the beginning of Q1 FY06. This reporting was fixed in Q2 FY08 and the count decreased back to about 44,000 enrollees per month.	7/21/2009
MO	Eligibility	Private Health Insurance	Missouri has a HIPP program. Missouri will provide more information on how many enrollees are currently enrolled and under what MASBOES/ SS groups. It is not clear that all are enrolled in Health Insurance Code= 3, or that other enrollees aren't included under this code as well, so this may not be an appropriate way to identify this group.	9/26/2011
MO	Eligibility	Race/Ethnicity	Through FY 09, Missouri's RACE-CODE variables and the ETHNICITY-CODE variable are not being properly combined when calculating the combined RACE-ETHNICITY-CODE variable. We see many more individuals reported with 'Hispanic or Latino' ethnicity (45,000) in the 'Ethnicity' field (ETHNICITY-CODE= 1), than in the combined race-ethnicity field (5,000 individuals reported as Hispanic or Latino; 5,000 individuals are reported as "Hispanic or Latino with no other race data" (RACE-ETHNICITY-CODE = 6), and no individuals are reported to RACE-ETHNICITY-CODE = 7 (for Hispanic and Latino ethnicity plus one or more races)). Additionally, since we see about 6,000 people per quarter reported with more than one RACE-CODE variable, but no one is reported to RACE-ETHNICITY-CODE = 8 (one or more races). This issue was corrected in Q4 FY 2011.	4/6/2012
MO	Eligibility	Restricted Benefits Flag	Some presumptively eligible pregnant women in MAS/BOE 34 (state code 58PL00) are assigned restricted benefits code 4 (pregnancy related).	NA
MO	Eligibility	Restricted Benefits Flag	MO does not assign RBF '2' to any individuals. The state indicated that they do not identify and track these and have no logic to assign a '2'.	5/21/2008
MO	Eligibility	Restricted Benefits Flag	Beginning in Q2 FY2008, MO began implementation of a Money Follows the Person (MFP) program and started reporting	12/10/2008

State	File Type	Rec/Issue Type	Issue	Recorded
			enrollment in MSIS (RBF 8). MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP.	
MO	Eligibility	Restricted Benefits Flag	CMS approved a Medicaid state plan amendment for MO to use alternative benefit packages with some enrollees under the provisions of the 2005 DRA; however, the state did not implement this plan.	3/3/2011
MO	Eligibility	Restricted Benefits Flag	In Q1-2 FY07 and Q1-4 FY08, some Family Planning enrollees (reported to state group 80 and MASBOE 55) were assigned RBF code 1 (full Medicaid benefits) or 3 (Medicare cost-sharing benefits), when they should have been assigned RBF 6 (family planning benefits only). This problem did not occur in Q3-4 FY07. MO has fixed this starting in Q1 FY 09.	3/25/2011
MO	Eligibility	Restricted Benefits Flag	In FY07, MO had about 700 full duals assigned RBF 3, and 250 partial duals assigned RBF 1 each month. This problem appears to have been corrected in Q1 FY08. It is not known whether this was fixed with retro records for earlier quarters. It is also not clear how to correct problems of this type prior to Q1 FY08.	4/6/2012
MO	Eligibility	SSN	Through Q1 FY 2014, Missouri, a non-SSN state, 8-fills instead of 9-fills the majority of missing SSNs. The state has corrected this issue effective with the Q2 FY 2014 file submission.	8/29/2013
MO	Eligibility	Waivers	Linking results show that waiver claims submitted by MO (services being flagged as "waiver" (Type 6 or 7) do not match well with individuals enrolled in a 1915c waiver. Through Q4 FY 2012, many more non-HCBS enrolled appeared to be receiving waiver services than the count of individuals who are flagged as enrolled in a HCBS waiver. Missouri appears to have corrected this issue starting in Q1 FY 2013, but the issue re-appears in Q4 FY 2013 before being corrected again in Q1-Q2 FY 2014. Additionally, through Q4 FY 2012, only about 11 percent of individuals reported as enrolled in an HCBS waiver had claims reported for service use. Missouri appears to have improved this issue somewhat starting in Q1 FY 2013, when about 37 percent of HCBS enrollees assigned HCBS waiver claims, but the issue re-appears in Q4 FY 2013 before being improved again in Q1-Q2 FY 2014.	9/21/2011
MO	Eligibility	Waivers	Missouri acknowledged that enrollment reported to 1915c waiver C4 is lower than expected. The state expected waiver C4 to have enrollment of around 400 individuals monthly, whereas we see only about 200 per month reported in the MSIS files. Waiver C3 has an enrollment cap of 1500 in 2012 and 1575 in 2013, but enrollment fluctuates sharply between 800 and 1400 per month. Additionally, enrollment in Waiver C5 enrollment looked too high according to the state- this waiver has a cap of 216, whereas reported enrollment was closer to 300-400 individuals monthly. This issue appeared to be corrected in Q4 FY11 as enrollment drops to less than 216/monthly.	9/21/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
MO	Eligibility	Waivers	There was a large drop in enrollment in the state's IID/DD Comprehensive waiver (waiver ID 'C6') from approximately 7,400 in Q1-Q3 2009 to only 1,700 beginning in Q4 2009 (the state expects enrollment to have remained closer to 7,400). Most of the 7,400 individuals reported to Waiver ID = 'C6' in Q3 FY 2009 are reported to eligibility code 13M 00, and it appears that starting in Q4 FY 2009, most of these individuals remain in eligibility group 13M 00, but are no longer reported to Waiver ID = 'C6'. The state has reported that this is because the data for the current quarter is incomplete, but that this is corrected in subsequent quarters (via correction records).	9/21/2011
MO	IP	Crossovers	There is a much larger than expected percent of crossover claims, but the amount paid on those claims make them appear to truly be crossovers.	9/4/2005
MO	IP	DRG	The state does not report DRGs.	3/3/2011
MO	IP	FFS Claims	In FFY2014 Q2, Original Medicaid FFS claims jumped 10 fold and have remained high. In addition, the new claims do not have accommodation codes, so it is suspected that these claims are in fact outpatient claims.	4/29/2015
MO	IP	Managed Care Encounters	In 2003 about three percent of the IP encounter claims have an invalid Type of Service.	12/15/2004
MO	IP	Patient Status	There is a higher than expected percent of records with a Patient Status of 30 (Still a Patient).	12/10/2004
MO	IP	Procedure Code Flag	The IP Procedure Code Indicator was not correctly reported until Q1FY2005. Previously ICD-9 Procedure Codes were reported with a CPT-4 Indicator.	12/17/2007
MO	LT	Adjustments	FFY2014 Q2 saw a spike in resubmittals and voids. Request that the state verify the numbers.	1/22/2015
MO	LT	Admission Date	The Admission Date is missing. MO does not require this information.	3/3/2011
MO	LT	Crossovers	Medicaid Original Crossover claims jumped significantly in FFY2014Q1 (an almost 10 fold increase, for ~23K to ~230K claims). Question posed to state regarding accuracy and reason for numbers.	1/22/2015
MO	LT	Medicaid Amount Paid	A small number of Medicaid FFS non-crossover claims have a negative Medicaid paid amount.	1/22/2015
MO	LT	Patient Status	About 37% of all Medicaid Original Encounter claims are reported with a PATIENT-STATUS=00, a code not recognized by MSIS. These are likely PATIENT-STATUS=30, still a patient.	5/14/2015
MO	LT	Type of Service	Consistently between 100 and 200 original claims with unknown ToS every quarter.	1/22/2015
MO	OT	Managed Care Capitation	There are PHP capitation claims in the OT file for non-emergency transportation, but MO does not report transportation managed care enrollment.	6/9/2009

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
MO	OT	Managed Care Capitation	Missouri original capitation payments include adjustments and resubmissions. The state has indicated that their system for handling resubmissions of capitation payments automatically the payments and marks them as original payments. The number of original HMO capitation payments jumped significantly in FFY 2014 Q3, other values such as total amount of capitation payments did not. There were negative values in the capitation payments, and the capitation payments included dates of service for up to two years prior to the reporting quarter. It is suspected that the capitation claims include adjustments and resubmission of claims.	4/29/2015
MO	OT	Managed Care Plan IDs	Plan IDs are being reported in the OT that are not shown in EL. According to state, cap payments for NEMT on ME code and whether or not they are in a health plan. They do not have a lockin segment that readily identifies them as being eligible for NEMT payments. The information for MSIS reporting comes out of the state system and not the MMIS. There are no immediate plans to make system changes for NEMT eligibles.	11/26/2012
MO	OT	Revenue Code	Outpatient hospital claims have Service Codes rather than UB-92 revenue codes.	12/10/2004
MO	OT	Servicing Provider ID	The Servicing ID is mostly missing.	12/10/2004
MO	OT	Type of Service	More than 20 percent of claims have Type of Service 19 (Other Services). Missouri says these are mostly claims for homemaker chores.	1/19/2010
MO	OT	Type of Service	In Q1 FY12, there was a large increase in costs for transportation claims (TOS=26). State acknowledges that the information is correct. The state switched NEMT brokers in 10/2011 with the new broker's contract effective 10/30/2011. The increase was due to paying the former broker for past trips and the new broker for current trips.	11/26/2012
MO	RX	Compound Drugs	All compound drugs are coded as "COMPOUND" in the NDC field.	12/10/2004
MO	RX	Date Prescribed	Date Prescribed is always missing.	12/10/2004
MO	RX	FFS Claims	Original FFS Medicaid and SCHIP claims decreased 25% from FFY 2014 Q4 to FFY 2015 Q1.	4/29/2015
MO	RX	Managed Care Capitation	In Q1 and Q2FY2011 MO submitted SCHIP capitation claims in the RX files.	9/23/2011
MO	RX	New Refill	New Refill Indicator is always missing.	12/10/2004
MS	Claims	Medicaid Amount Paid $0	Mississippi began including $0 paid claims (previously not included) with Q1FY2005. These claims sometimes have TPL amounts.	2/22/2011
MS	Eligibility	1115 Waivers	MS has an 1115 Family Planning waiver that provides family planning and family planning-related services to uninsured women of child-bearing age (13-44 years) with family incomes <= 185% FPL, who are not eligible for Medicare, Medicaid, or	11/6/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
			CHIP. The waiver had an initial effective date of 01Oct2003. The state reported an average waiver enrollment of 42,200 in Q1 FY 2008. Enrollment fell sharply in Q2 FY 2009 to about 21,500 per month, when the state purged beneficiaries with third-party health coverage. As of Q4 FY 2013, enrollment in the waiver was 21,600 per month.	
MS	Eligibility	1115 Waivers	The Healthier Mississippi 1115 Medicaid expansion waiver covers aged and disabled individuals with incomes <= 135% FPL, who are not eligible under the State Medicaid Plan, and who are not Medicare-eligible. The waiver covers about 5,000 – 5,500 enrollees per month. MS reports nearly all enrollees in the waiver to SSG '045D'. It also reports about 98% of them to MASBOE '52' and the rest to MASBOEs '51' and '54'. The state notes that it reports some dual eligible enrollees to the waiver in error. It indicated that this can occur, when there is a delay in receiving Medicare eligibility information.	11/6/2013
MS	Eligibility	CHIP	MS began to report separate CHIP (CHIP-CODE '3') enrollment data to MSIS in Q2 FY 2011. Starting in January 2011, the state reported enrollment of about 68,000 – 70,000 per month. Enrollees have full- benefit FFS coverage. The state assigns children in the program to SSG '099000'. MS uses separate CHIP to cover children aged 0 – 19 years with family incomes up to 200% FPL and offers presumptive eligibility.	11/6/2013
MS	Eligibility	County Codes	During FY 2013, MS assigned County Code '000' to about 3,500 – 3,700 enrollees each quarter. The total has increased modestly over the last three fiscal years. It was about 3,200 – 3,300 per quarter in FY 2011, and 3,400 – 3,500 in FY 2012. The state indicates that most of these enrollees are children in foster care.	11/6/2013
MS	Eligibility	Dual Eligibility Codes	MS stopped reporting enrollees to dual code '04' (SLMB+) in Q4 FY 2006.	6/22/2011
MS	Eligibility	Dual Eligibility Codes	In October 2004, MS restructured its eligibility rules for the aged and disabled. After October 2004, aged and disabled nonduals with income<135% FPL are covered for full Medicaid benefits (through an 1115 waiver).	11/1/2011
MS	Eligibility	Dual Eligibility Codes	Each month MS reports about 5,000 fewer QMB+ enrollees to MSIS than it does to MMA. The state also reports about 5,000 more Other Full Duals to MSIS than it does to MMA. We have not asked Mississippi to explain this result. However, the state has reported duals this way as far back as Q1 FY 2010.	12/9/2013
MS	Eligibility	Managed Care	MS reports Logisticare Solutions (a transportation PAHP) to Plan Type 08 in MSIS. All Medicaid enrollees are eligible for this non-emergency transportation coverage (except for partial-dual eligibles and family planning-only enrollees). (S-CHIP enrollees are also ineligible for transportation coverage.) MS pays Logisticare a global capitation payment based on the number of eligibles. Enrollment in this plan was not reported in MSIS until Q1 FY10 even though the plan started at least as early as 2008.	3/15/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			MS does not report capitation payments for Logisticare. The state is not sure when it will be able to report service tracking claims for the capitation payments as this payment is generated outside of MSIS.	
MS	Eligibility	Managed Care	In January 2011, Mississippi's Division of Medicaid (DOM) implemented the Mississippi Coordinated Access Network (MississippiCAN) managed care program. The state began to report enrollment to Plan Type '01' (comprehensive) during Q2 FY 2011. Initial enrollment was about 57,700 per month. It subsequently ranged from 49,000 to 52,300 from Q3 FY 2011 through Q4 FY 2012. Enrollment increased substantially during Q1 FY 2013, from 49,600 in November 2012 to 138,600 in December 2012. MississippiCAN includes two populations: mandatory and optional. The mandatory population includes individuals in aid categories '001' (SSI, Ages 19-65 Years), '025' (Working Disabled, 19-65 Years), '027' (Breast & Cervical Cancer patients, Ages 19-65 Years), '085' (TANF Families/Children, Ages 0-1 and 19-65 Years), '087' (Children, 0-1 Years), '088' (Pregnant Women and Infants, Ages 0-1 and 8-65 Years), and '091' (Children, 0-1 Years). The optional population includes individuals in aid categories '001' (SSI, 0-19 Years), '003' (DHS-Foster Care Children, 0-19 Years), '019' (Disabled Children Living at Home, Ages 0-19 Years), and '026' (DHS-Foster Care Children, 0-19 Years). Enrollees in the mandatory population have a choice of two plans, Magnolia Health Plan (Plan ID '09253560') and United Healthcare Community Plan (Plan ID '02821762'). Enrollees in the optional population have a choice to enroll in a Coordinated Care Organization (CCO) or can choose to stay in a traditional FFS program.	11/6/2013
MS	Eligibility	MASBOE	MS does not have a medically needy program.	8/16/2010
MS	Eligibility	MASBOE	MS insures about 1,860 disabled workers each month under a provision of the Balanced Budget Act (BBA) of 1997. The BBA lets states cover these 'Medicaid Buy-in' enrollees, who otherwise meet SSI eligibility criteria, but have net incomes <= 250% of FPL. MS reports almost all of them to SSG '025D' (Avg = 1,849). It reports a very small number (Avg = 9) to SSG '025B'. Prior to Q2 FY 2011, the state reported these enrollees to MASBOE '32'. It began reporting them to MASBOE '42' in Q2 FY 2011.	11/6/2013
MS	Eligibility	MASBOE	Starting in Q2 FY 2011, MS began to report all non-citizen aliens eligible for only emergency services to SSG '021' and MASBOEs '44' – '45'.	11/6/2013
MS	Eligibility	MASBOE	Through Q4 FY 2011, MS reported a small number (N <= 35 month) of enrollees to MASBOE '99'. The state indicated that they are refugees covered under a separate federal grant. They should have been mapped to MASBOE '00' or removed from the file. This is no longer an issue. Beginning in Q1 FY 2012, the number of individuals with MASBOE '99 was consistently <= 6 per month.	11/6/2013

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
MS	Eligibility	Private Health Insurance	The number of enrollees assigned HEALTH-INSURANCE '2' (private insurance) has fluctuated substantially from Q1 FY 2010 through Q4 FY 2013. In Q1 FY 2010, the monthly average was about 12,600. The average increased to 31,000 in Q4 FY 2011 and 37,400 in Q1 FY 2012. As of Q4 FY 2013, the average was roughly 29,900. Sometime during the period from Q3 FY 2010 through Q2 FY 2011, MS hired a new contractor to identify individuals with private health insurance. This resulted in the increased reporting.	11/6/2013
MS	Eligibility	Restricted Benefits Flag	Enrollees in state group 021 (alien) should receive Restricted Benefits Flag 2. Enrollment in this group fluctuates monthly, often dropping to 0 by the end of a quarter. MS confirmed that this occurs because eligibility for non-citizen aliens is entered retroactively, usually after an individual receives emergency services.	3/6/2012
MS	Eligibility	Restricted Benefits Flag	MS assigns RBF '5' (restricted benefits – other) and MASBOE '34' to infants whose family incomes < 185% of FPL. They are restricted from receiving dental services and eyeglasses. As of Q4 FY 2013, the state assigns about 1,700 enrollees per month to this group.	11/6/2013
MS	Eligibility	Restricted Benefits Flag	MS received an MFP grant from CMS in 2011 and began to enroll recipients on 01Jan2012. It began to report them to RBF '8' in Q4 FY 2012.	11/6/2013
MS	Eligibility	Restricted Benefits Flag	MS was one of nine states awarded a Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant. The five-year Demonstrations ended in each state on 30Sep2012. Beginning in Q2 FY 2009, MS reported about 5 – 10 enrollees per month to RBF 'A'. It continued to report enrollees to RBF 'A' through Q4 FY 2013. According to CMS, cumulative enrollment in the state's Demonstration was about 1,500. However, the number of enrollees reported to MSIS was never more than 10 per month. This suggests that MS did not report everyone enrolled in the Demonstration to MSIS.	11/6/2013
MS	Eligibility	Restricted Benefits Flag	Since FY 2008, MS has reported a small number of non-duals each month to RBF '3'. The total number of enrollees fluctuates from month to month. However, it increased modestly from Q4 FY 2010 through Q4 FY 2013. In Q4 2010, it was about 100 per month. In Q4 FY 2013, it was about 140 – 150 per month. The state believes that there will always be some inconsistency in coding these enrollees, because of a lag in obtaining information about Medicare enrollment.	11/6/2013
MS	Eligibility	SSN	Starting in Q2 FY 2011, MS began to report an increased number of SSNs with duplicate records. This problem corresponds to MS adding complete S-CHIP reporting in its eligibility files. If a CHIP beneficiary moves in and out of CHIP and regular Medicaid within the quarter, MS reports two records for that child (an ID from the CHIP data and one for the regular Medicaid data). MS does not know how to merge these records	8/30/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			into a single record per SSN. The state also notes that in some of these cases County Code differs across records.	
MS	Eligibility	TANF/1931	MS began to '9-fill' the field TANF-CASH-FLAG in Q2 FY 2004. As of Q4 FY 2013, it continues to do so.	11/6/2013
MS	IP	DRG	Mississippi does not report DRGs.	2/22/2011
MS	IP	Family Planning	Family Planning is not reported.	2/22/2011
MS	LT	Type of Service	There aren't any claims with a service type of 02 (Mental Hospital for the Aged) as this is not covered in the Mississippi state plan.	2/22/2011
MS	OT	CHIP	Starting Q1FY2011, the OT file includes dummy CHIP claims that contain valid information only for two fields: MSIS-IDENTIFICATION-NUMBER and MEDICAID-AMOUNT-PAID. According to the state, these records are produced to show premium payments that were paid by the state, but these SCHIP claims do not actually exist in their system. The rest of the information on these claims are essentially only place holders and 8-fills that the state and CMS agreed upon and are designed to enable the file to pass the claims validation edits. For this submission, the state used the value 'B' and 'D' in TYPE-OF-CLAIM to distinguish these dummy CHIP claims from the rest of the valid records. These records will be sent to CMS in this format until a process is created to receive and send actual claims.	2/22/2011
MS	OT	Managed Care Capitation	The capitation claims for disease management managed care are submitted as service tracking claims but not with a Type of Service of PHP capitation. The state plans to correct this in the future.	2/22/2011
MS	OT	Type of Service	Starting in Q1FY2008 state got a new contractor for MSIS. Prior to this, the state assigned most T1017 codes to TOS=31 (targeted case management). With the change in contractors in 2008, all T1017 got assigned to various TOS codes namely 08 (physicians), 10 (other practitioners), and 12 (clinics). None got assigned to TOS=31. State fixed this problem starting with Q1FY2011.	2/22/2011
MS	RX	Managed Care Encounters	There was a drop in the number of RX FFS claims and an increase in the number of RX encounter claims in FY2013 Q2. This change in the balance of FFS to encounter claims has held steady in subsequent quarters. This coincides with Mississippi's expansion of the Managed Care program beginning in December 2012 to include 3 additional categories of eligibility groups (Women with Children and 2 Children groups).	3/6/2015
MS	RX	Medicaid Amount Paid Total	Starting with FFY Q2FY2005 some RX drugs began being processed by Presbyterian. The state currently is unable to include those claims in the file, but they are working on the problem.	10/12/2006

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
MT	Eligibility	1115 Waivers	MT's Basic Medicaid for Able-Bodied Adults is an 1115 waiver that provides a reduced level of Medicaid benefits to parents or caretaker relatives of dependent children. Enrollees have to be ages 21-64 years and not pregnant or disabled. Implementation began in February 2004, with no initial eligibility expansion; however, in December 2010, CMS approved an expansion to this waiver. This expansion can cover up to 800 individuals who have a primary clinical diagnosis of a severe disabling mental illness (SDMI) of schizophrenia or bipolar disorder, who are qualified for the State only Mental Health Services Plan (MHSP) Program, aged 18 through 64, with incomes at or below 150% FPL, who are residents of Montana, and who are not otherwise eligible for Medicaid. These groups are assigned state-specific eligibility groups HS and HB. The state initially reported this expansion as a HIFA waiver, but changed this to an 1115 waiver in its FY 11 resubmission. All Basic Medicaid recipients are reported to RBF '5.'	12/21/2011
MT	Eligibility	All	CMS has granted Montana permission to cease MSIS reporting after Q2 FY 2014 and to not correct issues noted in the Q2 FY 2014 EL or claims reviews. The state has said that it will be submitting T-MSIS claims data back to January 2014 and EL data back the standard 7 years. The state also said that it will address any issues that are present in the T-MSIS file.	3/11/2015
MT	Eligibility	CHIP	Montana has an S-CHIP program and began reporting its S-CHIP data in FY 2000. In July 2007, MT expanded its S-CHIP coverage from 150 percent to 175 percent of FPL. This resulted in a small enrollment increase in Q4 FY07. As of October 1, 2009, Montana's SCHIP program became a combined M-CHIP - S-CHIP program; prior to this date, the state did not have an M-CHIP program. Consequently, children between 134-250% FPL are 'CHIP funded-CHIP enrolled' (SCHIP) and children between 100-133% FPL and between the ages of 6-18 y.o. are 'CHIP funded Medicaid Expansion' (M-CHIP, reported to group 'HK'), meaning they are enrolled in children's Medicaid (HMK Plus) but their benefits are paid for with CHIP funds. All other children who live in households with income at or below 133% FPL are 'Medicaid funded-Medicaid enrolled', known as HMK Plus (and reported to Medicaid).	4/17/2012
MT	Eligibility	CHIP	FY 2010-FY 2012: Montana has had a variety of CHIP coding issues. In FY 10, MT reported about 5,000 partial dual eligibles to CHIP code = 0. Then in FY 2011, the state began assigning nearly all Medicaid eligibles to CHIP code = 0. The state corrected this issue in Q1 FY 2012. Additionally, in Q1 FY 2011-Q4 FY 2011, the state assigned all SCHIP (group S7) and many other Medicaid ineligibles to CHIP code = 1. This issue was corrected in Q1 FY 2012. In Q1-Q4 FY 2010, the state failed to assign M-CHIP enrollees (group 'HK') to CHIP CODE = '2'. This issue was corrected in Q1 FY 2011. Finally, in FY 2012 there were some SCHIP enrollment discrepancies between MSIS and SEDS, but the state verified that the MSIS counts are accurate and the discrepancy resolves in FY 2013.	10/18/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
MT	Eligibility	CHIP	Through Q1 FY 2014, a small number of M-CHIP continue to be mapped to MASBOE other than '34'. This issue was corrected in Q2 FY 2014.	11/11/2014
MT	Eligibility	Data System Change	MT planned to implement a new MMIS system (CHIMES) in October 2009, but did not. As of November 2009, MT has not awarded a contract for the new CHIMES system. In February 2011, we asked the state for an update on when it plans to implement CHIMES. According to a newer RFP dated April 27, 2010, the new projected date of MMIS/PBM/DSS replacement go-live and transfer of fiscal agent responsibility is July 1, 2013. However, other documentation indicates that the CHIMES system was implemented in 2009, and planned updates to the system will be completed in October 2012.	12/22/2011
MT	Eligibility	Dual Eligibility Codes	Starting with the new monthly dual code reporting in Q1 FY06 through Q4 FY11, we noticed that in addition to most of the 9-filled dual codes, MT also reported some individuals with dual codes 01 (QMB only), 03 (SLMB only), and 06 (Qualified Individual-1) to MASBOE 00 each month. It appears that other monthly data elements are 0-filled for these enrollees.	12/21/2011
MT	Eligibility	Dual Eligibility Codes	Through FY 09, the comparison of MSIS counts to MMA counts shows that the counts of duals in codes 01, 03, and 06 are lower in MSIS than in the MMA file. These differences cause the total count of duals to be much lower in MSIS than in MMA as well. The state believes that the MMA count is more accurate. The MSIS system failed to include dual eligibles whose Medicare eligibility started in the first month of a quarter. This problem was corrected in Q1 FY 2010.	4/6/2012
MT	Eligibility	Managed Care	Individuals in the state's new (as of 12/2010) 1115 expansion population for the MHSP group are also reported to a behavioral health care plan (plan type = '3').	12/21/2011
MT	Eligibility	Managed Care	The "Passport to Health" waiver (a 1915(b) waiver, officially called the 'Passport to Health, Health Improvement Program, and Nurse Advice Line' waiver) establishes the PASSPORT plan (a PCCM) and the Health Improvement Program (HIP), an enhanced PCCM, both for the 1915b waiver enrollees. It also establishes the Nurse Advice Line, which is a service available to PASSPORT enrollees. Most (but not all) of the 1916(b) waiver enrollees are reported to both the PASSPORT PCCM and the HIP PCCM. Additionally, the number of HIP enrollees at any given time will be larger than the number of PASSPORT PCCM enrollees. Through the HIP, 14 providers statewide provide capitated care management services to this population. Though the HIP and PASSPORT PCCMs began on January 1, 2010, HIP PCCM enrollment was not reported in MSIS until Q1 FY 2011.	10/18/2012
MT	Eligibility	Managed Care	In Q1FY12, Montana begins reporting some MC information for SCHIP enrollees. As a result, 0-filling does not line up across all data elements, as SCHIP enrollees receive a MASBOE '00' but a valid managed care assignment.	1/28/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
MT	Eligibility	Managed Care	Montana's "Nurse First" is reported (with plan type of "nurse advice help line") in the 2011 CMS managed care summary as a fee-for-service voluntary program. It is not reported as a managed care plan in MSIS, which appears to be okay as the state has clarified that it is a service available to PASSPORT PCCM enrollees, not a separate plan.	8/19/2013
MT	Eligibility	MASBOE	All Years: MT appears to report many of disabled SSI age 65 and older to MASBOE 11.	NA
MT	Eligibility	MASBOE	Starting in Q2 FY 2014, MT began to assign about 300 individuals per month to MAS/BOE '99'. All of these individuals seem to be adults age 21-64 assigned to deprivation code 'HD' and RBF '5' (Other restricted benefits). The state has said that this is a new eligibility group that was added to the MMIS. We have asked the state to assign these enrollees to a valid, two-byte MASBOE code in the next file submission and to send an updated eligibility crosswalk. Since CMS has given the state permission not to submit MSIS files after Q2 FY 2014 and to not correct issues present in the Q2 FY 2014 files, it will not be sending an updated MASBOE crosswalk and this issue will not be corrected in MSIS and will need to be corrected in T-MSIS. The state has confirmed that it will correct any issues present in T-MSIS and that it will submit claims data back to January 2014 and EL data the standard 7 years in T-MSIS.	11/11/2014
MT	Eligibility	MSIS ID	Starting in Q1FY05, MT switched from being an SSN state to a non-SSN state in MSIS since they had previously been using the state ID as the unique identifier and reporting it in the SSN field, even though it was not always the SSN. Starting in Q1 FY05, MT reported the state ID in the MSIS ID field, which will be the permanent ID stored in the MMIS. Depending on the client, this original ID may or may not be the same as the SSN.	NA
MT	Eligibility	Restricted Benefits Flag	Montana's welfare reform program, called "FAIM," extended reduced Medicaid benefits to some adult eligibles through 1/31/04. Starting on 2/1/04, MT continued providing limited benefits to a group of able-bodied adults under its 1115 "Basic Medicaid" waiver. These persons appear to be assigned restricted benefits code 5 and are mapped to MASBOE 15 and 45.	NA
MT	Eligibility	Restricted Benefits Flag	Starting in FY04, MT assigned restricted benefits flag 5 to a small number of individuals in several other MASBOE groups, including 11, 12, 22, 34, 35, 42, 44, and 48. The state believes that most of the individuals should have received RBF 1 and is working to make this fix. In Q1 FY08, MT reported about 300 total enrollees per month in these other MASBOE groups to RBF 5. The state explained that many of these are "team care" recipients who must use primary care physicians and pharmacies for Medicaid services. These recipients must obtain referrals from their PCPs to visit specialists. Team Care started in MT in August 2004.	2/6/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
MT	Eligibility	Restricted Benefits Flag	In April 2007 (Q3 FY07), MT implemented a PRTF grant (Psychiatric Residential Treatment Facility). By January 2009, the program had covered 8 persons in Billings. The state planned to have 5 sites by the 5th year of the program (sites can serve up to 20 people each). Starting in Q3 FY08, MT assigned RBF 'A' to all PRTF recipients. More recently, Montana stated that the grant ended September 30, 2012 and funds were no longer available after that; enrollees were then transitioned to a "PRTF bridge waiver." However, through Q1 FY 2015, Montana continues to report about 16-18 individuals to RBF 'A'. We have asked Montana to clarify why it is still reporting individuals to RBF 'A' given that the PRTF grant has ended. Since CMS has given the state permission not to submit MSIS files after Q2 FY 2014 and to not correct issues present in the Q2 FY 2014 files, this question will not be answered and the issue will not be corrected in MSIS and will need to be corrected in T-MSIS. The state has confirmed that it will correct any issues present in T-MSIS and that it will submit claims data back to January 2014 and EL data the standard 7 years in T-MSIS.	2/1/2011
MT	Eligibility	Restricted Benefits Flag	MT has not been assigning RBF 2 to any enrollees. The state indicated that they do not have the appropriate codes available to identify whether any persons who only qualify for emergency Medicaid services are currently included in the state's MSIS data to assign RBF 2.	4/6/2012
MT	Eligibility	SSN	Starting in Q1FY05, MT switched from being an SSN state to a non-SSN in MSIS state since they had previously been reporting the state ID in the SSN field and thus using it as the unique identifier. In many instances, this state ID was not really an SSN since the state does not require the SSN field to be completed during the enrollment process. MT 9-fills the SSN field for individuals they know with certainty did not have an SSN in the field; however, less than 1% are 9-filled which is unusually low. For the remaining SSN data, the state is not able to differentiate which numbers are true SSNs and which are not. This results in some non-SSNs continuing to be reported in the SSN field that the state is not able to identify and remove from the field (analysis of MT SSN data in MSIS suggested that only about 70% of the SSNs were valid). (In addition, over 99% of the numbers reported in the MT SSN field passed the SSN high group test, which also makes it difficult to discern which SSNs are valid or not.) MT plans to implement a new MMIS system ("CHIMES") and intends to make the SSN field required in this new system. SSN data may improve once CHIMES is in place. This new system will require workers to enter an enrollee SSN (a requirement that has not been in place in the past). MT has been asked to provide a cross reference file of known SSNs plus "original IDs" to CMS for those records in their FY 2003 and 2004 MSIS submissions. The state indicated they hope (but did not fully commit) to provide this file once CHIMES is implemented. As of January 2011, the CHIMES system had not yet been implemented.	3/3/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
MT	Eligibility	SSN	Between Q1 FY 2011 and Q1 FY 2014, the percentage of enrollees without a valid SSN has steadily declined from only 1.09% to 4.80%. The state made a programming change that was supposed to pull the SSN correctly into the MSIS extract and reduce the high percentage with a missing SSN. In Q2 FY 2014, the percentage of individuals with a valid SSN improved. However, instead of 9-filling the SSN field for individuals without a valid/available SSN, it appears that the state switched to 0-filling it. The state has said that it will 9-fill all invalid/missing SSNs in future submissions. Additionally, the number of individuals with SSNs that have a leading 8 increased from 94 in Q1 FY 2014 to 2,700 in Q2 FY 2014. While SSNs with a leading '8' are valid as of July 2012, this is a large increase. The state has said that it updated the logic to report the SSN field more completely and in doing so they removed logic that 9-filled the field and also removed logic that prevented the IDs that begin with an 8- the IDs that begin with an 8 were being used by the local CHIP eligibility broker. This field is stored in the same table that all the alternate IDs are stored in such as the SSN. The state has said that it will update the logic to prevent sending any ID that begins with an 8 in the SSN field. We clarified (again) for the state that not all leading-8 SSNs are invalid, but to please 9-fill those that are invalid. Since the state has received permission from CMS not to submit MSIS files after Q2 FY 2014 and to not correct issues present in the Q2 FY 2014 files, this issue will not be corrected in MSIS and will need to be corrected in T-MSIS. The state has confirmed that it will correct any issues present in T-MSIS and that it will submit claims data back to January 2014 and EL data the standard 7 years in T-MSIS.	1/12/2014
MT	Eligibility	State-Specific Eligibility	In Q2 FY 2014, MT began to assign a substantial number of enrollees to several new deprivation codes- FC, D7, P5, and HD. The state said that these are new eligibility groups that were added to the MMIS. We have asked the state to send an updated MASBOE crosswalk that includes these groups. Since the state has received permission from CMS not to submit MSIS files after Q2 FY 2014 and to not correct issues present in the Q2 FY 2014 files, the state will not be sending an updated MASBOE crosswalk. This will need to be addressed in T-MSIS. The state has confirmed that it will correct any issues present in T-MSIS and that it will submit claims data back to January 2014 and EL data the standard 7 years in T-MSIS.	11/11/2014
MT	Eligibility	TANF/1931	Montana cannot identify TANF recipients. All eligibles are coded with TANF = 9, indicating that TANF status is unknown.	1/27/2011
MT	Eligibility	Waivers	Montana implemented a Family Planning Waiver (Montana Plan First) on May 24, 2012. Reporting begins in MSIS starting in June 2012.	2/3/2012
MT	Eligibility	Waivers	Q4 FY 2008 onward: only about 50% of MT's 1915c waiver enrollees have HCBS waiver services reported in the claims files. In addition, 24-30 percent of HCBS service recipients are not	9/25/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			enrolled in a 1915c waiver. The state has said that the former issue is because claims for clients in the Waiver 'D6', 'ME', and 'MF' were not being mapped to program type 6 or 7 as they should have been, and that the state updated its code so that the claims-enrollment linkage should be improved in Q1 FY 2012. However, as of Q1 FY 2013 (the latest quarter for which complete matched data are available) This both issues were unimproved. The state said that this is because waiver claims for individuals in Waiver 'D6' and 'ME' are paid outside the state's MMIS, and are therefore not reported in the MSIS claims files, while waiver enrollment is reported. Additionally, some enrollees who do not have a waiver-specific deprivation code, but are enrolled in a waiver, are not identified as being enrolled in an HCBS waiver in the MSIS EL files. We have asked the state to correct both issues in T-MSIS.	
MT	Eligibility	Waivers	Several dual eligibles show up in the 1115 Basic Medicaid for Able Bodied Adults and 1915(b) Passport to Health waivers, both of which are supposed to exclude duals. MT has said that for the Passport waiver, this appears to be a timing issue, as when these individuals were enrolled in the Passport waiver, they did not have any Medicare enrollment. Now that the individuals have Medicare spans they are no longer being enrolled into the Passport waiver. The state has not made a change to its reporting because it contends that MSIS data reflect what appears in the MMIS for these individuals. The state did not address the issue of dual enrollment in the 1115 Montana Basic Medicaid for Able Bodied Adults waiver.	9/25/2012
MT	Eligibility	Waivers	Beginning in Q4 FY 2013, Montana ceases reporting any enrollment to 1915c waiver "Montana HCBS Waiver: DD Age 18 and Older" (Waiver ID = 'MF', CMS Waiver # 0371.R02.00, expiration date 6/30/2014). The state confirmed that the waiver ended after June 2013.	1/12/2014
MT	Eligibility	Waivers	In February 2014 (Q2 FY 2014), MT started to report enrollment to 1915C MSIS Waiver ID 'D7'. The state has clarified that this is the MT Supports for Community Work and Living waivers, which was implemented into the MMIS on July 1, 2013.	11/11/2014
MT	Eligibility	Waivers	Montana confirmed that the 1915(c) Bridge Waiver for Youth with Serious Emotional Disturbance was implemented October 1, 2012 to allow youth in the 1915(c) PRTF Waiver to continue to receive HCBS services until they were no longer eligible. This waiver has not been reported in MSIS through Q1 FY 2015. The PRTF Waiver was only available to states that received a demonstration grant and was no longer available as of September 30, 2012 when that grant ended. Montana reports that it still has one youth receiving services in the 1915(c) Bridge Waiver. We have asked Montana to begin reporting this waiver. Since the state has received permission from CMS not to submit MSIS files after Q2 FY 2014 and to not correct issues present in the Q2 FY 2014 files, this issue will not be corrected in MSIS and will need to be corrected in T-MSIS. The state has	3/11/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
			confirmed that it will correct any issues present in T-MSIS and that it will submit claims data back to January 2014 and EL data the standard 7 years in T-MSIS.	
MT	IP	DRG	Montana used CMS-DRGs through FY2009Q2, but the DRG flag identifies them as state-specific DRGs. Since MT converted from CMS-DRGs to APR-DRGs in FY2009Q2 the APR-DRGs appear to be truncated. They appear to be missing the last digit of the root DRG value. The severity code that is usually associated with APR-DRGs is also missing but there are not enough allowable spaces in the MSIS DRG field to capture it anyway.	10/16/2014
MT	IP	Family Planning	There are few claims with a Program Type of Family Planning. The incomplete reporting is the result of the exclusive use of service codes to define it, rather than family planning status being reported on the MMIS claims.	8/22/2005
MT	LT	Crossovers	There are no crossover claims in MT's LT file. Montana does not process long term facility claims as crossovers.	12/10/2004
MT	LT	Patient Liability	The TPL amount is mostly combined with the Patient Liability field due to system reporting.	8/22/2005
MT	LT	Patient Status	1999 to 2009 files: Patient Status is not available on most claims even though it was submitted on 1998 MSIS files. Montana claims that only a few facilities ever report anything in the field, and that when something is reported it is almost always 99 (Unknown).	12/10/2004
MT	OT	Adjustments	MT has been submitting TPL adjustments as original claims with a negative amount paid and a positive TPL. If the adjustment to a claim with line items the TPL is not associated with the specific line item, but with all of them. Starting in 2008 MT will submit the TPL adjustment as an adjustment and not as an original claim.	NA
MT	OT	Adjustments	There are some debit adjustment claims with a negative Medicaid Amount Paid	12/10/2004
MT	OT	Managed Care Capitation	Since at least Q1FY2011 MT has reported two PCCM enrollments per person per month and one PCCM capitation payment for each person enrolled in their Health Improvement Program. One PCCM enrollment represents enrollment in the state's PCCM program called PASSPORT. The other PCCM enrollment represents concurrent enrollment in the Health Improvement Program which replaced the state's old disease management program.	10/16/2014
MT	OT	Type of Service	MT has a lowers than expected percentage of lab claims, but the lab service codes are properly mapped.	10/18/2008
MT	OT	Type of Service	Prior to FY2008, MT erroneous reported some claims with a Type of Service of Abortion. The abortion service codes need to be used to identify these claims.	6/9/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
MT	OT	Type of Service	Starting in Q1FY2008, TOS=31 increased four-fold from previous years. This is due to a change where the state moved the type of service assignment for State Provider Type 60 (Targeted Case Managed) from TOS=99 to TOS=31.	8/4/2009
NC	Claims	Adjustments	There are fewer than expected adjustment claims because many adjustments are done as cost settlements and not as adjustments to individual claims.	12/10/2004
NC	Claims	FFS Claims	NC 2013Q4 FFS crossover claims decrease due to new reporting requiring taxonomy which was not previously required. State expects FFS crossovers to be submitted in 2014 Q1.	4/10/2014
NC	Claims	Managed Care Encounters	North Carolina began receiving encounter data from plans in February 2014. Upon receiving the records, the states MMIS did NOT assign Category of Service to the records. The lack of Category of Service meant that the state could not produce MSIS files with encounter records coded with Type of Service. NC will re-submit FY 2014 files in T-MSIS that will include encounter records with TOS.	10/2/2014
NC	Eligibility	1115 Waivers	NC's is one of the few states that covers men in its family planning waiver.	4/24/2013
NC	Eligibility	1115 Waivers	Each month beginning in Q4 FY 2013, approximately 35 enrollees per month that are assigned to MAS 5 are NOT assigned to the corresponding RBF ('6') or waiver type and ID (Waiver type 'F' and Waiver ID 'FP'). The state has mostly corrected this issue starting in Q1 FY 2014, with just 6 enrollees/month showing this discrepancy. It is unclear if retro/correction records submitted with the Q1 FY 2014 file correct this issue in earlier quarters.	5/1/2014
NC	Eligibility	CHIP	North Carolina has opted to report eligibility data for all SCHIP enrollees. Claims for SCHIP enrollees, however, appear to be incomplete as claims were only reported for about 1.5% of enrollees in the OT file in FY 2009, and an even smaller percentage in other files.	7/8/2011
NC	Eligibility	CHIP	Reporting of M-CHIP enrollment in the SEDS data suddenly drops from about 120k to 2k in Q3 FY 2011, before resuming to previous levels in Q4 FY 2011 and thereafter. We have asked the state about this but did not receive a response.	6/5/2014
NC	Eligibility	Dual Eligibility Codes	Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled, up to 100 percent FPL. This is reflected in changing dual flags and restricted benefits for persons in MAS/BOE 31 and 32 beginning in Q2 FY 1999. This also caused some enrollment to shift from MAS/BOE 21/22 to 31/32.	NA
NC	Eligibility	Dual Eligibility Codes	In each quarter since at least Q4 FY 2009, there was a decline in the number of "Other" full dual eligibles (Dual Code= 08) in MASBOE 31 and 32. For example, in Q4 FY 10, the number with Dual Code = 08 and MASBOE 31 declined from 1,901 in month 1 to 1,361 in month 3, while the number with Dual Code= 08	6/2/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			and MASBOE 32 declined from 3,173 in month 1 to 2,377 in month 3. NC did not provide a reason for the shift.	
NC	Eligibility	Dual Eligibility Codes	The state assigns dual code 99 to aged, disabled, and some adult persons who appear to be duals but for whom the state is not yet showing a buy in.	4/6/2012
NC	Eligibility	Dual Eligibility Codes	Enrollment among QMB-only, SLMB-only, and QI-1 duals (dual codes 1, 3, and 5) increased in 2010. This may have resulted from implementation of a new method for counting income for dual eligibility.	4/24/2013
NC	Eligibility	Managed Care	Beginning in November 2009, NC implemented and begins reporting enrollees to a new Ambulatory Prepaid Health Plan (reported as plan type= '08' in the MSIS files). The plan provides prior approval on a selected number of high tech imaging services and has over 1,000,000 enrollees in its first month of operations. North Carolina confirmed that this plan is scheduled to end on 6/30/2014.	2/4/2011
NC	Eligibility	Managed Care	In Q3 FY08, NC started reporting enrollment in PACE (Plan IDs: 6700850 and 6700851, expanding to 6700852- 6700854 in FY 2012). NC's PACE plan was approved to start in January 2007 but first enrolled individuals in April 2008. PACE reporting ceases in Q4 FY 2013. The state submitted retro records with its Q1 FY 2014 file that correct this issue.	3/8/2011
NC	Eligibility	Managed Care	As of FY 2012, NC has implemented an SPA to include health homes model of care coordination, mainly to improve care for persons with mental health and substance abuse needs. It is unclear how these care coordination activities should be reported in the MSIS data.	11/6/2012
NC	Eligibility	Managed Care	In FY 2012- Q3FY13, Managed Care enrollment for Plan Type '3' increases sharply. The state has verified that this is due to the rollout of LME-MCO program under the 1915bc waiver, which transitions the provision of behavioral health services to managed care entities (LME-MCOs) in all 100 NC counties throughout 2013.	3/19/2013
NC	Eligibility	Managed Care	Starting in Q4 FY 2013, there are 17,000 individuals with duplicate enrollment in Plan Type '3' each month. In prior quarters, just a handful were assigned twice per month to plan type 3. We have asked the state about this.	5/1/2014
NC	Eligibility	MASBOE	1999: Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled to 100 percent FPL. This caused some enrollment shifts from MAS/BOE 21/22 to 31/32.	NA
NC	Eligibility	MASBOE	All Years: Enrollment in several of the MAS/BOE groups shows a seam pattern each quarter, with enrollment highest in Month 1 and lowest in Month 3, but increasing in Month 1 of the next quarter. This may be smoothed out over time by retroactive and correction records.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
NC	Eligibility	MASBOE	All Years: North Carolina's count of SSI recipients is somewhat different from SSA data for two reasons. First, North Carolina administers its own SSI Supplement program. Second, the state appears to report most disabled persons age 65 and older to MAS/BOE 11.	NA
NC	Eligibility	MASBOE	NC reports Family Planning waiver enrollees to state eligibility group MAFDN and MASBOE 55. The waiver was implemented in October 2005. Effective 10/1/2014, this program transitions to coverage under the state plan.	NA
NC	Eligibility	MASBOE	2008: NC implemented a Medicaid Buy-In program on November 1, 2008 (Q1 FY09). These individuals are reported to MASBOE 42 and RBF 1. The program had a monthly enrollment of approximately 1,200-1,400 in 2010.	3/8/2011
NC	Eligibility	MASBOE	Each month beginning in Q4 FY 2013, there are 40-190 people per month with a blank MAS / BOE code. The state improved the issue in its Q4 FY 2013 EL file; still, about 30 individuals/ month have a blank MAS/BOE code. Additionally, in month 1 and month 2 of Q4 FY 2013, there are 2-3 individuals assigned MAS/ BOE '00' (not Medicaid eligible) and CHIP CODE = '1' (Medicaid eligible, no CHIP). We have asked the state to correct this in its Q1 FY 2014 submission but a small discrepancy remains.	5/1/2014
NC	Eligibility	Restricted Benefits Flag	The women in MAS/BOE 35 who receive RBF = 2 (restricted benefits on the basis of alien status) are aliens who receive coverage for emergency services, including labor and delivery. Enrollees in other MASBOE groups are also assigned RBF=2.	2/10/2010
NC	Eligibility	Restricted Benefits Flag	Persons with restricted benefits code 5 (other) are medically needy enrollees with spend down; however, starting September 1, 2008 (Q4 FY08), NC also started assigning RBF 5 to individuals under a new coverage that continues Medicaid in a limited capacity for inmates of prisons and inpatient psychiatric facilities so that all medical care provided while the person is in an inpatient hospital is paid by Medicaid (inpatient hospital, physician, surgeon, anesthesiology, radiology, etc.). This also allows full Medicaid coverage to restart quickly if the person is released before the Medicaid certification period ends.	6/2/2011
NC	Eligibility	Restricted Benefits Flag	Starting Q2 2008, NC implemented a Money Follows the Person (MFP) program. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. The state assigns RBF 8 to MFP enrollees.	4/6/2012
NC	Eligibility	Retroactive/ Correction Records	NC submits a higher than expected number of correction records (generally, about 15% total each quarter). Analysis of these records has shown that changes included in the records do not generally affect any key data fields.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
NC	Eligibility	TANF/1931	In FY 2000 through FY 2002, TANF counts in MSIS were 13 - 14 percent higher than ACF TANF counts. In FY 2003, MSIS counts were 19 percent higher. MSIS counts continued to be 10-13% higher than ACF counts in FY 2004 - FY 2005. Starting in Q1 FY06, TANF counts became much more consistent (4% difference), but then diverged again (14%) in FY08. Then in FY07 and FY08, TANF counts continued to fall in ACF data, as well as MSIS, but MSIS data once again lagged so that the MSIS TANF count in 12/07 was 14 percent higher. By Q1 FY 2011, the MSIS TANF count was 22% higher than ACF.	4/6/2012
NC	Eligibility	Waivers	The Piedmont Pilot waiver (a 1915bc waiver) became effective 4/1/2005 (Q3 FY05). Waiver enrollees are provided mental health, developmental disability, and substance abuse services to all age groups in five counties. Because the waiver offers managed care services to all enrollees (the 1915b component of the waiver), but offers 1915c/HCBS services to just a small portion of the waiver's enrollees (the 1915c component of the waiver), individuals enrolled in this waiver that are receiving HCBS services are reported to Waiver Type '4' (1915bc) (Waiver ID 'P2') while those only receiving managed care services are reported to waiver type '2' (1915b) (Waiver ID 'P1'). In FY 2008 and prior, NC had switched the waiver IDs for these waivers; the state was reporting the waiver's HCBS enrollees (1915b and c) to Waiver ID P1, and the 1915b-only enrollees to waiver ID P2. The 1915bc waiver ended effective 7/1/2013 and all enrollees transitioned to the 1915b and a 1915c waiver.	3/3/2011
NC	Eligibility	Waivers	In FY 2012-FY 2013, enrollment in NC's 1915b waiver (Waiver 'P1') increases sharply. The state has said that this is due to the state's expansion of its 1915bc waiver, which gives the state authority to shift the provision of behavioral health services to new managed care entities (LME-MCOs).	3/19/2013
NC	Eligibility	Waivers	In Q2 FY 2013, several of NC's 1915c waivers - CC, CH, and DA- nearly double in enrollment. We have asked the state about this.	5/1/2014
NC	Eligibility	Waivers	Beginning in Q4 FY 2012, we begin to see a divergence between individuals with reported HCBS claims (Program Type 6 or 7) and HCBS waiver enrollment. The percentage of individuals with HCBS claims that have no corresponding HCBS waiver enrollment climbs from 27 percent in Q4 FY 2012 to 87 percent in Q3 FY 2013. The state has corrected this issue effective Q1 FY 2014 (when the discrepancy falls to 3 percent). It is unclear whether the state's retro or correction records submitted with the Q1 FY 2014 file will correct this issue in prior quarters.	5/20/2014
NC	Eligibility	Waivers	Enrollment reported in Q1 FY 2013 EL file for NC's 1915c waivers 'CC', 'DA' and 'CH' was only about half of what the state expected. This issue likely persisted earlier in 2012 as well but was only detected when waiver enrollment doubled in Q2 FY 2013. According to the state, the Q2 FY 2013 enrollment levels are correct. The state initially included retro records in its Q1 FY	6/6/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			2014 EL file that corrected the enrollment in these three waivers in Q1 FY 2013; however, when the state resubmitted its Q1 FY 2014 EL file to correct other issues, it failed to include these retro records. As a result, waivers CC, CH, and DA are under-reported through December 2012.	
NC	Eligibility	Waivers	In Q3 FY 13 and before, there were just a handful of individuals enrolled in more than one waiver. Starting in Q4 FY 2013, about 12,000 individuals were enrolled in more than one waiver. Each of these individuals is reported with both 1915b and 1915c waiver enrollment. The state has said that this reporting is expected due to the ending of its 1915bc waiver effective July 1, 2013. After this point, individuals formerly enrolled in 1915bc should now be enrolled in a 1915c waiver and also the 1915b. However, in the state's initial Q1 FY 2014 file submission, former 1915bc enrollees were transitioned to a 1915c, but not the 1915b waiver. The state corrected this in its resubmitted Q1 FY 2014 file.	7/7/2014
NC	Eligibility	Waivers	Starting in Q4 FY 2013, a sizeable number (more than half) of people with HCBS waiver enrollment do not have any HCBS waiver claims. NC has said that this is expected and the volume was low due to the NCTracks implementation in July 2013 and rollout of MCOs.	8/31/2014
NC	IP	Adjustments	There are some apparent duplicate claims in the file that are probably the original claim and the resubmission (coded as an original claim) without a void.	7/23/2007
NC	IP	Diagnosis	Starting in FY2011Q3, the state began reporting Present on Admission (POA) values on IP claims. POA is not a reportable data element in MSIS -- no MSIS data elements are setup for it. The 6th byte of a diagnosis code in NC's MSIS IP file represents the POA value. CMS stripped the POA value from NC's IP files before loading the data to the CMS mainframe. With ICD-9-CM coding currently reported in MSIS, this is not a major issue because ICD-9-CM only requires 5-bytes. However, this issue needs to be revisited before the state can begin reporting ICD-10 diagnosis codes which are up to 7-bytes long.	6/3/2014
NC	IP	Medicaid Amount Paid $0	In Q4FY2007 the percentage of claims with $0 Amount Paid increased to 29% from 5%. The TPL percentage and claims with missing ancillary codes also increase. The state has no explanation.	NA
NC	IP	Procedure Date	Some claims have procedure dates after the date of the file because this field is not validated by the state MMIS system.	12/10/2004
NC	LT	Type of Service	A slightly higher than expected percent of claims are for ICF/IID services which the state has confirmed is correct.	12/10/2004
NC	OT	Adjustments	A number of adjustment claims contained an incorrect sign based on the adjustment indicator.	11/14/2011
NC	OT	Capitation	NC has coded all of its Capitation payments (TOC=2) for behavioral health plans with a Type of Service = 20	8/20/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			(comprehensive) in FY 2013 Q4 OT file. Those capitation claims should be coded with a TOS=21.	
NC	OT	HCBS Waiver	HCBS Claims-Enrollment Discrepancy: In the resubmitted Q4 FY 2013 files, there is still a sizeable discrepancy with the HCBS claims-waiver link. Specifically, 39 percent of people with HCBS waiver claims (those with PROGRAM-TYPE 6 or 7) do not have corresponding HCBS waiver enrollment (WAIVER-TYPE 3 or 4) on the EL side. In the resubmitted files, the state has corrected the issues on the EL side so that the HCBS claims-waiver link has improved slightly since the first submission; however, the state believes that the remaining discrepancy is due to an incorrect flagging of some "management fee and prof claims" on the OT file as PROGRAM-TYPE 7, which are not actually HCBS claims. It seems that correcting these claims so that they are not reported as PROGRAM-TYPE 7 would be a straightforward and beneficial fix for the state to make.	9/4/2014
NC	OT	Managed Care Capitation	NC started a Medication Therapy Management Program in June, 2006. NC will be paying pharmacies $10 a month for drug case management recipients. The pharmacies will be paid prospectively based on the number of people locked into the program. However the fee will be recouped if no case management actually takes place.	6/7/2006
NC	OT	Managed Care Capitation	Effective January 1, 2010 state will be implementing system generated capitated payments to MedSolutions for selected lab/xray services. They anticipate that this will add just over 1 million capitated claims to the MSIS Claim OT universe. This is not a waiver cohort so the MSIS Eligibility file will not carry any indicator of enrollment. Medsolutions will have a single Provider Number to which the capitated payments will be paid. NC MMIS will also serve as the fiscal intermediary for Medsolutions. Therefore they will be able to send the encounter detail as paid to a Rendering Provider to MSIS as well. State will update the appropriate Attachments to show this limited Ambulatory HMO without Inpatient Services once a contract is signed.	3/8/2011
NC	OT	Managed Care Capitation	In Q4FY2010, cap payments for Plan ID=6704000 were only reported for the first two months of the quarter. The third month was held back by the state's DMA until 10/5/2010--Q1FY2010.	11/22/2011
NC	OT	Managed Care Capitation	Beginning in November 2009, NC implemented and begins reporting enrollees to MedSolutions (plan id=6704000), a new ambulatory prepaid health plan. The plan provides prior approval on a selected number of high tech imaging services and has over 1,000,000 enrollees in its first month of operation. Premiums for MedSolutions were handled through NC's DHHS controller's office and outside the MMIS. The MMIS was not updated to reflect any MedSolutions Managed Care enrollment prior to Q2FY2010.	2/6/2012
NC	OT	Managed Care Capitation	Capitation claims show a 3:1 ratio vs. enrollees. NC's MMIS generates CMS-1500 format claims monthly for any cap	2/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			payments due for Behavioral Health HMOs, PACE, or PCCM clients. BHO and Pharmacy Mgmt Fees were retro paid in 2008 as well.	
NC	OT	Medicaid Amount Paid $0	In 2007 and 2008 the percent of claims with $0 paid is higher than expected.	NA
NC	OT	Type of Service	PCS sometimes reported as Other Services and sometimes as PCS.	2/11/2006
NC	RX	Prescribing Provider ID	The prescribing physician ID is missing.	12/10/2004
NC	RX	Prescription Fill Date	The state reported the fill date in both the Fill Date and Prescribed Date fields until Q3FY2005. After that the Prescribed Date field is reported as missing.	4/12/2005
ND	_All	Data System Change	As of August 2013 implementation of ND's new MMIS is scheduled for the second quarter of calendar year 2014.	10/1/2013
ND	Claims	Adjustments	Until at least 2010 ND has only reported adjustment ICNs on resubmittal claims, not on void, credit, or debit claims.	4/8/2011
ND	Eligibility	0-filling	In Q2 FY09, ND made two errors related to zero-filling. One individual was reported to MASBOE 00 and RBF 8 in February and March 2009. Additionally, the state did not zero-fill the waiver type field for one person in MASBOE 00 in March 2009. We asked the state to correct the RBF reporting in future files. However, we did not ask about the waiver zero-filling because this is a less serious problem.	9/22/2011
ND	Eligibility	CHIP	ND passed a CHIP expansion from 150 to 160 percent of the FPL and dedicated additional funding for outreach to eligible but uninsured children. The expansion was effective July 1, 2009 (Q4 FY 2009).	NA
ND	Eligibility	CHIP	North Dakota reports its M-CHIP children. The state has an S-CHIP program, and started reporting those children in MSIS in 10-99.	NA
ND	Eligibility	CHIP	Beginning in Q2 FY 2002, the state reports M-CHIP enrollees with multiple state-specific eligibility groups and MAS/BOE codes. Through Q1 FY 2002, all M-CHIP enrollees were mapped to MAS/BOE 34 and state group 33. However, the M-CHIP program in ND is very small (fewer than 1,500 enrollees per month in FY05) and we chose not to question the state about this.	8/21/2007
ND	Eligibility	CHIP	In Q1 FY09, SEDS data showed an approximately 800-person decline in M-CHIP enrollment. However, enrollment in this program increased slightly in the MSIS file. The state indicated that this was due to a problem with SEDS reporting and that the MSIS data are accurate. Discrepancies between SEDS and MSIS reporting continued through Q4 FY09.	6/14/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
ND	Eligibility	County Codes	In Q3 and Q4 FY09, ND assigned county code 999 to a few enrollees. We asked the state to assign valid FIPS county codes to all enrollees in future files.	6/14/2011
ND	Eligibility	Dual Eligibility Codes	With the new monthly dual code reporting in FY06, ND reported about 400 individuals each month in dual code 08 to MASBOE 00 (not Medicaid eligible). Generally, a person who is not enrolled during a given month should not be assigned a dual code for that month. A couple individuals in dual codes 01, 02, 03, and 04 were also reported to MASBOE 00 in only month 3 of the quarter. The state fixed these inconsistencies in FY 2007.	5/7/2009
ND	Eligibility	Dual Eligibility Codes	Most dual eligibles receive dual code 08 (code 09 before FY 2003), including SSI recipients. ND asserts that SSI duals should not be required to apply for QMB or SLMB status since they are already getting premium payments and cost-sharing.	9/22/2011
ND	Eligibility	Dual Eligibility Codes	Between Q4 FY11 and Q1 FY12, the partial duals in ND experience significant dips. QMB and SLMBs decrease from about 1,400 and 1,100 to 525 and 460 respectively. QI's also experience significant decrease in this time period from about 500 to 55. These shifts occurred as the result of an error in the extract processes. The state has indicated they have made a correction to the extract process logic.	3/6/2014
ND	Eligibility	Managed Care	In November 2006 (Q1 FY07), ND terminated enrollment in its HMO plan (Plan ID MCO). This was ND's only non-PCCM managed care plan. ND confirmed that MCO enrollment ended in October 2006.	3/8/2011
ND	Eligibility	Managed Care	The CMS PACE status sheet shows a PACE plan for ND (Northland PACE). Through Q1 FY09, ND did not report any PACE enrollment in MSIS. We identified a fact sheet from March 2009 produced by the ND Dept of HHS that describes the program. The state confirmed this program and began reporting it in MSIS in Q2 FY09 with 10 - 16 enrollees each month. We asked the state if this low enrollment number was correct and they confirmed that it was.	5/13/2011
ND	Eligibility	Managed Care	In Q3 and Q4 FY09, ND began reporting approximately 1,150 to 1,650 individuals each month to more than one plan type. All of these individuals had Plan Type 08 (other) as one of their plan types, indicating that they were enrolled in the Experience Health Disease Management Waiver. We asked the state if this enrollment pattern was expected but the state did not reply.	3/28/2012
ND	Eligibility	Managed Care	The June 2008 CMS managed care report included a new PAHP (Experience Health) with about 3,800 enrollees. This plan did not appear in the FY08 MSIS data. The state confirmed that this is a new PAHP that started in October 2007. This plan is offered under a section 1915(b) waiver. We asked the state to add these enrollees to managed care reporting and to waiver reporting starting in Q1 FY09, but the Q1 FY09 file did not include this enrollment. The state initially explained that this program is operated outside of the MMIS and that it was unsure	3/28/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			how to add this reporting to MSIS. The state began reporting the waiver in Q2 FY09, but the state reported these individuals to Plan Type 07 during that quarter. We asked the state to report these individuals to Plan Type 08 in future files. The state used correction records in order to improve plan type reporting for these enrollees for Q2 FY09. Additionally, in Q3 and Q4 FY09, the state reported individuals in this waiver to Plan Type 08 and Plan ID 'PCCM.' We asked the state to change the plan ID in future files because this is not a PCCM program. In Q1 FY10, the plan was reported with plan ID 'DM.' In January 2010, the state also reported this program with plan ID 'DM,' but resumed reporting it with plan ID 'PCCM' for February and March of that year. The state then used plan ID 'DM' for this program in subsequent quarters.	
ND	Eligibility	Managed Care	In June 2009 in ND, MSIS reporting indicated that there were approximately 36,800 PCCM enrollees, but the CMS managed care report indicated that there were only about 29,300 PCCM enrollees. Additionally, while MSIS reporting indicated approximately 2,000 PAHP enrollees, the CMS June managed care report included approximately 2,400 PAHP enrollees in ND. We asked the state to explain these differences in reporting but did not receive a response.	4/6/2012
ND	Eligibility	Managed Care	In Q1 FY11, ND submitted correction/update records that go back to Q4 FY10 and disenroll about 8,000 individuals from PCCM plans. This lower level of PCCM enrollment (about 33,000 per month) continues in the Q1 FY11 file. North Dakota has indicated that the correction/update records to disenroll individuals from PCCM is due to a system change to correct the discrepancy between the number of individuals enrolled in PCCM and the number of capitated payments. The difference in counts from enrollment to capitated payments was due to PCP selection and provider encounter pricing. ND allows recipients to choose an Indian Health Services clinic or a Rural Health Clinic as a PCP. The enrollee does not have PCP assignment. For Q2FY2010, ND was reporting those enrollees with an IHS or an RHC as their PCP as PCCM, but the PCP portion of the encounter rate payment was not seen as a PCCM payment. Therefore, the counts appeared skewed, with a higher number of enrollees as PCCM. ND excluded reporting these enrollees as PCCM, which is what has caused the drop in enrollment.	3/18/2013
ND	Eligibility	Managed Care	In October 2011 reporting to the Experience Health Disease Management Waiver managed care plan (Plan-Type = 08, Plan ID = 'DM') ended; as of 10/1/2011, it is no longer covered through waiver, but it is covered under State Plan authority. This lapse in reporting was due to a date edit that prevented the extract of the information for Disease Management, which has been corrected and should be reflected in the FY13 files. We continued to report disease management individuals under the DM Plan ID, but since the services are no longer covered under the waiver, the waiver reporting ceased. The reason it would appear that reporting of individuals in the 'DM' plan stopped in	4/30/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			December 2012 is that the eligibility for disease management (Plan ID = 'DM') is based on claims with date of service (DOS) paid in the month in question. When Q1FY13 files were created, disease management claims with dates of service in December had not been paid. Claims with DOS in December 2012 will be reflected in Q2FY13, as they will paid in January 2013.	
ND	Eligibility	MASBOE	2008: In April 2008 (Q3 FY08), ND implemented a new program under the Family Opportunity Act aimed at helping low-and middle-income families with special-needs children by creating a Medicaid buy-in program for families that would not otherwise be eligible (see 4/30/07 email). Children enrolled in this program should be mapped to MASBOE 32. ND confirmed that this program was implemented in April as planned but we did not see any new enrollment in MASBOE 32 or any new aid categories in Q3-4 FY08. The state started reporting these enrollees in Q1 FY09 in state aid category '53' and mapped them to MASBOE 42.	5/26/2010
ND	Eligibility	MASBOE	Through Q4 FY08, ND did not report anyone to MASBOE 3A. The state does have a BCCPTA program (called Women's Way). In Q1 FY09 they started reporting these enrollees to MASBOE 3A (aid category 51).	5/26/2010
ND	Eligibility	MASBOE	All Years: Because North Dakota is a 209(b) state, they may report a somewhat lower proportion of SSI recipients in MAS/BOE 11 and 12 than usually expected. In addition, it appears that disabled SSI recipients age 65 and older are reported to MASBOE 11.	6/29/2010
ND	Eligibility	MASBOE	ND confirmed that aid category 52 (Working Disabled) is the state's Medicaid Buy-In population.	9/17/2010
ND	Eligibility	MASBOE	In Q3-4 FY08, enrollment in MASBOE 24 drops and enrollment in MASBOE 34 and 44 increases. In Q1 and Q2 FY09, growth in MASBOE 34 continues. The state clarified that these changes correspond to implementation of continuous eligibility for children. Children whose recipient liability was $0 and were medically needy were determined to be poverty-level eligible under continuous eligibility. ND updated its MSIS reporting to reflect this change.	3/29/2011
ND	Eligibility	MASBOE	Starting in FY04, ND reported a couple individuals to MASBOE 30 and one individual to MASBOE 40 during some months. In FY07, ND also started reporting enrollment in MASBOE 20. These are invalid MASBOE codes. By Q2-4 FY08, this reporting had almost been eliminated. It was completely eliminated by Q1 FY09. However, in Q2 FY09, ND reported 1 person to MAS/BOE 20 and 1 person to MAS/BOE 30. After Q2 FY09, the state discovered that this reporting was due to a missing aid category in the records for these individuals, and corrected the problem beginning in Q3 FY09.	5/13/2011
ND	Eligibility	MASBOE	The medically needy group in ND was expanded in Q4 FY09 via CMS' approval of a state plan amendment.	6/14/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
ND	Eligibility	MASBOE	Starting in FY06, ND reports only 1-2 people in MASBOE 41. While it seems unusual to have so few enrollees in this MASBOE code, the state confirmed that it is correct.	4/6/2012
ND	Eligibility	MASBOE	Starting in Q1 FY12, enrollment to MB 31-32 goes from 1800 and 1200 respectively to about 525. These shifts occurred as a result of an error in the extract processes. QMB individuals (who were in the affected MASBOE groups) were not passed to the Q1 FY12 MSIS eligible file. The state has made a correction to the extract process.	3/6/2014
ND	Eligibility	MSIS ID	In January 2011, ND realized that there are some cases each quarter in which a caseworker opens a new case for someone who is already enrolled in Medicaid. The enrollee then receives a new MSIS ID number, a new eligibility record is generated, and new claims are attached to this ID. Later, in cases where the state recognizes that this has happened, the newer eligibility record is reassigned the old MSIS ID number, which results in duplicate eligibility files with duplicate IDs. Additionally, the claims that occurred under the new MSIS ID are left with that ID, and there is no longer an eligibility record to which the claims can be attached. The state has indicated that this has probably been going on for a very long time. Because this issue affects a relatively small number of records, it will not be fixed in ND.	9/22/2011
ND	Eligibility	MSIS ID	When ND updates the MSIS ID or SSN for any enrollee, the MMIS makes this ID change retroactive 4 quarters (triggering retro records to add the new IDs and correction records to remove enrollment under the previous ID). Before submitting the Q1 FY09 file, the state was working to resolve some of its ongoing ID issues and ensure that all records had MSIS IDs that were NOT equal to SSN (see SSN anom). The Q1 FY09 file included a larger than normal number of retro/correction records. ND confirmed that these records were generated when ND switched its MSIS IDs. This change in MSIS IDs should improve the link between claims and eligibility MSIS IDs. The state has indicated that it will provide a cross-reference file so that the new MSIS IDs can be linked to old MSIS IDs. However, if this file is not received, we will use other MSIS data elements in order to perform this linkage.	4/6/2012
ND	Eligibility	Private Health Insurance	North Dakota reports that about 17 percent of its eligibles have private insurance, a higher than expected proportion.	3/8/2011
ND	Eligibility	Private Health Insurance	In Q1 FY10, ND began reporting approximately 20 enrollees each month to health insurance flag 3 (state purchased insurance) and approximately 5 enrollees each month to health insurance flag 4 (third party and state insurance OR either third party or state insurance of unknown source). We asked the state if it had implemented a new Health Insurance Premium Payment (HIPP) or Employer Sponsored Insurance (ESI) program and to provide the name of this program for our documentation.	3/28/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
ND	Eligibility	Restricted Benefits Flag	ND implemented an MFP grant. These enrollees appear in RBF 8 in MSIS starting in August 2008 (Q4 FY08).	5/26/2010
ND	Eligibility	Restricted Benefits Flag	ND does not extend full benefits to aged and disabled enrollees up to 100% FPL. However, by the end of Q4 FY09, the number of enrollees reported to MASBOE 31 or 32 and RBF 1 reached 46.	6/14/2011
ND	Eligibility	Restricted Benefits Flag	ND generally reports only a very small number (<5) of individuals to restricted benefits code '2' -- emergency services only for unqualified aliens. While this count may seem low, the state confirmed that they have a very small unqualified alien population and the count is not unreasonable. However, from Q2 FY07 through Q1 FY09, ND often reported only 1 person to RBF 2 (and 0 persons in many months). ND confirmed that this reporting is correct.	4/6/2012
ND	Eligibility	SSN	About 600 SSNs in ND's Q1 FY08 file have duplicate records. This number has been increasing over the previous few quarters. ND explained that the state gets separate data files from S-CHIP and from M-CHIP. Through 5/31/08, these programs did monthly eligibility reviews and children frequently moved between the programs, resulting in multiple MSIS records. Starting 6/1/08 ND implemented an annual eligibility review, which the state believes will lead to more stable CHIP enrollment and fewer duplicate records.	9/29/2009
ND	Eligibility	SSN	In FY05, 18 percent of the eligibility records in ND used SSNs as the MSIS ID. The state contact suggested that ND is using SSNs as ID numbers for QMB duals. We asked the state to stop using SSNs in the MSIS ID field. Analysis suggests that ND has submitted records to change MSIS ID from SSN for some, but not all, of these records. And, it appears that other persons (in addition to QMBs) have MSIS IDs equal to their SSNs.	9/22/2011
ND	Eligibility	SSN	ND accidentally submitted 10-digit numeric MSIS IDs in Q1 FY08 for some records. Most records, however, had the previous MSIS ID format (9-digit alpha-numeric). The 10-digit IDs were created when ND tried to address an ongoing ID issue in the state. ND had been using SSNs as MSIS IDs for QMB-only dual eligibles. We asked them to change these to new non-SSN ID numbers. In changing these IDs, ND accidentally added a leading 0 (creating 10-digit IDs).	10/7/2011
ND	Eligibility	SSN	A review of ND's SSN reporting in its Q4 FY05 file for MSIS showed that ND is submitting what appear to be valid SSNs (9 digit numeric data) for 99.6 percent of Medicaid enrollees each quarter. We generally expect to see the SSN field 9-filled (or 8-filled for SSN states) for at least 2-3 percent of enrollees, given that SSNs are not always available for some enrollees. However, the state explained that newborns are the only enrollees that may not have an SSN, and the state requires them to have an SSN or proof that an SSN has been applied for. ND eligibility staff are confident in their SSN numbers.	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
ND	Eligibility	TANF/1931	ND reports several hundred persons in MASBOE other than 14-17 as TANF recipients. The state has indicated that this reporting is correct because in ND Medicaid is budgeted prospectively while TANF is budgeted retrospectively. This means that a change in income could cause a recipient's MASBOE to change to 34, 44, or 45 while he or she continues to receive a cash payment from TANF.	3/8/2011
ND	Eligibility	Waivers	ND has a PAHP program that it operates through a section 1915(b) waiver. People covered under this waiver receive services in Experience Health PAHP. ND pays a monthly capitation payment for each enrollee. ND did not report this waiver or the managed care enrollment to MSIS until Q2 FY09 because the program is operated outside of the state's MMIS and it was difficult to add the reporting to MSIS.	7/8/2011
ND	Eligibility	Waivers	For each quarter in which ND had reported its Children with Medically Fragile Needs Waiver (waiver ID '96,' beginning in Q4 FY08) and its Technology Dependent Medicaid Waiver (waiver ID '94,' beginning in Q4 FY07), the state reported enrollment in these waivers only during the first month of the quarter. After Q2 FY09, we asked the state if this enrollment pattern was expected. They indicated that this was due to a coding error and corrected this reporting beginning in Q3 FY09.	9/22/2011
ND	Eligibility	Waivers	In ND, between April 2009 and September 2009, enrollment in the Experience Health Disease Management Waiver (Waiver ID 'WW') decreased from approximately 2,300 to approximately 1,700. This enrollment further decreased to approximately 1,500 in January 2010 before increasing to approximately 2,300 in April 2010 and then to approximately 3,200 in July 2010. As of 10/1/2011, it is no longer covered through waiver; it is covered under State Plan authority	4/6/2012
ND	Eligibility	Waivers	ND indicated that the Children's Hospice waiver (0834.R00.00) was implemented on 7/1/10, but this waiver was not assigned a MSIS waiver ID or reported in the Q4 FY10 file. We asked the state to assign a MSIS waiver ID to this waiver and to indicate when we should expect to see this waiver reported in MSIS.	10/11/2012
ND	Eligibility	Waivers	In Q4 FY11, the Self Directed Support for Families 1915(c) waiver (0421.R01.00, MSIS ID 'RR')had its services added to the Traditional ID DD HCBS waiver and are now reported under that waiver (Waiver ID '90').	4/29/2014
ND	IP	Revenue Code	A slightly higher than expected percentage of the claims do not have UB-92 Revenue codes for ancillary services. This is because mental health and rehabilitation claims are billed using the comprehensive UB-92 revenue code that includes accommodations and ancillary services. This percentage decreases over time, probably because these claims were moved to the LT file.	12/10/2004

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
ND	LT	Crossovers	In Q1FY2010, ND reported invalid Medicare deductible amounts. Medicaid amount paid was not affected. This occurred again in Q1 and Q2FY2011.	8/9/2013
ND	LT	Total Non-Crossover FFS claims	In Q2FY11 the number of all FFS non-crossover original claims with type of service of Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under increased from fewer than 20 claims in Q1FY11 to over 200 claims and average paid per IP psych day decreased by 39 percent from Q1 to Q2. It was only a difference of 199 claims but it seemed unusual and represents a relatively large amount paid (between $1 and 2 million; 2-3 percent of all LT original claim expenditures).	8/13/2013
ND	OT	Crossovers	In Q1FY2008 ND started reporting crossover claims in large numbers.	NA
ND	OT	Crossovers	In Q1FY2010, ND reported invalid Medicare deductible amounts on crossover claims. Medicaid amount paid was not affected.	4/4/2012
ND	OT	HCBS Waiver	All claims that ND reports as personal care services (TYPE-OF-SERVICE = 30) are also identified as Section 1915(c) waiver claims (PROGRAM_TYPE = 6 or 7), even for enrollees who do not have a 1915(c) waiver enrollment in the EL file.	10/1/2013
ND	OT	Managed Care Capitation	In Q1FY11 there were 9,610 original capitation claims (TYPE-OF-CLAIM = 2) with TYPE-OF-SERVICE = 01 (INPATIENT HOSPITAL). These may be capitation claims for ND's disease management PHP which have not been reported in previous quarters. The issue appears to be resolved in Q2FY11.	8/13/2013
ND	OT	Managed Care Capitation	ND had not reported capitation payments for active PACE or Disease Management programs through Q1FY2010.	12/2/2013
ND	OT	Service Code	North Dakota has state specific Service Codes that are a single letter (e.g., 'M', 'L', or 'E').	8/22/2005
ND	OT	TPL	The percent of claims with Other Third Party Payment (or Third Party Liability/TPL) is slightly higher than expected.	12/10/2004
ND	OT	Type of Service	Over 40% of the claims have a TOS of 19.	9/16/2005
ND	OT	Type of Service	The number of claim records for Personal Care Services (TYPE-OF-SERVICE = 30) is about the same in FY2012Q4 and FY2013Q1. However, in FY2012Q4, none of the claims for Personal Care Services are identified as HCBS waiver services (PROGRAM-TYPE = 6 or 7); in FY2013Q1, all of the claims for Personal Care Services are identified as HCBS waiver services. The state confirms that they incorrectly reported Personal Care Services under Program Type 7, when it should have been reported under Program Type 0. This should be fixed in FY2013Q2. (Needs to be fixed in MAX 2012)	7/7/2014
NE	_All	MSIS ID	Nebraska converted to a new MSIS ID numbering scheme in January 2008. They has been using the SSN primarily as the MSIS ID even though they are not an SSN state.	3/8/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NE	Eligibility	0-filling	Starting in Q2 FY12, there are some individuals reported to MASBOE 00 that have valid values reported to the monthly data fields (CHIP, Health Insurance, etc.) Enrollees in MASBOE 00 were also reported to CHIP code 1 (Eligible and No CHIP) for that same month. NE indicated that they recently discovered that the logic was missing a needed CHIP code which caused some people to be reported as 00. Truven is fixing the logic which should correct/eliminate this problem; these changes are expected by the state's FY13 submissions.	7/11/2013
NE	Eligibility	All	In October 2011 coding updates to correct issues with MASBOE reporting, Dual Eligible reporting, and Medicaid Buy-In Reporting were sent to NE's MMIS vendor, but never implemented. These missed coding updates and more recent coding updates (December 2012) that also have not been completed yet will be implemented starting in July 2013. These corrections should be reflected by NE's FY13 submissions.	7/11/2013
NE	Eligibility	CHIP	In May 2009, the Governor signed legislation that increased Medicaid eligibility from 185 to 200 percent of the FPL, effective September 1, 2009 (Q4 FY 2009).	NA
NE	Eligibility	CHIP	In Q3 FY09, MSIS and SEDS M-CHIP counts compared poorly. SEDS showed a considerable increase in CHIP enrollment, but MSIS enrollment remained about the same as in previous quarters. We asked the state to review this discrepancy and identify which source was more reliable. The comparison had improved by Q4 FY09.	1/28/2010
NE	Eligibility	CHIP	Pregnant women who are only eligible for Medicaid as a result of their unborn child are not entered into the MSIS system. Instead, an MSIS ID is assigned to the unborn child. The unborn child's SSN is 9-filled and the sex is reported as Unknown. The DOB is reported as the expected DOB. After birth, the SSN, sex, and DOB fields are corrected. Most of these unborn children are initially mapped to BOE 5, although some are mapped to BOE 4.	3/8/2011
NE	Eligibility	CHIP	NE's MSIS data include the state's M-CHIP enrollees. The state added S-CHIP reporting to MSIS in FY13.	9/22/2011
NE	Eligibility	CHIP	Starting in Q3 FY12, a small number (<10) are reported as separate CHIP (CHIP flag = 3) and to the Poverty-Related Adult MASBOE (MB = 35), where we would generally expect that if these individuals were truly separate CHIP that they would have a MASBOE of 00 (as well as other monthly fields) The state notes that this is a system error that affects a small number of individuals for which they do not expect a timely resolution.	12/11/2013
NE	Eligibility	CHIP	Starting in Q2 FY12, there were some individuals (˜ 27 per month in Q2 FY13 (at its highest was around 60 individuals in Q4 FY12) reported to MASBOE 00 (Not Eligible) and CHIP flag = 1 (Eligible and No CHIP) that have valid values for the monthly data fields (Health Insurance, Restricted Benefits Flag, etc.). Overall, the state has indicated that what caused these cases to error in the MAS BOE settings is some specific issue or	10/3/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			circumstance that could not be foreseen or generalized in a manner that could be corrected prior to it happening.	
NE	Eligibility	County Codes	Each quarter, NE assigns about 2,000 - 3,200 persons to county code '000' and approximately 30 - 100 to county code 999. This occurs because county is not a required field in the NE eligibility system. The state is working on this issue.	3/15/2011
NE	Eligibility	Date of Birth	See Unborn Child note.	3/8/2011
NE	Eligibility	Dual Eligibility Codes	From Q2 FY10 through Q2 FY12, large discrepancies existed between MSIS and MMA counts of QMB only (dual code 01), QMB+ (dual code 02), SLMB only (dual code 03), QI-1 (dual code 06), and other full dual (dual code 08) enrollees. These discrepancies were accompanied by declines in QMB+, SLMB only, and QI-1 enrollment (including the elimination of SLMB only and QI-1 enrollment in Q4 FY11) and an increase in other full dual enrollment in MSIS. Also, the state began reporting QMB only enrollment in MMA in Q2 FY10, but did not report any QMB only enrollment in MSIS during FY10 or FY11. When asked about these discrepancies in a review of the FY10 data, the state indicated that most of them occurred because the state had failed to properly update its mapping logic and that the MMA and MSIS counts would likely be comparable once updates were completed. Additionally, the state noted that QMB MSP dual enrollment was implemented in NE in January 2010, and that this group should be mapped to QMB only (dual code 01) in MSIS. In the FY11 review, we again asked the state to correct these issues. In July 2013, the state indicated that these issues were due to the changes in the October 2011 Attachment A that did not get implemented that would include new codes and changes to existing codes that would identify the Dual Eligibles. Truven is in the process of adding these codes and these changes are expected to be seen by the FY13 submissions.	3/15/2011
NE	Eligibility	Dual Eligibility Codes	Before Q1 FY 2009, the MSIS distribution of full benefit duals between dual codes 02 and 08 is not consistent with MMA data. In FY08, about 9,000 duals are reported as 02 in MSIS, but as 08 in MMA. The state indicated that the error was in the MMA reporting, which has now been corrected.	9/22/2011
NE	Eligibility	Dual Eligibility Codes	NE does not use dual codes 04 or 07.	4/6/2012
NE	Eligibility	Managed Care	NE implemented mandatory behavioral health care for many adults and children in July 2005 (through a 1915(b) program). All foster care children and many full benefit dual eligibles are enrolled in BHPs.	3/8/2011
NE	Eligibility	Managed Care	In Q1 FY10, PCCM enrollment increased from approximately 37,950 to approximately 51,200. Then, between July 2010 and August 2010, PCCM enrollment dropped from approximately 50,540 to 0. NE explained that the state has implemented a two MCO model with no PCCM and that PCCM ended in NE Medicaid on July 31, 2010.	3/15/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NE	Eligibility	Managed Care	Between Q4 FY10 and Q1 FY11, enrollment in plan type 01 (comprehensive) increased by over 100% (from approximately 40,250 in July 2010 to approximately 98,820 in Q1 FY11). Additionally, NE used correction records to add approximately 45,000 enrollees to comprehensive managed care for August and September 2010. Most of this enrollment appears to be due to enrollment in a new managed care plan (plan ID 10025863800), Coventry Nebraska. The state has confirmed this increase was expected. They cited some of the increase was due to the end of PCCM. During this time Nebraska also added Full-Risk Managed Care to 10 counties.	10/15/2012
NE	Eligibility	Managed Care	Starting in Q3 FY13, there were some unusual patterns in Nebraska's managed care reporting. The state terminated one behavioral health plan and implemented another. Plan ID 52213546300 (Plan Type '03' Behavioral) is reported through August 2013. Reporting to a new plan, Plan ID 10026304000 (Plan Type '03' Behavioral, begins in October 2013. The state did not report any enrollment for behavioral health in Sep 2013. Full-risk capitated behavioral health managed care began on 09/01/2013. In Q1 FY14, we noticed that 47.79% out of 233,592 of all of the records submitted for the quarter were correction records for Q4 FY14, and all of these corrections were for Month 3 [Sep 2013] of Q4 FY 2013 (this is also the month where Nebraska did not report any behavioral health enrollment). For these correction records, nothing but the Plan Type and Plan ID for Sep 2013 were changed. These correction records were used to fix the reporting error for your behavioral health plan in Sep 2013.	8/29/2014
NE	Eligibility	MASBOE	All Years: Nebraska requires SSI recipients to separately apply for Medicaid, accounting for the somewhat lower than expected count in MAS/BOE 11 and 12. In addition, NE reports most SSI disabled age >65 years to MASBOE 11.	NA
NE	Eligibility	MASBOE	2007 - 2008: NE's FY07 data showed larger than expected fluctuations in reporting to several MASBOE groups. According to the state, due to changes in federal regulations and other program changes, the number of TANF recipients in Nebraska decreased significantly during this time causing the decrease in MASBOE 14-15. Many of the adults removed from TANF then received Transitional Medical Assistance (TMA) which explains the increase in MASBOE 45. However, many of the children removed from TANF remained Medicaid eligible due to the higher income standard for children and moved to MASBOE 34 (explaining why reporting to this group increased). If income is low enough for the children to be Medicaid eligible, they are not put on TMA and would be MASBOE 34 rather than 44. These trends in MASBOE reporting continued in FY08. The number of TMA children in MASBOE 44 increased in Q2-4 FY09 as children were moved to TMA to reflect their household eligibility.	5/28/2010
NE	Eligibility	MASBOE	All Years: See note about unborn children, which complicates reporting into MAS/BOE 35.	3/8/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NE	Eligibility	MASBOE	CMS documentation shows that NE has a Medicaid Buy-In program operated under BBA authority. In March 2011, the state indicated that these individuals are reported in MASBOE 32 with state-specific eligibility groups with '30' in bytes 1-2 and 'BG' in bytes 5-6. The state also indicated that these individuals would be moved to MASBOE 42 in the future. As of July 2013, the state indicated that these changes had been included in the October 2011 Attachment A which was previously not implemented but that they are working on these changes and expect them to be included by the state's FY13 submissions.	9/22/2011
NE	Eligibility	MASBOE	During FY10 in NE, there were notable increases in enrollment in MASBOE groups 24, 25, 42, 44, and 45 as well as notable decreases in enrollment in MASBOE groups 31, 32, and 35. When asked about these fluctuations in enrollment, the state indicated that the eligibility crosswalk and MASBOE mapping logic needed to be updated and that these fluctuations were likely a result of problems related to the MASBOE mapping process. The state initially indicated that it would fix these problems in the FY11 files, however, the issues appear to have grown worse or stabilized (rather than being reversed). We asked the state to review this reporting: - Between Q1 FY10 and Q2 FY10, enrollment in MASBOE 24 increased from about 190 to about 390. Enrollment in this group further increased to about 430 in Q3 FY10 and about 520 in Q4 FY11. - Between Q1 FY10 and Q2 FY10, enrollment in MASBOE 25 increased from about 9,150 to about 14,250. It then increased to about 17,470 in Q4 FY11. - Between Q4 FY09 and Q1 FY10, enrollment in MASBOE 42 increased from about 400 to about 800. This growth was caused by enrollment in a new group (30ADB4). Enrollment in MASBOE 42 further increased to about 4,590 in Q2 FY10, to about 6,650 in Q3 FY10, to about 8,200 in Q4 FY10, and to about 11,170 in Q4 FY11. - Between Q3 and Q4 FY10, enrollment in MASBOE 44 increased from approximately 9,920 to approximately 10,950. It then increased to about 11,760 in Q4 FY11. - Between Q3 and Q4 FY10, enrollment in MABOE 45 increased from approximately 5,760 to approximately 6,370. It then increased to about 6,740 in Q4 FY11. - Between Q1 and Q2 FY10, enrollment in MASBOE 31 decreased from about 8,360 to about 5,220. Enrollment in this group further decreased to about 3,240 in Q3 FY10, to about 1,800 in Q4 FY10, and to about 330 in Q4 FY11. - Between Q1 and Q2 FY10, enrollment in MASBOE 32 decreased from about 12,040 to about 8,000. Enrollment in this group further decreased to about 5,720 in Q3 FY10, to about 4,090 in Q4 FY10, and to about 2,670 in Q4 FY11. - Between Q1 and Q2 FY10, enrollment in MASBOE 35 decreased from about 8,530 to about 2,330. Enrollment in this group further decreased to about 1,600 in Q3 FY10, to about 1,180 in Q4 FY10, and to about 670 in Q4 FY11. The coding updates needed to correct these enrollment shifts were included in the October 2011 attachment A. that did not get implemented by Truven. The coding updates that were missed in 2011 are being added and should be reflected by the FY13 submissions.	9/22/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NE	Eligibility	MASBOE	2000 - Q3 FY08, Q1 FY10 - Q4 FY11: When Nebraska converted to a new eligibility system in 2000, they had difficulty placing roughly 5,000 - 6,500 eligibles into MAS/BOE groups each month. CMS increased the error tolerance to 3%, allowing these eligibles to be mapped to MAS/BOE 99. By FY05, NE reported < 1,000 enrollees each month to MASBOE 99 and by FY07 this dropped further to 300-400 individuals each month. NE continued to report a few hundred persons to MASBOE 99 through Q3 FY08, but eliminated reporting to this category in Q4 FY08. Then, in Q1 FY10, NE resumed reporting to MASBOE 99 (about 200 people per month). The number of individuals reported to MASBOE 99 then increased throughout FY10 and FY11, reaching approximately 5,350 by month 3 of Q4 FY10 and approximately 8,700 by the end of Q2 FY12. All of these individuals are age 65 or older and all but one are reported as 'Other' full dual eligibles (dual code 08). These individuals are mapped to state specific eligibility groups 10ADBP, 10ADBT, 10ADB2, 10ADBX, 10AD03, 10ADB2. When asked about this, the state indicated that the eligibility crosswalk and MASBOE mapping logic needed to be updated and that MASBOE 99 reporting will likely be eliminated once the update is complete. In July 2013, the state reported that coding changes to correct this issue that were supposed to be implemented in October 2011 were never made. These changes in addition to subsequent changes identified in December 2012 but not yet completed will be implemented and should be reflected by the state's FY13 submissions.	12/27/2011
NE	Eligibility	MASBOE	FY2013-FY2014: In May 2013, reporting to MB 48 (foster care children) decreased from 10,636 in M1 to 6,932. In May 2013, Child and Family Services made a change so that only IV-E eligible children could receive Medicaid through the CFS program case. All of the other foster children must be eligible under another category in order to be eligible for 'regular' Medicaid. The state is currently working on a change to MMIS to identify wards. It is targeted for December 2014 implementation. Between Q4 FY13 and Q1 FY14, there were significant decreases in MAS 1: MB 11 (decreased from 4,066 to 1,012); MB 12 (decreased from 21,415 to 5,603), MB 14 (decreased from 11,388 to 2,316), MB 15 (decreased from 2,715 to 379), MB 16 (decreased 19 to 9). During this same timeframe, there were also enrollment increases in MAS 3: MB 31 (increased from 9,250 to 12,029) and MB 32 (increased from 14,895 to 29,813). Making systems changes to move the Cash cases to utilize the MAGI methodology is what caused the shifts in MASBOE settings. Cash cases conversion was complete by February 2014.	8/29/2014
NE	Eligibility	Private Health Insurance	Each month, NE reports a small number of people (10 to 15) with health insurance code 3. The state believes this may be a small pool of HIPP recipients with high-risk pool insurance, but they are still looking into this.	5/28/2010

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NE	Eligibility	Private Health Insurance	Counts of enrollees with third party health insurance in NE are not reliable from December 2009 until late October 2010 due to a problem with data matching files from BCBS. BCBS is NE's largest TPL intermediary with a data match to its MMIS.	3/15/2011
NE	Eligibility	Restricted Benefits Flag	In April 2008, NE implemented a Money Follows the Person (MFP) program. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. These persons have been reported to MSIS with RBF 8 since June 2008.	1/28/2010
NE	Eligibility	Restricted Benefits Flag	Estimates from INS suggest that NE has an undocumented population of about 24,000 and we expect that some of them might qualify for emergency services under NE's Medicaid program. The state reviewed their processing and found 63 cases for aliens opened in 2006, yet < 5 were included in MSIS due to an error in how the cases are approved (none were reported in FY07 or in Q3-4 FY08). The state made a system fix, but it is not working correctly. NE is currently investigating to see if the problem is with how these cases are being loaded into the eligibility system, or with how the eligibility system sets the flag in its MMIS that indicates emergency medical services for aliens. The state has also indicated that technical resources are currently extremely limited due to a large portion of the technical staff devoting their time to developing a new MMIS. They do not have an estimate for when restricted benefits code 2 will start being set correctly.	4/6/2012
NE	Eligibility	Sex	See CHIP Unborn Child note.	3/8/2011
NE	Eligibility	State-Specific Eligibility	Starting in Q2 FY12, there were 2 new state specific eligibility groups with a large number of individuals assigned to them initially. The first group was 90AD79, which had 300 individuals assigned to it initially and had increased to about 1,400 by the end of the quarter. The second group was 90CH79, which had 20 individuals assigned to it initially and had increased to about 70 by the end of the quarter. Both groups are mapped to MASBOE 35. The state has identified the individuals in the 90_79 group as pregnant women who should be assigned MASBOE 35.	7/11/2013
NE	Eligibility	TANF/1931	Over time, TANF enrollment in MSIS is about 15 - 40 percent higher than ACF data. This may be because there is a separate TANF plan that is not reported to ACF.	NA
NE	Eligibility	TANF/1931	Nebraska only reports a few non-TANF eligibles in MAS/BOE 14 - 17, contrary to expectations. Additionally, until FY 2001, there were 3,000 persons receiving TANF outside of MAS/BOE 14 - 17.	1/28/2010
NE	Eligibility	TANF/1931	Each month since at least Q2 FY 2008, NE has reported several hundred persons in MASBOE>00 with 9-filled TANF codes. We asked the state to review and correct this reporting. In March 2011, they indicated that they would work on fixing this problem, however the problem persisted in the FY11 and FY12	3/15/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			files. The state has indicated that corrected TANF codes have been provided to Truven and they are making the changes which are anticipated to be made by the state's FY13 submissions.	
NE	Eligibility	Waivers	NE does not report persons enrolled in multiple waivers according to the correct hierarchy.	10/27/2010
NE	Eligibility	Waivers	Although NE originally indicated that its Waiver for Children with Autism (waiver ID '10') would be implemented in July 2010, NE did not report enrollment in this waiver in Q4 FY10 through Q4 FY11. The state indicated that this waiver has not been implemented yet and its start date is currently set for April 2014.	10/15/2012
NE	Eligibility	Waivers	In Q1 through Q3 FY11, NE reported one person to the expired Early Intervention Waiver (waiver ID '07'). We asked the state to correct this reporting.	10/15/2012
NE	Eligibility	Waivers	NE's Developmental Disabilities Community Supports Program waiver (Waiver ID '09', Waiver '0454') was terminated on 12/31/2011. Erroneous reporting to this expired waiver occurred until February 2012.	12/27/2013
NE	Eligibility	Waivers	NE's Waiver for Adults with Developmental Disabilities – Residential (Waiver ID '04', Waiver '0395') ended 12/31/10. There was erroneous reporting after the waiver expiration date through April 2011.	12/27/2013
NE	Eligibility	Waivers	Between August and September 2013, overall waiver reporting decreases significantly:(Waiver ID '01' (1915(b) NE03.R04, Nebraska Health Connection Waiver) disappears, Waiver ID '02' (1915(c) 0187.90.R3, Aged and Disabled Waiver) decreases from 4,580 to 45, Waiver ID '03' (1915(c) 0396, Waiver for Adults with Developmental Disabilities - Comprehensive) decreases from 3,509 to 26, Waiver ID '05' (1915(c) 0394, Waiver for Adults with Developmental Disabilities - Day) decreases from 814 to 2, Waiver ID '06' (1915(c) 4154.R04.00, Waiver for Children with Developmental Disabilities) decreases from 268 to 2, and Waiver ID '08' (1915(c) 40199.R02.00, Traumatic Brain Injury Waiver) disappears.	8/29/2014
NE	IP	Adjustments	NE includes negative debit adjustments in the IP file. According to the state: "The adjustments are being made for underpayment adjustments on claims with multiple lines. The negative adjustments you are seeing are being done on one line of the claim. Then there are positive adjustments being made on another line on the same claim for the same amount, so the Net change is $0. The reason these adjustments are showing up is because the Adjustment Indicator is set at the claim level not the line level. Changing how the adjustment indicator is set will not happen until the new system is completed."	6/7/2013
NE	IP	FFS Claims	The number of FFS, non-crossover claims dropped more than 20% in FY 2012 Q2. NE believes this is due to the conversion of	6/7/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			certain residential providers to Psychiatric Residential Treatment Facilities (PRTF) to come into compliance with the IMD regulations. There were several providers that did not participate in the conversion and thus stopped offering services.	
NE	IP	Managed Care	There was a $6 million drop in dollars paid on original, FFS, non-crossover claims in the Q1FY2011 IP file. The state confirms this is due to the expansion of managed care into 10 counties from the previous 4 counties. There are no encounter records in this file. The state has switched to a two MCO model and has had issues with the new MCOs submitting encounter data using their new format. Encounters will be submitted into the MSIS submissions as soon as problems are worked out.	7/8/2011
NE	LT	Crossovers	The number of crossover claims reported dropped from over 1,000 each quarter to 300 in 2011 Q1. The state reported that in July 2010, NE implemented a new policy that eliminated the payment of coinsurance beyond the Medicaid allowable amount on Nursing Facility claims and that is what accounts for the drop in crossovers.	4/18/2011
NE	LT	FFS Claims	The number of FFS, non-crossover claims in FY 2012 Q1 and Q2 dropped more than 20%. The drop is overall, but most attributable to claims with Program Type = 2. Over 82% of claims in the file appear to have patient liability, compared with 67% in prior quarters. NE related to CMS that there were three major changes related to the implementation of HIPAA 5010 that affected Nursing Facilities. 1) NPI provider validation, 2) The elimination of the turnaround billing document, and 3) Requirement that Nursing Facilities bill on a new HIPAA compliant billing document.	6/7/2013
NE	OT	HCBS Waiver	Nebraska includes a lump sum claim in each quarter for their waiver and targeted case management claims. Most of these claims are processed outside of Nebraska's MMIS, and the State has indicated that it will not be able to create line item claims. The State notes that when their methodology for creating line item claims is complete, they will be able to create historical records.	3/9/2011
NE	OT	Managed Care	Q1FY2011 OT file contains no encounter claims. According to NE, the encounters are in the process of getting tested since the move to two MCOs that went into effect August 2010. They plan to submit the claims when they are available.	4/18/2011
NE	OT	Managed Care Capitation	Capitation claims in the EL file do not line up with capitation claims in the OT file. Nebraska has a Radiology Management Organization contracted to authorize radiology procedures. RMO claims have been coded by their system as TOS 57 which translates to cap payment in MSIS. They need to modify programming for MSIS, but are unsure where the RMO needs to be reported and need direction from CMS on this. This affects the alignment of capitation payments in the EL and OT files for 2010 Q4 and forward files (possibly earlier).	NA

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NE	OT	Managed Care Capitation	In Q2-4 2009 BHO capitation claims were not paid due to a contract dispute, but the BHO continued to provider services.	NA
NE	OT	Managed Care Capitation	BHO capitation claims were not paid in Q2-4FY2009 due to a dispute but the coverage continued. Contract issues were resolved for 2010 and BHO payments are made in the aggregate.	4/18/2011
NE	OT	Service Tracking Claims	In 2005, Nebraska starting using claims with service codes of the format 'NFxxxx' where xxxx=4 digit numeric. These NF codes are claims paid through a state computer system called NFOCUS. They are used to determine and track eligibility and to pay some types of claims and benefits. A few of the state's Medicaid waivers have their claims paid through this system in addition to a couple other services. In particular, DD waivers, Aged & Disabled Waiver, medical transportation and personal assistance services are all paid through this system, and would show up with the NF codes. Prior to 2005, the state was only sending claims data from MMIS. NFOCUS claims were not included in the DSS. Waiver and transportation expenditures were included in MSIS as a service tracking / gross adjustment record with MSIS-IDENTIFICATION-NUMBER = &HCBSWAIVER, &MEDTRANS.	NA
NE	OT	Type of Service	The BHO case management capitation claims are reported as individual claims through Q1FY2002. From Q2FY2002 through Q3FY2003 they were not included in the file in any form. Starting in Q4FY2003 they are reported as service tracking claims with a Type of Service of PCCM because they are only for BHO case management. In Q4FY2009 they are reported as Service Tracking claims with a TOS of TCM instead of PHP capitation.	10/12/2006
NH	Claims	Crossovers	Policy changes implemented in the new MMIS (beginning on March 31, 2013) for the processing of crossover claims using the lesser of logic resulted in an increase in the number of claims reimbursing $0. In the LT file, the percentage of crossover claims with $0 Medicaid paid increased from less than 1% in Q2 to 36.5% in Q3. In the OT file, the percentage of crossover claims with $0 Medicaid Amount Paid, $0 Coinsurance and Deductible, and $0 Third Party Liability increased from 12.2% (about 28,700 claims) in Q2 to 49.7% (about 117,400 claims) in Q3.	2/23/2015
NH	Eligibility	CHIP	In Q2 FY09, S-CHIP enrollment dropped notably. The state explained that in March 2009 income eligibility limits increased for a variety of Medicaid groups (including QMB, SLMB, QI, TMA, and Healthy Kids). With these increases more children became eligible for Medicaid and fewer were enrolled in S-CHIP.	7/14/2010
NH	Eligibility	CHIP	New Hampshire operates both M-CHIP and S-CHIP programs, but it only reported its M-CHIP eligibles in MSIS initially. S-CHIP reports began in Q1 FY03. NH eliminated its separate CHIP program as of July 1, 2012. At this point SCHIP enrollment is transferred to the MCHIP program.	3/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NH	Eligibility	County Codes	NH routinely 0-fills the county code for about 2 percent of records. In July 2010 the state investigated this and found that many of the people with 0-filled county codes had moved out of state. These people were Medicaid eligible and living in NH during the quarter in which they were reported, but the state does not maintain historical address data so once people move out of state their address information is lost. The state believes this reporting can be improved when the state implements its new MMIS (October 2011) because the new system will carry historical address information.	7/14/2010
NH	Eligibility	Data System Change	NH is in the process of implementing HEIGHTS, with an expected implementation date of 4/1/13. The new MMIS that will allow the state to start identifying enrollees that: (1) should be assigned restricted benefits code 2 (individual is eligible for Medicaid but only entitled to restricted benefits based on alien status) and (2) possible changes to SSI reporting (dependent on results from state's review of this reporting process). In addition, the new system will use 4 byte NHTS codes, replacing the current 2 byte aid category codes.	6/11/2010
NH	Eligibility	Managed Care	CMS managed care data for NH started showing about 2,000 individuals enrolled in a capitated disease management plan in June 2005. In June 2006, this number had increased to over 83,000. NH's MMIS was unable to identify these individuals in MSIS. This program ended June 30, 2009.	4/6/2012
NH	Eligibility	MASBOE	In January 2008 (Q2 FY08), NH started reporting enrollees to MASBOE 3A (individual covered under the Breast & Cervical Cancer Prevention and Treatment Act).	3/2/2009
NH	Eligibility	MASBOE	In March 2009, NH increased income limits for several groups including: QMB, SLMB, SLMB135, QDWI, 12-Month EMA, MCPW, CMA, QPW, Healthy Kids-Gold and Healthy Kids-Silver Medical Coverage Groups and also updated income limits for Legally Liable Relatives and updated income and resource limits for MEAD. This policy release resulted in the increase of Medicaid eligibility, most notably in the higher percentage poverty level groups, while decreasing S-CHIP. The most relevant changes between Feb '09 and Mar '09, both positive and negative, are displayed below, which is an excerpt of the Monthly Enrollment by Aid Category report in MDSS: aid category 24 increased by 1,103 people; aid category 2E decreased by 416; 2X increased by 840; 61 decreased by 785.	7/14/2010
NH	Eligibility	MASBOE	All Years: Because New Hampshire is a 209(b) state, the number of eligibles reported in MAS/BOE 11 and 12 is lower than the number receiving SSI, according to the SSA. In addition, it appears SSI disabled >65 years are reported as SSI aged. The state is reviewing its MASBOE mapping and believes that the current approach may not be identifying all SSI recipients who enroll in Medicaid. The state is going to look into using data from the SDX to "remap" some enrollees to MASBOE 11-12 in the future. However, this will probably not happen until	4/6/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			the new MMIS is implemented, thus, we will probably continue to see an undercount in MASBOE 11-12.	
NH	Eligibility	MASBOE	Between Q1FY13 and Q2FY13, there were substantial enrollment decreases on MASBOE 11, 12, 14, and 15, and large (corresponding) increases in MASBOE 41, 42, 44, and 45. The state explained that this is a result of the DFA "Delinked" Cash for Medicaid project, effective 2/1/13. New HEIGHTS no longer builds the Cash Related MAs anymore. The system will build Categorically Needy MA if an individual who is found eligible for Cash Assistance is also requesting Medicaid Assistance.	11/3/2014
NH	Eligibility	Race/Ethnicity	NH had been reporting both Asian and Native Hawaiian enrollees as Asian (code 4) in the combined race/ethnicity data field instead of reporting the Native Hawaiian/Other Pacific Islanders separately to code 6 in the combined code. Then, starting in 2005 when CMS added the new, expanded codes, NH did not report any Asian enrollees (Race Code 4 = 1) or Native Hawaiian enrollees (Race Code 5 = 1) in these data fields. If the combined Race/Ethnicity data field = 4 (Asian) then we expect the same record would be reported with the expanded Race Code 4 = 1 (Asian) as well. It appears that this group of about 1,200 Asian and Native Hawaiian/Pacific Islander enrollees are being added to the unknown ethnicity code since there were about 1,100 enrollees with an unknown code in the old, combined code, but there were about 2,300 in the new, expanded codes (1,100 + 1,200 = 2,300). When NH implements its new MMIS, the state does expect to be able to separately report these enrollees.	4/6/2012
NH	Eligibility	Restricted Benefits Flag	NH's Money Follows the Person (MFP) program was approved in October 2007 and enrollment began in MSIS (RBF=8) in Q1 FY08. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP.	3/2/2009
NH	Eligibility	Restricted Benefits Flag	NH will be implementing a new MMIS that will allow the state to start identifying enrollees that should be assigned restricted benefits code 2 (individual is eligible for Medicaid but only entitled to restricted benefits based on alien status). From the state's new MASBOE crosswalk that will be implemented with the new MMIS, the state confirmed that the new state-specific eligibility codes that are defined as "Alien Emergency" (MMLR, MMLU) and mapped to MASBOE 44-45 should be assigned RBF 2. In addition, there are several other states codes that have "alien" in the definition (MMRA, MMRF, MPAC, MPAP, MPQ2, MMA1, MMA2, MMA3) that are mapped to RBF 1. NH explained that these are refugee groups that do receive full benefits and will remain mapped to RBF 1.	1/4/2010
NH	Eligibility	SSN	NH has typically submitted what appear to be valid SSNs (9 digit numeric data) for about 99 percent of Medicaid enrollees each quarter. We generally expect to see the SSN field 9-filled for at	3/8/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			least 2-3 percent of enrollees, given that SSNs are not always available for some enrollees, such as newborns, younger children, or undocumented aliens. Through FY06, NH had about 1,300 records (1.0 percent) with the SSN field 9-filled. While this is lower than expected, the state confirmed that they require an SSN or proof that an applicant has applied for an SSN as part of the Medicaid enrollment process.	
NH	Eligibility	State-Specific Eligibility	NH submitted a final MASBOE crosswalk for the new MMIS (planned for April 2013). Of note, the state will not be able to distinguish pregnant women who have presumptive eligibility. Also, the crosswalk identifies QI dual eligibles as SLM 135. These enrollees will be mapped to MASBOE 31-32.	6/11/2010
NH	Eligibility	State-Specific Eligibility	NH's new MMIS will use 4 byte NHTS codes, replacing the current 2 byte aid category codes. In advance of the new MMIS's implementation, the state sent a new aid category crosswalk in June 2010 and a few aid category codes were defined differently than before. For example, the S-CHIP code is reported as aid category 61 in the new crosswalk and 26 in the old. In addition, aid category definitions are not always the same in both versions of the crosswalk; the definitions in the new crosswalk primarily relate to the New HEIGHTS program codes, not the old aid category codes.	7/11/2011
NH	Eligibility	TANF/1931	From FY 1999 forward, all persons in MAS/BOE 14 - 17 are reported to be TANF eligibles. It is unclear whether any persons other than TANF recipients qualified for Medicaid under 1931 rules.	NA
NH	Eligibility	TANF/1931	In general, NH's TANF enrollment in MSIS for December of each year has been comparable to the administrative data from ACF; however, in December 2007 (Q1 FY08) the counts diverged to show a 20% difference. The ACF count shows a larger drop from December 2006 to December 2007 than the MSIS count. The counts compared well again in December 2008.	1/4/2010
NH	Eligibility	TANF/1931	In Q3FY11, NH stopped reported individuals assigned to MASBOEs 16 and 17. This is the result of the elimination of NH's TANF UP Cash program, which ended 7/1/11.	3/4/2014
NH	Eligibility	Waivers	NH does not report any waiver enrollment in the Home Support Waiver for Children with Developmental Disabilities (Waiver ID "CI" and Waiver Type "3") even though it was approved in 2003 and expires in 2010. The state noted that this waiver is for children who have come directly out of an institution and directly onto the waiver program. The state remembers only a couple children being enrolled since the start of the waiver which explains why few (or no) children are reported to this waiver in MSIS.	NA
NH	Eligibility	Waivers	CMS has approved New Hampshire's alternative Medicaid expansion plan, making the state the sixth to earn CMS approval to expand Medicaid through a waiver to the Affordable Care Act's standard expansion process. Under the plan, New	3/9/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
			Hampshire will use federal funds to help purchase coverage for residents with incomes up to 138% of the federal poverty level. Coverage under the expansion will begin Jan. 1, 2016.	
NH	LT	Adjustments	Some adjustment claims are not properly reported. There are sets of original and resubmissions without voids, probably resulting in duplicate claims. The days are on all adjustment and supplemental claims so they are over reported.	9/4/2005
NH	LT	Admission Date	The Admission Date is missing on most claims as that information is not collected on the New Hampshire claim form.	12/10/2004
NH	LT	Medicaid Amount Paid Avg	Until 2009, the average amount paid on the validation tables includes claims without covered days. Since most LT claims have covered days the measure is misleading in only a few states. This information is correct in the MSIS files.	9/30/2009
NH	LT	Type of Service	There aren't any claims with a Type of Service of mental hospital for the aged, even though that service appears in the state crosswalk.	12/10/2004
NH	OT	HCBS Waiver	Personal Care Services claims in FY13Q1 incorrectly reported Personal Care Services under Program Type 7, when it should have been reported under Program Type 0. This is probably also why there were more MSIS IDs on HCBS waiver claims for Personal Services without an HCBS waiver enrollment in EL than with an HCBS waiver enrollment in EL. (7/1 email from state)	7/2/2014
NH	OT	Type of Service	In 2013 Q3, the percentage of all FFS original crossover claims paid >$0 that had TYPE-OF-SERVICE = 11 (Outpatient Hospital Services) increased substantially but the percentage of all FFS original crossover claims paid $0 that had TYPE-OF-SERVICE = 11 (Outpatient Hospital Services) remained constant. In contrast, the state's analysis showed a decrease in claims volume for crossover claims paid >$0 from Q2 to Q3. However, the new value in Q3 looks more like what we would expect based on other states' values, so this issue is okay.	2/23/2015
NH	RX	Medicaid Amount Paid Total	State discovered that the RX claims for Q1FY2007 contained duplicate claims. Because the file year has already been closed by the time this discovery was made, CMS instructed the state as follows: "Please do resubmit your Q1FY2007 RX File. We will submit it thru our normal front end validation and back-end DQ processes. . . . However, we have decided at this point, not to reload it into our web data mart (available to the public). We shall annotate the issue (duplicate reporting of RX claims for Q1FY2007) in our data anomalies, however." The resubmitted file passed the edits and the DQ review.	3/8/2011
NJ	Claims	Adjustments	Because of reimbursement system, there are a few original and resubmittals claims with negative amount paid, particularly in the LT file.	3/8/2011
NJ	Claims	FFS Claims	NJ pays all behavioral health claims as FFS even if the client is enrolled in managed care.	2/10/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
NJ	Claims	Managed Care Encounters	There are fluctuations in the total managed care claims each quarter, for both SCHIP and Medicaid groups. These totals are by submission date and not by date of service and do not represent an aberration in utilization.	2/10/2015
NJ	Claims	Patient Status	For encounter claims in the IP and LT file, there are no claims in which the patient disposition is "still a patient" (PATIENT-STATUS = 30). The state will adjust they are reporting their patient status to map to the MSIS patient status.	2/10/2015
NJ	Claims	Provider ID	New Jersey 8-fills the Servicing Provider field for all Capitation Claims.	3/25/2011
NJ	Eligibility	1115 Waivers	Starting in 2001, NJ implemented a section 1115 demonstration waiver ("NJ FamilyCare") that covers: (1) custodial parents and caretakers of Medicaid and SCHIP children with incomes up to 133% FPL as M-CHIP enrollees, (2) custodial parents and caretakers of Medicaid and SCHIP children with incomes from 133 - 200% FPL as S-CHIP enrollees, and (3) pregnant women with family incomes between 185-200% FPL who are not insured and not otherwise covered by Medicaid as S-CHIP enrollees. Enrollment is reported to Waiver ID '08.' The state froze enrollment for parents as of June 2002, but initiated M-CHIP enrollment again in September 2005 for parents up to 100% FPL. This increased to 115% FPL in September 2006 and 133% FPL in September 2007. These changes caused steady enrollment growth in reporting to MASBOE 55 in MSIS during FY06 - FY08. Chip coverage for adults ended 9/30/13 and the clients were covered through Medicaid through 12/31/13. SCHIP adults were then terminated and the MCHIP adults were converted to the new ACA coverage beginning 1/1/14. NJ stopped reporting to HIFA Waiver ID '08' in Q2FY14.	7/8/2011
NJ	Eligibility	1115 Waivers	NJ received CMS approval for its section 1115 HIFA Standardized Parent Service Package waiver (Waiver ID '10', Waiver type '5') in January 2003. This waiver allowed NJ to institute a more limited benefit package for M-CHIP adults (similar to the S-CHIP adult package) and uses the savings to increase the number of S-CHIP adults with coverage. The waiver expired 1/31/09, but NJ incorrectly reported this waiver through Q3FY10.	4/6/2012
NJ	Eligibility	1115 Waivers	Beginning in Q1FY12, NJ began to report enrollment of about 48,000 in a new 1115 waiver under waiver ID '14.' According to the state, waiver 14 is the NJ Childless Adult waiver that was formerly covered under GA PSC 761. The program ended with adult expansion (12-31-13).	5/14/2014
NJ	Eligibility	1115 Waivers	There was an increase in enrollment of about 55,000 in MASBOE 55 between Q4FY11 and Q1FY12 (Sept-Oct 2011). The increase occurred in PSC 761. Childless adults PSC 761, formerly covered by GA PSC 761, were added to 1115 waiver ID '14' (NJ Childless Adult) on April 15, 2011, and the change was implemented in the MMIS system in October 2011, causing the increase in	6/24/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			MASBOE 55. These individuals should also be reported to waiver type 1, RBF 1, and either BOE 5 or 7.	
NJ	Eligibility	1115 Waivers	In 2012, NJ rolled most of its waivers into a comprehensive 1115 waiver. According to CMS's website, NJ Comprehensive Waiver is a statewide health reform effort that will expand existing managed care programs to include long term services and supports and expand home and community based services to some populations. It combines several existing Medicaid and CHIP waiver demonstration programs, including 2 1915b managed care waivers, title XIX Medicaid and title XXI CHIP section 1115 demonstrations and 4 1915c programs. Waiver ID '01' (DDD) is not included in the comprehensive waiver. Through Q2FY14, NJ has not reported a new ID for this comprehensive waiver and continues to report the old individual waiver IDs. NJ started reporting this waiver to waiver ID 15 in Q1FY15.	10/22/2014
NJ	Eligibility	1115 Waivers	In October 2012, NJ implemented a new comprehensive waiver, which combined all of NJ's existing waivers, with the exception of DDD (NJ Renewal, waiver ID '01'). According to CMS's website, the comprehensive waiver expands existing managed care programs to include long term services and supports and expands home and community based services to some populations. It combines several Medicaid and CHIP waivers, including two 1915b, a title XIX Medicaid and a title XXI CHIP 1115, and four 1915c waivers.	2/18/2015
NJ	Eligibility	CHIP	New Jersey reports both its M-CHIP and S-CHIP enrollees into MSIS. NJ has both M-CHIP and S-CHIP programs for both children and adults. As described below, there have been a few issues with CHIP reporting, but the S-CHIP reporting has been generally reliable since FY02 and the M-CHIP reporting since Q1 FY07. M-CHIP children are generally reported to MASBOE 34, while M-CHIP parents are reported to MASBOE 55. Coverage for M-CHIP adults seemingly ended 1-1-14 with the new adult expansion program. PSC 380 was reused to cover the new expansion population and they were moved to MASBOE 45. Both S-CHIP children and parents are reported to MASBOE 00.	NA
NJ	Eligibility	CHIP	Another MSIS reporting problem was discovered in FY05. It turns out state group 380 included about 6,000 - 7,000 children, as well as adults. These M-CHIP children should have been mapped to MASBOE 34. Instead, they were mistakenly mapped to MASBOE 55 (along with the adults) through Q4 FY05. In Q1 FY06, 5,100 individuals in state group 380 were remapped to MASBOE 34. However, about 2,500 individuals in state group 380 were mapped to MASBOE 15 and still assigned S-CHIP flag 2. These enrollees in MAS 14-15 are TANF-eligible individuals and not S-CHIP. They should not have been assigned S-CHIP enrollment. Then, in Q1 FY07, NJ corrected the assignment of the M-CHIP flag (SCHIP-=2) so that 380 enrollees in MASBOE 34 and 55 are generally reported as having M-CHIP enrollment and the 380 enrollees in MASBOE 14-5 were shown as regular	7/8/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			Medicaid enrollees (S-CHIP = 1). This is what we generally expect to see. (NOTE: about 10 enrollees in group 380 are also reported to MASBOE 44-45.). M-CHIP adult coverage seemingly ended on 1-1-14 with the new adult expansion coverage. PSC 380 was reused to cover the new adult expansion population and they were moved to MASBOE 45.	
NJ	Eligibility	CHIP	Beginning in January 2001, New Jersey added coverage for M-CHIP and S-CHIP parents under an 1115 waiver. M-CHIP parents have incomes<133% FPL, while S-CHIP parents have incomes from 133-200% FPL. However, there were problems with MSIS reporting for these enrollees. M-CHIP parents (state group 380) began to be reported in MSIS current records in Q2 FY 2001, but they were mapped to MAS/BOE 15 (they should have been mapped to MAS/BOE 55), and they were assigned SCHIP code 1 (they should have been assigned S-CHIP flag 2). The correct coding for M-CHIP parents did not appear in current MSIS records until Q1 FY 2003. (In Q1 FY 2002, there were about 184,000 correction records in S-CHIP for state group 380 (M-CHIP parents). M-CHIP adult coverage seemingly ended on 1-1-14 with the new adult expansion program. PSC 380 was reused to cover the new adult expansion population and they were moved to MASBOE 45. S-CHIP parents (state groups 497,498, and 499) were not reported in MSIS current records until Q1 FY 2002, when they were correctly reported to MAS/BOE 00 and assigned S-CHIP code 3.)	4/6/2012
NJ	Eligibility	CHIP	Through Q3FY12, NJ reports about 550 SCHIP individuals to MASBOEs other than 00. The state fixed this issue starting in Q4FY12. Also, through Q3FY12, there are about 13,000 SCHIP individuals assigned to MASBOE 00 and TANF Flag 1 (no TANF received) and RBF 1 (full benefits). Starting in Q4FY12, there are about 102,000 SCHIP individuals assigned to MASBOE 00 and TANF flag 1. About 101,500 SCHIP individuals are assigned RBF 1 and 500 are assigned RBF 4 (restricted pregnant). Although we typically expect to see the MASBOE 00 individuals 0 filled for TANF and RBF, from NJ's explanation, CHIPRA groups of non-citizen children and pregnant women are being assigned to MASBOE 00, CHIP code 3, TANF 1 if an individual did not receive TANF (2 if individual did receive TANF, although this number is small), RBF 1 if receiving full benefits, and 4 if receiving pregnant benefits.	5/14/2014
NJ	Eligibility	Dual Eligibility Codes	New Jersey does not report any eligibles with dual eligibility flag 01, since the state extends full Medicaid benefits for all aged/disabled up to 100 percent FPL.	NA
NJ	Eligibility	Dual Eligibility Codes	NJ reports some aged and disabled duals in MASBOE 11-12 to dual code 08. File correspondence indicates these are duals without Part A entitlement.	NA
NJ	Eligibility	Dual Eligibility Codes	CMS approved NJ to use dual code 09 in FY03 for aged/disabled medically needy duals in nursing homes who do not get drug benefits. Starting in Q1 FY06 (with the switch to monthly dual	12/31/2007

State	File Type	Rec/Issue Type	Issue	Recorded
			code reporting), counts of enrollees with dual codes 08 and 09 follow a similar pattern each quarter. Counts of 09 start low in month 1 of each quarter and increase substantially by month 3 of the quarter. The reason is that most of these enrollees are eventually determined to be medically needy and move to full dual status (code 08). Therefore, many of the 09s later in the quarter eventually move to code 08 through correction records once more complete data are available. This also explains why counts to dual code 08 start high in month 1 of each quarter and then drop by month 3. Finally, this trend in MSIS current records also explains why counts of 08 and 09 do not appear consistent in comparisons to MMA files for month 3 of a quarter since the MMA files already have the correction records applied to the dual counts.	
NJ	Eligibility	Dual Eligibility Codes	Starting in Q1FY12, about 700 individuals in MASBOE 15 are assigned dual code 08 (other full benefit duals. Enrollment stays consistent through Q3FY13, then drops off completely by Q1FY14. NJ indicated that these were PSC 380, which had many groups of recipients with different MASBOEs assigned. On Jan 1, 2014, these were converted to a group of Medicaid expansion recipients, thus explaining the drop off. The state confirmed that these were full benefit duals.	6/24/2014
NJ	Eligibility	Dual Eligibility Codes	Through Q1FY12-Q1FY14, there are about 200-400 individuals in MASBOE 55 assigned to dual code 02 (QMB full duals). The state indicated that these were PSC 761 GA converted to federal match for 19-64 year olds that had Medicare (disability). These were not reported to CMS on the MMA for determining Part D.	6/24/2014
NJ	Eligibility	Dual Eligibility Codes	IN Q2FY14, NJ began reporting 1-2 individuals to dual code 10 (S-CHIP entitled to Medicare). We have not brought this up to the state but will continue to see if this number increases.	10/27/2014
NJ	Eligibility	Dual Eligibility Codes	In Q2FY14, about 1,000 individuals in MASBOE 45 were assigned dual code '02' (mostly in PSCs 320 and 762) (increased to about 2,600 by Q1FY15) and about 800 individuals in MASBOE 45 were assigned dual code '08' (mostly in PSC 380). NJ explained that for PSC 380, these could have had Medicare prior to the 1-1-14 expansion; however, the new expansion group is not supposed to have Medicare but sometimes shows up and the eligibility unit must terminate the client according to the fair hearing rules. They do not send those PSCs on the MMA file for deeming LIS. The eligibility unit is trying to get reports and attempting to automate corrections.	12/23/2014
NJ	Eligibility	Managed Care	Starting in July 2009 (Q4 FY09), NJ implemented a new capitated transportation service managed care plan. Enrollees are reported to Plan Type 08 (other) and Plan ID 0194557.	3/8/2011
NJ	Eligibility	Managed Care	In Q3 FY09, NJ implemented a new PACE initiative. The state reports these enrollees to Plan Type 06 and Plan IDs 0169129, 0180084, and 0233722.	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
NJ	Eligibility	Managed Care	There was an increase of about 94,000 in managed care plan type 01 (comprehensive HMO) between Q3FY12 and Q4FY12. The increase occurred in most of the plans (3 out of 4). Although the state is unsure of a specific reason for this increase, they suspect it was caused by the start of D-SNP (Dual Special Needs Plan) Jan 2012. Because of the delayed system implementation in May/June 2012, this increase would have been caused by duals already in managed care switching to D-SNP.	6/24/2014
NJ	Eligibility	Managed Care	There was an increase of about 97,000 in managed care plan type 01 (comprehensive HMO) between Q4FY11 and Q1FY12. The HMO increase occurred in all 4 plans. The state explained that this was caused by the implementation of mandatory managed care for aged, blind, and disabled (ABDs) and duals that occurred in Oct-Nov 2011.	6/24/2014
NJ	Eligibility	Managed Care	Between Q1FY14 and Q2FY14, Plan Type '08' increased by about 223,000. Plan Type '08' is the capitated transportation plan and the new expansion group is enrolled on day one of program eligibility, explaining the increase. Plan Type '01' also increased by about 100,000 during this time. Again, the new expansion group is enrolled in HMOs; however, they may not be enrolled day one, explaining the different increases in Plan Types '01' and '08.'	12/23/2014
NJ	Eligibility	MASBOE	All Years: New Jersey provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.	NA
NJ	Eligibility	MASBOE	All Years: New Jersey's MAS/BOE data appear to have a "seam effect," but this is supposedly remedied by retroactive coverage and correction records.	NA
NJ	Eligibility	MASBOE	All Years: NJ has an 1115/HIFA waiver for SCHIP parents.	NA
NJ	Eligibility	MASBOE	2004 - Present: Starting in FY04 and forward, NJ reports a few individuals (about 5-10) to MASBOE 40 (an invalid combination) each month. These individuals are assigned SCHIP flag = 3, but all the monthly fields for these individuals were 0-filled. The state confirmed that the MAS data element should be 0-filled as well. The state has requested the fix in its data, but it will involve a high level of effort that is not believed to be worth the effort until NJ gets more caught up with MSIS submissions.	10/1/2008
NJ	Eligibility	MASBOE	All Years: NJ reports several thousand aged enrollees (age 65+ yrs) to MASBOE 32 (poverty-related, disabled) instead of MASBOE 31 (poverty-related, aged). In addition, several thousand aged enrollees are reported to MASBOE 42 (other, disabled) instead of MASBOE 41 (other, aged). The state indicated that these individuals enroll as "disabled" and do not get updated for age. Thus, enrollees in BOE 2 stay in the same status and do not shift to BOE 1. It would take a large effort to fix, but we've asked the state to revisit the issue once file submissions are more current.	11/18/2008

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
NJ	Eligibility	MASBOE	2006: After freezing adult 1115 waiver enrollment in June 2002, NJ opened enrollment to adults again in September 2005 (see 1115 Waiver anomaly) causing increases in reporting to MASBOE 55 during FY06 and FY07.	3/8/2011
NJ	Eligibility	MASBOE	Between Q1FY12 and Q2FY12, there was an increase of about 16,000 in MASBOE 34 (poverty related/children). This increase occurred mostly in PSCs 480, 481, 483, and 485. NJ confirmed this increase and indicated the NJ is consistently advertising for enrolling children into the NJ Family Care program.	5/14/2014
NJ	Eligibility	MASBOE	A new group of SED Children (PSC 641-37) was added in October 2012, causing an increase of about 3,500 in MASBOE 54 between Q3FY13 and Q4FY13. Retro records were submitted for October 2012- June 2013.	6/24/2014
NJ	Eligibility	MASBOE	About 50 individuals are reported to invalid MASBOE 99 starting Q4FY13. This increases to over 2,000 in Q2FY14. These enrollees were in PSC 641 and also reported with RBF 1 (full benefits) and other valid monthly values for CHIP, TANF, MC, etc. The state indicated that these individuals should not have been reported unless they had PSC 641-37 (new SED Children) and that they would be corrected through retro/corrections on future files.	6/24/2014
NJ	Eligibility	MASBOE	In Q2FY14, several changes in MASBOE reporting occurred. MASBOE 15 decreased about 62,000, mostly occurring in PSCs 380, 310, and 410. PSC 380 was reused 1/1/14 (formerly M-CHIP parents. MCHIP ended) to cover the new expansion group, which is now mapped to MASBOE 45. Kids and med specials were moved to new PSCs 1/1/14. MASBOE 45 increased by about 338,000, occurring mostly in PSCs 320, 380, 420, and 762. PSCs 380 and 762 are the new expansion group; 420 was eliminated 1-1-14; and 320 was redefined to adults (as of 1/1/14, there are no new 320 children; however, there could still be some children in that code prior to that date). MASBOE 55 decreased ended (about 175,000) with the new expansion. PSC 380 moved to MASBOE 45 and most of PSC 761 moved to 762 in MASBOE 45.	12/22/2014
NJ	Eligibility	Race/Ethnicity	New Jersey reports about 10-12 percent of its eligibles with an unknown race.	NA
NJ	Eligibility	Restricted Benefits Flag	Persons with restricted benefits flag 5 are generally in waivers and do not qualify for full Medicaid benefits. RBF 5 is also used for groups of nursing home recipients with dual code 09 who do not qualify for prescription drug benefits.	NA
NJ	Eligibility	Restricted Benefits Flag	In June 2008, NJ's Money Follows the Person (MFP) program was approved by CMS. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. Enrollment was reported in MSIS starting in Q1 FY09 with the assignment of RBF 8.	5/25/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
NJ	Eligibility	State-Specific Eligibility	The 4th and 5th bytes of NJ's state-specific eligibility group codes are the Special Program Code that applies to home and community-based services (HCBS), emergency services, premium assistance, CHIPRA children, Money Follows the Person (MFP), etc. Premium assistance (officially known as premium support) enrollees have a 5 in the 4th byte of the SSEG to indicate premium assistance; the 5th byte represents the form of insurance (e.g., vision, dental, etc.). There are about 200-300 people receiving this benefit, and premium supports are not reported in the MSIS claims.	2/16/2012
NJ	Eligibility	TANF/1931	Some persons in MAS/BOE 44 receive TANF. This is not an error according to NJ. The state reports that they do receive TANF, but that they are not 1931 eligibles (I.e. they are mapped correctly, and do not belong in MAS/BOE 14).	3/8/2011
NJ	Eligibility	TANF/1931	Between Q1FY14 and Q2FY14, there was an increase in the number of individuals in MASBOE 14 who receive TANF of about 107,000. NJ explained that with the implementation of the ACA, they can no longer distinguish who gets TANF. They collapsed programs to make a larger group, but this does not necessarily mean that they receive TANF. They will 9-fill TANF for this group and fix through correction records.	12/23/2014
NJ	Eligibility	Waivers	Effective January 1, 2009, NJ received approval from CMS to consolidate three Medicaid-supported home and community-based service programs into a single program known as Global Options (GO) for Long Term Care. This waiver program will move enrollees in Waiver IDs '06' and '07' into Waiver ID '12'. NJ incorrectly reported enrollment in the expired Waiver ID '06' through Q1 FY11.	6/16/2011
NJ	Eligibility	Waivers	In Q2FY12, enrollment in HIFA waiver '08' (NJ Family Care and NJ Kid Care increased by about 3,000, NJ explained that waiver 08 now includes new PSC 641-37 (SED children), 762, 763 (childless adults/other adults) that were federally matchable in October 2012.	5/14/2014
NJ	LT	Adjustments	A small percentage of the adjustment claims have the wrong sign on the amount paid field. In Q1FY2011, NJ explained that there are circumstances where they pay (-) on a claim for LTC, so if they are avoiding or adjusting that would have a (+).	6/13/2011
NJ	LT	Adjustments	In Q1FY2011, NJ processed a large LTC mass rate adjustment that would have attributed to the large # of adjustment versus original claims.	6/13/2011
NJ	LT	Admission Date	NJ is unable to report Admission Dates on claims with a Type of Service of ICF/IID, Aged MH and IP Psych under 21 years.	NA
NJ	LT	Leave Days	New Jersey does not reimburse for Leave Days on encounter claims.	2/10/2015
NJ	LT	Managed Care	Transitioning all clients (or most) to managed care is a goal and in fact NJ implemented Managed Long Term Services and Supports in July. However, the State grandfathered those	2/10/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			already in nursing facilities to remain FFS and only new LTC clients go to managed care currently. As of January, 2015, 94% of our clients were managed care.	
NJ	LT	NPI/Taxonomy	Approximately 25% of all Medicaid FFS claims do not have an NPI number or Provider Taxonomy. The state may have to expand the logic for HIPAA claims that should deny these.	2/10/2015
NJ	OT	Adjustments	In 2005, more than 1.6 million adjustment sets are of the 1/2 type (no original, one void, and one resubmit). After reviewing the adjustment sets, we determined that the reason that the original claims are not showing up in these sets is that the service code in the adjustments are 8-filled while the original claim has the correct service code. Service code is part of what makes up an adjustment set so therefore the original isn't part of the sets. Given that the standard adjustments for NJ has been consistently low for a number of years, we believe that this anomaly has existed for some time. Prior to 2005, adjustments to 1-2 adjustment combos was that the void got dropped so only the resubmittal got retained. Because the original to this set is being counted as a non-adjusted claim due to the non-matching service code, usage by people with these adjustments were overcounted. For 2005, the adjustment rules were changed such that the 1/2 combo claims offset each other avoiding the overcounting. In a "normal" 0/1/2 adjustment set, the 1 knocks out the 0 thus retaining the 2, but here the 1 knocks out the 2, so only the 0 is retained. The state needs to be informed that in future submissions, they have to fix these sets when they submit adjustments. The service code that was in the original claim as well as the UB92 code, if any, MUST be included in the adjustment claims.	NA
NJ	OT	Adjustments	NJ's FY10Q4 OT file contains adjustments of some fairly old claims. The number of FFS voided non-crossover claims is over 780,000, up from 40,000 the previous quarter. Most of the voided claims (over 729,000) appear with a TOS=19 (other) and program type=7 (home care waiver). NJ says they processed a mass rate adjustment for the Community Care Waiver for the NJ Division of Disability Services. It was large (over 800,000 claims) and did go back several years.	4/5/2011
NJ	OT	Managed Care Capitation	In Q1FY2007 the state started to report supplemental payments to HMOs for maternal care with a Type of Service of HMO capitation and Type of Claim of Supplemental instead of Type of Claim of Capitation. In 2010, the state reported that these supplemental payments were not just for maternal care through the Maternal Kick program, EPSDT incentive payments, and pharmacy blood products. They say the bulk of the claims are EPSDT, although the bulk of costs are the maternity payments.	4/5/2011
NJ	OT	Type of Service	There aren't any claims with a Type of Service of 34 [Physical Therapy (PT), Occupational Therapy, Speech Pathology and Language Therapy].	12/10/2004

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State	File Type	Rec/Issue Type	Issue	Recorded
NJ	RX	Compound Drugs	All compound drugs are coded as "COMPOUND" in the NDC field.	12/10/2004
NJ	RX	Date Prescribed	Date Prescribed is always missing.	12/10/2004
NJ	RX	Total Non-Crossover FFS claims	In FFY2014 Q2, there was a sharp decline in the total number of Medicaid FFS claims. The General Assistance population moved into Managed Care as of 1/1/2014 (a group of about 35-40K clients). They are a higher than normal group in terms of RX utilization	2/10/2015
NM	Claims	Managed Care Plan IDs	FY2011 forward: NM is adding a leading zero for all plan IDs in claims files so they match the way they are reported in the EL file	3/8/2011
NM	Claims	Service Tracking Claims	Service tracking expenditures are only reported in Q4 files.	7/30/2006
NM	Eligibility	1115 Waivers	In Q4 FY05, New Mexico implemented an 1115 HIFA waiver (waiver ID '02') to cover uninsured parents of Medicaid and M-CHIP children in a partnership with employers in the State. Those eligible for coverage include uninsured parents of Medicaid and M-CHIP children, who are themselves ineligible for Medicaid under the State's current rules, with incomes up to 200% FPL. These are reported to RBF 5 and CHIP code 1. Childless adults up to 200% FPL are covered under the 1115 SCI Demonstration (waiver ID '13').	9/8/2010
NM	Eligibility	1115 Waivers	Under CHIPRA, States are no longer allowed to collect Title XXI funds for childless adults and must instead cover them using Title XIX funds. Starting January 1, 2010, NM moved all childless adults previously covered under the HIFA Waiver (ID '02' and Waiver Type '5') to a new 1115 State Coverage Demonstration Waiver (Waiver Type '1', Waiver ID '13'). Childless adults are reported with CHIP Code '1.' The HIFA waiver was extended and now covers only parents, who are flagged with CHIP Code '2.' Both parents and childless adults enrolled in these two waivers receive state codes 062, 063, and 064. While the State's eligibility file contains a parent indicator that can differentiate between the two populations, the MSIS state code alone cannot differentiate whether a client is a parent or childless adult.	1/24/2011
NM	Eligibility	1115 Waivers	NM originally implemented an 1115 family planning waiver in 1997 to cover uninsured women of childbearing ages 18 through 50 with family income at or below 185% FPL. This waiver was approved in 2003 for extension through September 30, 2009, and again through January 31, 2011. The state stopped serving clients in the waiver after February 1, 2011; the waiver was reported in MSIS through Q3 FY11.	2/24/2012
NM	Eligibility	1115 Waivers	In March 1999, New Mexico implemented a section 1115 waiver for its title XXI M-CHIP program covering children from 185 to 235% FPL. This demonstration permits the state to implement co-payment requirements and a 6-month waiting period for the demonstration population.	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
NM	Eligibility	CHIP	NM had CHIPRA-related SPAs approved in March 2010: revises pre-print for deemed newborns to reflect CHIPRA requirements effective January 1, 2010; implements 12-month continuous eligibility for children younger than 19 effective October 1, 2009; and, lifts waiting period for children and women subject to 5-year bar effective July 1, 2009.	7/8/2011
NM	Eligibility	CHIP	From Q2-4 FY08, there were significant differences in the comparison of adult M-CHIP enrollment in MSIS compared to SEDS (18-37%). Overall, both sources showed increasing counts of enrollment during the year, but SEDS shows a much higher level of enrollment. The state believes that the MSIS counts are reliable and reviewed the criteria used for the SEDS data to better understand why the numbers differ. The two data sources compared extremely well starting in Q1 FY09.	4/6/2012
NM	Eligibility	County Codes	NM has two even-numbered county codes (06 and 28) that are legitimate FIPS codes.	NA
NM	Eligibility	County Codes	NM uses county code 999 for records where county code is unknown.	2/22/2011
NM	Eligibility	Dual Eligibility Codes	Through Q3 FY09, about 1,600 enrollees in MASBOE 32 are assigned restricted benefits flag 1 and about 500 of these enrollees are assigned to dual code 02 (the other 1,000 enrollees are assigned to dual code 00.) These enrollees are in state group 074 (working disabled) and were mapped to MASBOE 42 at our request starting in Q4 FY09.	6/22/2010
NM	Eligibility	Dual Eligibility Codes	Through Q3 FY09, NM did not report persons in dual flags 03 and 06 because these enrollees were not part of the MMIS. The state was able to make this a priority issue and started reporting a low number of individuals to dual codes 03 and 06 in the Q4 FY09 file. Only a small number of people (<50) were reported to these groups through Q4 FY09. By Q1 FY10, counts in these groups reflect MMA	6/22/2010
NM	Eligibility	Dual Eligibility Codes	Through Q2 FY12, a small number of partial dual eligibles were mapped to MASBOE other than 31-32 and to restricted benefits flag '1' (full benefits). The state researched this reporting and found that the cause was people with COE 042 (QI-1) who were identified as full Medicaid enrollees. They determined that the code of 042 is incorrect and that these individuals should be mapped to a different code and should have RBF 1. In Q4FY11-Q2FY12, the state mostly corrected this issue with the exception of approximately 1 individual per month. The issue was resolved starting in Q3FY12.	4/6/2012
NM	Eligibility	Dual Eligibility Codes	In Q1FY14, about 50 partial duals (qualified individuals code 06) were reported to MASBOEs other than 31-32 (occurred mostly in MASBOE 35). These individuals were assigned COE 029.	6/26/2014
NM	Eligibility	Dual Eligibility Codes	In Q1FY14, NM reported several hundred QMB Plus (Dual Code '02') and other full benefit (Dual Code '08') duals to MASBOE 35. NM explained that with the implementation of their new	7/3/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			eligibility system, ASPEN, clients who previously were not evaluated for family planning eligibility are now routinely assessed for this eligibility and assigned to COE 029. MASBOE 35 consists of COEs 029, 030, and 035 (pregnancy and family planning categories) and with the increase in COE 029, there is an increase in the number of clients who have Medicare and/or QMB status.	
NM	Eligibility	Family Planning	On February 1, 2011, NM approved a state plan amendment to transition family planning services formerly provided under their 1115 Family Planning waiver (Waiver ID=03, which expired 1/31/11) to state plan coverage. Through Q3FY11, the state was working to modify the MSIS reporting to correctly capture the clients under their new State Plan services and continued to report family planning clients to the 1115 waiver. As of Q4FY11, NM correctly stopped reporting family planning clients to the waiver and began mapping them to MASBOEs 34-35.	4/6/2012
NM	Eligibility	Managed Care	In Q4 FY05, NM started reporting BHP managed care enrollment when the state started a 1915(b) program that provides comprehensive mental health and substance abuse services to enrollees.	NA
NM	Eligibility	Managed Care	NM implemented an ASO arrangement in December 2004 for prescription drug administration. This plan is not included in MSIS managed care reporting.	NA
NM	Eligibility	Managed Care	NM started a PACE program (Total Community Care) in 2004, but was not able to start reporting any PACE enrollment in its MSIS data until Q4 FY08.	9/1/2009
NM	Eligibility	Managed Care	In Q4 FY08, NM started reporting new enrollment in Long Term Care (Plan Type 05) when the state began providing services under a new coordinated LTC program in August 2008 called CoLTS (Coordination of Long Term Services). This program started in a few counties and expanded to other counties during the following year (enrollment started at about 12,000 in August 2008 and increased to about 36,000 by Q3 FY09).	2/1/2010
NM	Eligibility	Managed Care	Through Q3 FY09, NM reported all enrollment in behavioral health care (Plan Type 03) to one Plan ID: '71006010 – Value Options'. However, in Q4 FY09, all behavioral health care plan (BHP) reporting was switched to a new Plan ID: '38900882' when NM switched from ValueOptions to OptumHealth (new contractor). Effective with that transfer, all COLTS enrollees were considered managed care and included in the managed care plan for BH causing an increase in BHP enrollment from about 310,000 enrollees each month in Q3 FY09, to over 340,000 enrollees each month in Q4 FY09.	2/18/2010
NM	Eligibility	MASBOE	All Years: NM has a state-administered SSI supplement program, which may cause the number of enrollees reported to MASBOE 11-12 to be somewhat higher than the number of SSI recipients reported by SSA.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
NM	Eligibility	MASBOE	2002-2009: In Q1 FY 2002, state-specific eligibility group 074 ("working disabled") was incorrectly moved from MAS/BOE 32 to MAS/BOE 15. The group was returned to MAS/BOE 32 in Q2 FY 2002 and then remapped to MASBOE 42 starting in Q4 FY09.	6/22/2010
NM	Eligibility	MASBOE	Q1 FY10: MASBOE 31-32 increased when NM added reporting for all persons in dual codes 03 and 06.	6/22/2010
NM	Eligibility	MASBOE	2007: Reporting to MASBOE 44 increased at the beginning of Q3 FY07 and then significantly dropped by month 3 of the same quarter. This was caused by an increase in reporting to state group 71 when the state added children and pregnant women eligible for presumptive eligibility during this quarter due to a problem with the eligibility recertification process that had terminated eligibility to clients enrolled in regular Medicaid (SCHIP children were also reported to this state group, but their enrollment stayed consistent).	3/8/2011
NM	Eligibility	MASBOE	NM reports aged disabled persons to BOE 2. We have not raised this issue with the state.	3/8/2011
NM	Eligibility	MASBOE	In Q4 FY11, state group '029' (Family Planning) moved from MASBOE 55 to MASBOE 35, causing a large increase in MASBOE 35 (about 34,000). This is due to the state transitioning family planning services from the 1115 waiver to the state plan.	2/24/2012
NM	Eligibility	MASBOE	In Q1FY14, there was an increase of about 15,000 in MASBOE 35. Enrollment started at about 68,000 in October 2013 and ended at 83,000 in December 2013. The increase primarily occurred in COE 029. NM explained that with the implementation of their new eligibility system, ASPEN, clients who were previously not evaluated for eligibility for family planning eligibility are now routinely assessed for this eligibility and assigned to COE 029. This increase is consistent with the new way of evaluating eligibility.	7/21/2014
NM	Eligibility	Private Health Insurance	For many years NM has reported about 100 enrollees with Health Insurance flag '3' (state purchased insurance). NM indicated that this reporting is being set from the Client Coverage Table (TCCLN TTB) and represents enrollees for whom NM is paying a HIPP payment to purchase insurance for them.	4/6/2012
NM	Eligibility	Restricted Benefits Flag	Restricted benefits code '5' is used for state groups 62, 63, and 64 - NM's HIFA waiver enrollees/M-CHIP adults, since they have some limits to their benefits coverage.	9/22/2008
NM	Eligibility	Restricted Benefits Flag	In MASBOE 34/35, NM assigns state groups 030 (Medical Assistance - Pregnant Women), 031 (Newborns), 032 (133% of Poverty Kids), and 036 (185 % of Poverty Kids) to RBF 1. It assigns group 035 (Pregnant Women (FM 3 = Presumptive Eligibility) to RBF 4.	4/6/2011
NM	Eligibility	Restricted Benefits Flag	Through FY2011, the family planning program counts in Waiver Type 'F', Wavier ID '03', RBF '6', and state code '029' are slightly inconsistent. The state explained that this is because they allow	6/9/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			a one month overlap of state code 029 with code 035. It also explains why the small number of people who are reported to the Family Planning waiver are in eligibility category 035 (pregnancy-related).	
NM	Eligibility	Restricted Benefits Flag	Each month, NM assigns a small number of enrollees to RBF '3' (Medicare/Dual-eligible) and MASBOE 35 (poverty-related/adults. Enrollees with RBF 3 should only be assigned to MASBOEs 31 or 32. NM explained that this was a programming issue and would fix it when they report TMSIS.	7/21/2014
NM	Eligibility	Retroactive/ Correction Records	NM submitted retroactive records in the Q4 FY08 file that add in reporting for the two NM Mia Via waivers for Q2-3 FY08; however, there was an unusually large number of records that essentially went back and replaced the whole original Q2-3 FY08 files (over 450,000 records for each quarter). The majority of these retro records do not change anything from the original file, and the state indicated that it had not meant to send in such a large number of retro records.	3/8/2011
NM	Eligibility	TANF/1931	NM 9-fills the TANF flag.	6/22/2010
NM	Eligibility	Waivers	Not all enrollees in NM's 1915(b) (c) Coordinated Long-Term Services (CoLTS) waiver (waiver ID '12') are eligible for HCBS; however, the state is not able to distinguish between who is not eligible for HCBS (to report them to waiver type '2') and who is eligible for HCBS (to report them to waiver type '4'). Therefore, everyone enrolled in the waiver is assigned to waiver type '4'. CoLTS waiver enrollees are also the new LTC plan (Plan Type 05) that started enrollment in Q4 FY08.	2/1/2010
NM	Eligibility	Waivers	NM does not appear to be following the correct waiver reporting hierarchy. In April 2011, the state confirmed that they allow anyone to enroll in more than three waivers, so the hierarchy is not an issue.	7/8/2011
NM	Eligibility	Waivers	Beginning in Q4 FY08, enrollment declined in NM's 1915(c) Disabled & Elderly HCBS waiver (waiver ID '06', waiver type '3') when these enrollees were moved into the CoLTS waiver. Enrollment in the 1915(c) declined from 3,087 enrollees in September 2007 to only 15 enrollees by June 2008, and the state expected that reporting to the 1915(c) would end completely. The waiver expired 6/30/09. Enrollment reported after this date was an error.	4/6/2012
NM	Eligibility	Waivers	In January 2007, NM implemented two waivers: NM Mia Via NF (waiver ID '10') and NM Mia Via (waiver ID '11'). By the end of FY07, enrollment in waiver ID '10' increased to about 120 individuals and enrollment in waiver ID '11' increased to about 40 individuals. NM did not start reporting enrollment in these waivers until Q4 FY08 (although retro/corr records included in the Q4 FY08 file restored enrollment reporting to these waivers back to the start of Q2 FY08).	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
NM	Eligibility	Waivers	All Years: NM reports about 7,000 individuals to MAS '5' and waiver type '2'. These individuals have WAIVER-TYPE-1 = 1 (1115) and WAIVER-TYPE-2 = 2 or WAIVER-TYPE-3 = 2. Since waiver type 1 is an 1115 demonstration, they are reported to MAS 5. Although the waiver hierarchy dictates that 1915b waivers should be reported before 1115, these individuals should still be reported to MAS 5 since MAS is used to report an individual's eligibility pathway, which in this case in an 1115 demonstration. 1915b waivers are service delivery mechanisms.	7/18/2014
NM	IP	Adjustments	The Q3 IP file in both 2010 and 2011 have a large percentage of adjusted claims.	9/26/2011
NM	IP	DRG	Approximately 20% of the claims do not have DRGs. These include Indian Health Service (IHS) inpatient per-diem claims.	4/4/2011
NM	LT	Type of Service	There is a large decrease in LT NFS claims starting in 2009 due to enrollment in a LT managed care plan. NFS numbers continue to stay lower than expected range through 2010 and Q1FY2011 files.	4/4/2011
NM	LT	Type of Service	There are not any claims with a Type of Service of Mental Hospital for the Aged. A Kaiser Foundation publication says NM covers this group but not IP Psych<22.	7/8/2011
NM	OT	Adjustments	Adjustment claims that are resubmittals are reported as original claims.	7/12/2005
NM	OT	Diagnosis	The diagnosis code is missing on over 40% of FFS claims in 2010 and 2011 files.	4/4/2011
NM	OT	Managed Care	2012Q1-2013Q3 NM is reporting two long term care managed care plan ids in their OT file that are not in their EL file, 016785851 and 021535353.	12/23/2013
NM	OT	Managed Care Capitation	For 2012Q1-2013Q3 there are capitation payments reported for two Long-term care managed care plan ids reported in the EL file, 016785851 and 021535353.	12/6/2013
NM	OT	Type of Service	The percent of clinic claims fluctuates considerably across quarters, probably reflecting billing cycles.	12/10/2004
NM	RX	Total Non-Crossover FFS claims	The total number of FFS claims went from consistently hovering around the mid to high 60,000s to 90,061 and the percentage of FFS, non-crossover files with "None" in program type went from the mid-30s consistently to 50.31%. The state explained that these shifts are almost certainly related to the termination of the NMRx program, a coordinated pharmacy program that was administered by Presbyterian Health Plan. This plan was terminated and these services moved to the FFS program effective August 1, 2010.	3/8/2011
NV	Claims	Data System Change	NV transitioned to a new fiscal agent on December 5, 2011. Upon transition the new fiscal agent assumed responsibility for all data including the outstanding 2010 MSIS reporting.	6/8/2012
NV	Claims	Leave Days	The files do not include leave days.	3/25/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NV	Claims	Type of Claim	Starting in December 2006 there was a small group of HIFA waiver pregnant women whose claims should be classified as state only S-CHIP that are included in the MSIS claims. This is still true in 2009 files.	7/11/2011
NV	Eligibility	1115 Waivers	In December 2006, NV implemented a HIFA 1115/Title XXI/CHIP waiver that covers two adult populations: (1) pregnant women with income between 133-185% FPL through direct coverage, and (2) parents and caretakers of Medicaid or CHIP children with income below 200% FPL by subsidizing employer sponsored insurance.	11/11/2009
NV	Eligibility	1115 Waivers	When NV's HIFA waiver was implemented in December 2006, the state shared data from a progress report to CMS that showed enrollment at 44 pregnant women for the month. Enrollment grew to just over 100 by September 2008. MSIS data, however, are not correctly reporting this enrollment to Waiver ID "PR" (identified as 'HIFA: Pregnant Women Initiative' in NV's waiver crosswalk submitted to CMS). Reporting to this waiver ID started in October 2005 (much earlier than the 12/06 waiver implementation date) and at a much higher level (1,300 - 1,900 enrollees per month). The state confirmed that waiver ID 'PR' did not correctly report HIFA pregnant women through Q4 FY08. Instead, HIFA enrollees can be identified by state eligibility code 'PS' (bytes 1-2). In addition, CMS confirmed that these enrollees are considered S-CHIP and should be assigned CHIP flag 3 and have all monthly data fields (except CHIP flag and state code) 0-filled. Starting in Q1 FY09 forward, enrollment reporting to NV's Waiver ID 'PR' was reliable in MSIS. In addition, NV correctly assigned Waiver ID 'PR' enrollees to CHIP '3'; however these enrollees did not have their monthly data fields 0-filled (including MASBOE). Starting in Q1FY11, NV also started assigning Waiver ID 'ES' (HIFA ESI program) to CHIP flag '3'. The HIFA waiver expired in November 2011.	1/12/2011
NV	Eligibility	CHIP	NV has covered children and adults in its S-CHIP program. NV does not report its child S-CHIP enrollees to MSIS. Adult S-CHIP (state groups 'ES' and 'PS' in bytes 1-2) is provided under a HIFA waiver, which expired in November 2011. In Q1FY07, NV started reporting S-CHIP enrollees to the CMS SEDS system; however, NV only reported some of these adults (group 'PS') as S-CHIP enrollees (CHIP flag 3) starting in Q1 FY09. In Q1 FY11, NV fixed the reporting for state group 'ES' and started assigning them to CHIP code 3 as well. In earlier quarters, these S-CHIP adults can be identified only by state codes 'ES' and 'PS.' Also, when NV started reporting these enrollees to S-CHIP they didn't move them to MASBOE 00 or 0-fill monthly fields. S-CHIP reporting should have ended when the HIFA waiver expired in November 2011; however, it was incorrectly reported through March 2012 (Q2FY12).	3/18/2011
NV	Eligibility	County Codes	Nevada reports eligibles with County Code = 510. These are residents of Carson City. While this FIPS code is technically correct, documentation for the Area Resource File suggests that	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
			researchers might want to recode these persons into county "025."	
NV	Eligibility	County Codes	In 2004, NV started reporting to code 975. The description provided by the state is "Medicaid Office." No further information was provided by the state regarding this "Medicaid Office" category.	1/11/2013
NV	Eligibility	County Codes	In 2004, NV started reporting new FIPS values for Washoe Co and Clark Co that distinguish between rural vs. urban: 703 Urban Clark 731 Urban Washoe 803 Rural Clark 831 Rural Washoe 003 and 031 are no longer reported.	1/21/2014
NV	Eligibility	County Codes	In 2004, Nevada started reporting new FIPS values for Washoe County and Clark County that distinguish between rural vs. urban (see below) as opposed to just one code for the county (003 and 031, which are no longer reported). 703 Urban Clark 731 Urban Washoe 803 Rural Clark 831 Rural Washoe	1/22/2014
NV	Eligibility	Managed Care	NV reports enrollees to Plan Type 08 (other) that are in the state's non-emergency transportation program.	1/12/2011
NV	Eligibility	Managed Care	In month 2 of Q1 FY07 (November 2006), NV shifted enrollees in HMO Plan ID '006202003' (NV Care Link - Southern NV Region) to new Plan IDs '100509996' and '100509997' for Anthem plans in Southern NV and Northern NV. Reporting to these two plans ended in Q2 FY09 (February 2008) as the Anthem HMO contract expired on 02/01/2009. Enrollees were automatically shifted to two new Amerigroup plans, "100515749" (Southern NV Region) and "100515750" (Northern NV Region), or the existing Health Plan of Nevada if requested.	1/31/2011
NV	Eligibility	Managed Care	In Q1FY14, enrollment in plan type 01 (comprehensive) increased by about 13,000 between Oct and Nov 2013. NV explained that this increase was due to Medicaid expansion from health care reform.	6/23/2014
NV	Eligibility	MASBOE	All Years: Although all SSI recipients would qualify for Medicaid, Nevada requires them to apply separately for Medicaid coverage. Monthly data show enrollment in MAS/BOE 11 - 12 about 10 percent below SSI enrollment levels.	NA
NV	Eligibility	MASBOE	2007-2008: During FY07, enrollment in MASBOE 14-17 increased (mostly state-specific eligibility groups 'AF C1', 'AM A5', 'SN, A5') while there was a corresponding decrease in reporting to MASBOE 44-45 (mostly groups 'TR A5', 'TR C5'). This trend continued somewhat in FY08, although reporting to MASBOE 16-17 ended altogether. The exact cause of these changes are unknown, but the state made some changes to its aid categories during this time and might be due to more families qualifying for Medicaid under the TANF/Section 1931 provisions due to recent economic conditions.	11/11/2009
NV	Eligibility	MASBOE	There was an increase of about 22,000 in child enrollment from March to April 2010. CMS indicated that there were 2 possible explanations for this increase. 1. Welfare created centralized	9/21/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			newborn units for newborn enrollments. This happened in March, and so the enrollment could have been postponed with the expected opening of the centralized newborn enrollment units, and then when the units started up, there may have been an influx of newborn enrollment. 2. Also, there was a change to welfare policy in regards to newborns. The eligibility of children is based on their mother's Medicaid eligibility and are considered to have provided satisfactory evidence of citizenship and shall not be required to provide further documentary evidence, even after the OBRA coverage period.	
NV	Eligibility	MASBOE	In Q1FY14, enrollment in MASBOE 34 increase by about 14,000. The increase occurred in codes CH A5, CH1A5, and CH1C5. The state explained that CH1 (effective 10/1/2013) is for the Medicaid expansion program. Also, enrollment has increased in CH because of outreach efforts from health care reform.	6/23/2014
NV	Eligibility	MSIS ID	Through Q4 FY05, NV was not submitting any Temp IDs (even though it was an SSN state). In addition, everyone was reported to have a 9 digit SSN in MSIS data. However, we learned that NV had been reporting pseudo SSNs for many enrollees. Thus, many enrollees had as their MSIS IDs what were really pseudo SSNs. Beginning in Q1 FY06, NV fixed this and began to report about 9 percent of its records with Temp IDs and about 8 percent of its records with 8-filled SSNs. Further analysis indicated that about 15,000 of those with Temp IDs (beginning in October 2005) were children who previously had pseudo SSNs or invalid SSNs used as their MSIS IDs. We think this because about this number of enrollees had two different records: a record with enrollment in months 1-9 of 2005 and a record with enrollment in months 10-12. However, DOB and gender information were not sufficient to link these records.	3/18/2011
NV	Eligibility	Restricted Benefits Flag	Each month, NV reports a small number of enrollees (< 10) to RBF 5. These enrollees are in MASBOE 41-42. NV reported that RBF 5 is used for Medicaid/Ineligible Institutional Benefits with State Eligibility code 'C' (e.g., a child with ineligible parents or caretakers). NV also reports a small number of enrollees (<10) to RBF 9. The state stopped reporting RBF 5 in Q2 FY12 and to RBF 9 in Q3FY12.	4/6/2012
NV	Eligibility	Restricted Benefits Flag	NV started enrolling individuals in its Money Follows the Person demonstration during late 2012; however, the state has never reported and RBF 8. The state explained that MFP recipients are not indicated in the system and that participants are tracked manually by grant staff. The protocol for MFP is that the grant be used for operations, not IT upgrades; therefore, no RBF 8 will be reported in MSIS. NV is implementing a new MMIS in 2019, at which time MFP will be reported if the program is still current.	6/23/2014
NV	Eligibility	Sex	Each quarter, NV reports a small percentage (about 0.5 percent) of records with unknown gender. The state reports that the Welfare division will assign unborns the gender code 'U' and that	12/14/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			there is a lag in time of reporting the birth of the child which results in a lag of the gender being updated to either male or female.	
NV	Eligibility	SSN	Through FY05, NV used "dummy" SSNs (leading zeros and birthdates) for undocumented aliens and newborns in the SSN field instead of 8-filling the SSN field (and assigning a temporary ID number in the MSIS ID field) until a permanent SSN became available. In addition, NV did not assign a temporary ID in the MSIS ID field to provide the link between the temp ID and the SSN. Beginning in Q1 FY06, NV began 8-filling the SSN field and it began to assign Temp IDs.	2/25/2009
NV	Eligibility	TANF/1931	In FY02 and FY03, NV's TANF enrollment data in MSIS are over-reported. In FY04, the state corrected its TANF reporting in MSIS which brought the data consistent with ACF data. In FY05 and FY06, TANF data were over reported again, relative to TANF administrative data. The state believes the differences in reporting might be due to different time frames of the data, how check cancellations are processed, or the methods used for counting caseloads. In FY07, NV's MSIS data on TANF were consistent with ACF TANF counts; however, starting in Q1 FY08, NV essentially stopped reporting TANF enrollment completely. The state restored TANF reporting in Q1 FY09, but this reporting appears to dramatically overstate TANF enrollment. All persons in MASBOE 14-15, 34-35, 54-55 and some in 44-45 are reported as TANF recipients. We asked the state to review this reporting.	4/6/2012
NV	Eligibility	TANF/1931	As mentioned in the Q1-3 FY2009 review, ACF reports only 26,000 TANF enrollees; however, MSIS reported 161,000. In late of 2008 Nevada Welfare decided to eliminate some aid codes and consolidate them into already existing aid codes. Although some may be receiving TANF, not all of those within a certain aid code are receiving TANF. Since there is no indicator in the MMIS of if a recipient is receiving TANF or not, the default has to be made by the aid code. This would be the reason for the increase in TANF reported recipients. The Welfare Division would have more accurate data as to how many recipients are actually receiving TANF benefits.	9/21/2012
NV	IP	Adjustments	There are some FFS adjustments that are probably really service tracking claims since the Medicaid Amount Paid on them is very large. (This anomaly was originally written in 2004, and still appears to be true in 2014 files.)	NA
NV	IP	DRG	The DRG code is always missing as the state doesn't use DRGs for hospital reimbursement.	7/8/2011
NV	LT	Leave Days	NV rarely reported any LT leave days prior to Q3FY2006.	3/25/2011
NV	LT	Type of Service	There are very few claims with a Type of Service 02 (Mental Hospital for the Aged) or 04 (Inpatient Psychiatric Services for those Under Age 22). Still true in 2009 files.	3/25/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NV	OT	Diagnosis	2009 OT files: about 19-27% of claims are missing a DX code, depending on the quarter	3/25/2011
NV	OT	Service Code	Nevada's state-specific service codes are really six bytes long, with one alpha followed by five numeric. However, on the OT files, they seem to have been submitted as one alpha, trailing numeric, with a Service Code Flag of 10. Since they therefore look just like HCPCS codes, it is important to use the flag before determining each code's meaning. This accounts for about 10% of claims in 2009 OT files. (Previously, the codes were 5-numeric, similar to CPT format.)	3/25/2011
NV	OT	Type of Service	For Q1 to Q3FY2009: NV had a large jump in the number of claims for TOS 33 - Rehab services (and as a result, overall number of claims). The state submitted documentation that describes why there is a large jump. Two provider types were newly allowed to provide TOS 33: for this time period.	7/8/2011
NV	OT	Waivers	In Q3 and Q4 2013, the number of claims triples and almost doubles with respect to the previous quarter. Effective 1/1/2013, the state required providers to provide daily attendance detail for each person receiving services. The requirement caused the number of claims to increase from one monthly claim per person to approximately 22 (work days) claims per person per month. There was an increase in the number of claims at the end of May 2013 because bills were submitted back to the effective date once the database and processes were in place. NV says there will be "an increase in 2013Q3, Q4 and ongoing."	12/23/2013
NY	Claims	Adjustments	Each quarter New York State processes a large number of Retroactive Rate Adjustment transactions. The amount paid to Rate Based providers is provider and location specific. New York State retroactively adjusts the amount for any number of Rate Codes for a specific period of time for specific providers and locations. Even though these transactions are of a Mass Adjustment variety, they are applied at the claim level. Unlike provider submitted adjustments, the original claim is not credited and replaced with another debit transaction with a different ICN. Instead, a transaction with the same ICN is generated with only the differential in the payment. This differential may be either positive or negative. So if a claim originally paid $100, and through a retroactive rate adjustment was paid an additional $10, there is not a credit transaction for $100- and a replacement debit for $110+ each with a new ICN and a referral back to the ICN of the original claim. Instead there is only a transaction with the original ICN in the amount of $10+. When the ICN was added to the MSIS Files, a conference was held with CMS to discuss how these transactions should be handled, and the decision was made to submit the original ICN in both fields and to identify the claim as a Positive adjustment if the differential is positive and as a Negative adjustment if the differential is negative.	7/30/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
NY	Claims	Covered Days	MEDICAID-COVERED-INPATIENT-DAYS are missing on IP claims where there is another primary third party payer (other than Medicare) and Medicaid is only responsible for coinsurance or deductible.	7/30/2014
NY	Claims	Covered Days	The eMedNY claims processing system populates Medicaid Covered Inpatient Days only for days that are paid for by New York State Medicaid. For all of the days in hospital that are the responsibility of the managed care plan to reimburse, the Medicaid Covered days are set to zero.	7/30/2014
NY	Claims	Diagnosis	Through at least FY2012, NY reports noticeably high frequencies of diagnosis codes 7999 and 78009, diagnosis codes that are basically considered filler because they do not appear to be used appropriately. NY confirmed that these are the diagnosis codes received on claims from providers.	12/3/2012
NY	Claims	Managed Care Encounters	New York State captures the amount paid to the plans for encounters, but does not pass that field into MSIS process. Plans may submit charge amounts on encounters and that amount is passed into the MSIS process as Amount-Charged. If no charge amount is submitted, then zero is reported in the MSIS Amount Charged.	7/30/2014
NY	Claims	Provider Taxonomy	Through at least FY2014Q3 there are no NY claims or encounters reported with provider taxonomy codes. The state of New York does not collect provider taxonomy as part of its claims collection process	11/12/2014
NY	Claims	Revenue Code	When MSIS was initially implemented at the Legacy MMIS, Revenue Codes were not submitted on NYS Medicaid Claims, so New York State was allowed to submit MSIS Data without Revenue Codes. With the implementation of the new MMIS, eMedNY, in March of 2005, the Legacy MAR subsystem which is where the MSIS files are produced, was ported to the eMedNY system with minimal changes because MAR was intended to be transitioned to the Medicaid Data Warehouse. The transition has never taken place, and even though, under HIPAA, Revenue Codes are now available, the system changes were never made to include them. Such changes would require significant staffing and systems resources to accomplish with limited benefits as Revenue Codes are not utilized in the eMedNY adjudication processes. New York expects to begin reporting revenue codes in their T-MSIS rollout.	7/30/2014
NY	Claims	Supplemental Claims	NY submits their Public Goods Pool and Lombardi claims as supplemental payments in the IP and OT files as they are supplemental payments not adjustments to the regular claims. In Q1FY2006 they submitted almost 2 million Public Goods Pool IP retroactive rate adjustments as debit claims.	NA
NY	Eligibility	1115 Waivers	NY implemented its 1115 Partnership Plan Waiver in 1997. The initial waiver enrolled most of the Medicaid population in managed care. This waiver also extended Medicaid to adults in the state's Safety Net programs (previously Home Relief)	10/31/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			(including state groups 13, 15, 17, 18, 19, 21, 39, and 60). The Safety net program extends Medicaid coverage to childless adults with incomes up to 78 percent of FPL. Enrollees in these groups are reported to MAS 5 if they are between the ages of 21 and 64. Some additional individuals in these groups are reported to the Waiver if they are placed in managed care under 1115 authority. In October 2001, another group of low-income uninsured adults, with or without children, was added under the Family Health Plus program (state groups 68, 69), although this population qualified for a more restrictive set of benefits (not LTC, for example). Childless adults with incomes up to 100 percent of FPL and parents with incomes up to 150 percent of FPL are covered under Family Health Plus. Enrollees receive coverage through managed care plans. Finally, in October 2002, NY's waiver was expanded to include family planning-only coverage (state group 56).	
NY	Eligibility	1115 Waivers	New York's Section 1115 Partnership Plan waiver has been operating since 1997. The initial plan enrolled most of the State's Medicaid population in mandatory managed care. The waiver also expanded Medicaid coverage to adults in New York's Safety Net Assistance (SNA) Program, including those in SSGs 13, 15, 17, 18, 19, 21, 39 and 60. Enrollees in these groups are reported to MAS 5, if they are between the ages of 21 and 64. Essentially, SNA covers childless adults that would have been classified as Home Relief Cases before implementation of the Federal Welfare Reform Act of 1996. The Partnership Plan waiver also granted 24 months of Medicaid coverage to women that were losing coverage subsequent to giving birth. In 2001, New York implemented a waiver amendment, the Family Health Plus Program (FHPlus). FHPlus expanded coverage to childless adults with incomes up to 100 percent of FPL and to parents with incomes up to 150 percent of FPL. Before 2001, these individuals were covered under New York's SNA. In 2002, the state amended the waiver again, adding the Family Planning Expansion Program. The expansion offered family planning services to individuals with incomes up to 200 percent of the FPL. New York began to transfer its SSI population into mandatory managed care in 2005. It completed a phased enrollment in 2007. CMS renewed New York's Partnership Plan Waiver in 2006. At the same time, it approved a new 1115 Demonstration Waiver, the Federal-State Health Reform Partnership (F-SHRP). F-SHRP requires the state to realize roughly $3 billion in gross Medicaid savings over the waiver's five-year demonstration period. At the same time, New York shifted its SSI population into the F-SHRP waiver. New York views F-SHRP as a "system change". Consequently, it does not report it to MSIS. In 2007, New York further amended FHPlus to include a premium assistance program. Under the waiver, if an FHPlus enrollee has access to employee sponsored health insurance (ESHI), the state must evaluate the coverage to determine if it is cost effective for the state to pay the employee's share of the premiums instead of providing Medicaid	10/3/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			coverage. The state added an HCBS Expansion program as an alternative to institutional care for some adults with significant medical needs in 2010. CMS renewed the Partnership Plan in 2010, adding hospital-medical homes, preventable readmission initiatives and an indigent care pool to fund the State's program for uncompensated care. In September 2011, March 2012, and August 2012, CMS approved three additional amendments to the Partnership Plan. These amendments implement recommendations made by the Governor's Medicaid Redesign Team (MRT). They added the following elements to the plan: (1) enrollees have 30 days to select an MCO before they are auto-assigned to one; (2) individuals with chronic conditions under active treatment can continue receiving services from their specialist for six months; (3) certain exemptions and exclusions were eliminated (for example, people temporarily living outside their social services district); (4) individuals eligible for emergency Medicaid services are exempt from managed care; and (5) duals who need more than 120 days of home and community based care will be enrolled in managed long-term care.	
NY	Eligibility	CHIP	NY operates a combination Children's Health Insurance Program that incorporates separate CHIP and Medicaid-expansion CHIP components. As of March 2009, New York amended separate CHIP eligibility rules to increase the effective financial eligibility standard from <= 250% FPL to <= 400% FPL. The state does not report separate CHIP enrollees in MSIS. Effective November 11, 2011, NY implemented a Medicaid-expansion CHIP that includes children, age 6-18 years with family incomes from 100% FPL up to133% FPL. The state transitioned children into this program from separate CHIP. The state assigned all of these children to SSG '86' and MASBOE '34'. At the time of implementation a state contact estimated that the expansion would include about 80,000 enrollees. However, the total has been substantially greater than expected. Average monthly enrollment was 147,000 in Q4 FY 2013.	11/15/2013
NY	Eligibility	CHIP	Enrollment in New York's M-CHIP [CHIP-CODE '2'] program increased substantially between October 2011 and December 2013. The state reported 99 M-CHIP enrollees to MSIS in October 2011. By December 2013 the number of enrollees had increased to about 150,400. The state indicates that this change in reporting is accurate.	5/21/2014
NY	Eligibility	Date of Birth	NY reports about 60,000 – 70,000 enrollees with no DOBs each quarter. The state assigns most, but not all, of them to SSGs for children. NY believes that most enrollees in the group are unborn children. The state assigns them an ID number to ensure that they are eligible for services.	11/15/2013
NY	Eligibility	Family Planning	Enrollment in the New York Partnership Family Planning Program [MSIS Waiver Type 'F' / MSIS Waiver ID '10'] declined by nearly one-third between Q1 and Q3 FY 2014. Total enrollment was 41,300 in October 2013 versus 28,200 in June	12/5/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			2014 [-31.9%]. In November 2012, New York moved its Family Planning Benefit Program [FPBP] into the State Plan. According to the state, it is likely that recipients who were no longer eligible for MA applied for comprehensive health insurance through NYSoH [New York State of Health]. Clients reported in the FP waiver program are those with Coverage Code '18' ['Family Planning Services Only'] transitioning to Coverage Code '27' [Family Planning No transportation], which is a federally non-participating group.	
NY	Eligibility	Managed Care	New York's Senior Care Plan is reported as "other" in CMS data, but as "comprehensive" in MSIS.	NA
NY	Eligibility	Managed Care	As of Q2 FY 2010, NY no longer assigns enrollees to Plan Type '03' (behavioral). It is our understanding that behavioral health claims are now processed as clinic claims.	11/15/2013
NY	Eligibility	Managed Care	Each month, NY assigns some enrollees to managed care plans that have valid Plan IDs, but Plan Type '88' (Not Applicable). In December 2009, the total number of enrollees in this group was about 5,600. It increased to 7,000 during Q1 2011, 13,000 during Q1 2012, and 17,700 in Q4 2013. The state indicates that the Plan IDs are no longer in the state's list of plans. It has assigned the enrollees to new plans where the Plan Type has not been identified yet.	11/15/2013
NY	Eligibility	Managed Care	NY assigns a small number (<= 200) of partial duals each month to a managed care plan. The state says that this is 'random noise' that it cannot eliminate.	11/15/2013
NY	Eligibility	Managed Care Plan IDs	New York reported several new long-term care managed care plans during Q2 – Q3 FY 2014. The new plans and plan IDs are: Elderplan DBA HomeFirst ['03253707']; United Healthcare Personal Assist ['03439663']; Centers Plan for Healthy Living ['03506989']; Hamaspik Choice, Inc. ['03522947']; VNA Homecare Options MLTC ['03529059'].	12/5/2014
NY	Eligibility	MASBOE	2009: Starting in Q1 FY 2009, NY included PRUCOL and qualified aliens in the 5 year ban reported to state aid category 76 in its MSIS reporting. Only those receiving emergency services are included. This caused increases in MAS 4. There were also increases in reporting to MASBOE 31-32 with the new inclusion of partial duals trying to spenddown. There were also increases in MASBOE 14-15 and a decrease in reporting to MASBOE 34 (causes unknown). MASBOE 24-25 also declined during FY 2009.	9/8/2011
NY	Eligibility	MASBOE	The State budget included a Medicaid expansion for parents from 150 to 200 percent of the FPL and for childless adults from 100 percent to 200 percent of FPL. The expansion effective date was April 2010 (Q3 FY10). The budget also included several simplification measures, including elimination of the face-to-face interview for children and parents and the elimination of finger printing and the asset test for parents.	10/31/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NY	Eligibility	MASBOE	Enrollment in BCCPTA reported to MSIS has gradually, but steadily, increased since Q4 FY 2010. Average enrollment for Q4 FY 2010 was about 810 per month. This increased to 1,000 per month in Q4 2011. Average enrollment in Q4 FY 2013 was about 1,350. There appears to be a discrepancy between the number of BCCPTA enrollees reported to MSIS and the number reported to CMS. The number of enrollees reported to CMS reflects the cumulative count for the quarter, while the number reported to MSIS reflects the total on the last day of the month referenced.	11/15/2013
NY	Eligibility	MASBOE	Reporting to MASBOE '34' [poverty related/child] increased substantially (+26.5%) from Q1 FY 2012 to Q4 FY 2013. Average enrollment increased from about 429,600 per month in Q1 FY 2012 to 543,600 per month in Q4 FY 2013. The increase coincided with implementation of a new Medicaid-expansion CHIP that moved some separate CHIP enrollees to M-CHIP	11/15/2013
NY	Eligibility	MASBOE	The number of women and children assigned RBF '4' (restricted/pregnancy-related) declined 26% between Q4 FY 2010 and Q4 FY 2013. The average number of enrollees assigned to RBF '4' was 7,100 in Q4 FY 2010; it was 5,250 in Q4 FY 2013. Virtually of the enrollees were assigned to either MASBOE '44' or MASBOE '45'.	11/15/2013
NY	Eligibility	MASBOE	Several enrollment changes occurred in New York between Q3 FY 2014 and Q1 FY 2015. Enrollment in MAS 1 [Cash Assistance] fell by 425,000 between April and December 2014. Enrollment in MASBOE 14 declined from about 1.2 million to 913,000. Most of the change was in State Specific Groups 2130 and 3230. Enrollment in MASBOE 15 fell from 497,000 to 395,000, primarily in SSG 3230. Enrollment in MAS 2 [Medically Needy] fell by 95,000 over the same period. We can attribute most of the decline [-74,400] to MASBOE 25, specifically in SSGs 2701, 2730, and 9130. We can attribute the rest of the decline to SSGs 2701 and 2730 in MASBOE 24. Enrollment in MAS 3 [Poverty-related] grew by more than 1.2 million. Enrollment in MASBOE 34 rose from 622,800 to 1.1 million, mostly in SSGs 3130, 4430, and 4530. Enrollment in MASBOE 35 grew from 499,900 to 1,264,000 in SSGs H001, H030, H101, H130, 9001, and 9030. Enrollment in MASBOE 55 [1115 Demo/Adult] fell by about 475,000. Most of the decrease was in SSGs 2130, 3930, and 6934. According to the state, the majority of the changes were a result of Project "EP1765 WMS/NYHX Transition and Client Transfer". Aid Categories 90, H0 and H1 were new categories in January 2014. Aid category '90' is a new WMS [Welfare Management System] Category, while H0 and H1 are new categories from the Health Exchange (NYSoH). It is to be expected that they would show increases throughout the year as people are enrolled into the new Categories. The state transitioned many of these people from a previous Aid Category. This accounts for some of the decreases over this period. Typically, in these cases, people were not converted, but put into a new category as they recertify during the year. Along with	5/12/2015

State	File Type	Rec/Issue Type	Issue	Recorded
			that, Aid Category '69' [FHP] was in the process of being phased out, which accounts for the decrease in the '6934' Combination. Many of the FHP clients were also transitioned to one of the new categories. Lastly, Aid category '91' was a new Aid Category that was implemented mid-year. That category was populated with clients in Aid Categories '17', '18', '19' & '21' who were not entitled to the enhanced FFP that was given to clients ages 19 - 64 in those categories as of 01Jan2014. In this case, since we were claiming enhanced funding for clients that weren't entitled to it, a conversion was done to get these clients out of those Categories and into '91'. The conversion occurred in mid to late June. Upstate WMS converted their clients with a begin date of 01Jun2014, while NYC WMS did their conversion retroactively back to January 1st and in some cases even earlier.	
NY	Eligibility	Private Health Insurance	In Q2 FY 2010, the number of enrollees assigned HEALTH-INSURANCE '2' (private insurance) increased substantially compared to Q1 FY 2010. The average monthly total for Q1 FY 2010 was 309,200 enrollees. This increased to 441,800 per month in Q2 FY 2010 (+42.9%). Since Q2 FY 2010, the total has steadily increased. Average enrollment of individuals with HEALTH INSURANCE '2' was 534,800 in Q2 FY 2013. This reflects an increase over the base year of 73.0%.	11/15/2013
NY	Eligibility	Race/Ethnicity	The percentage of enrollees without a valid RACE-CODE [that is, with RACE-CODE-1 through RACE-CODE-5 = '0'] increased substantially between Q4 FY 2013 and Q3 FY 2014. In Q4 FY 2013 only 6.5% of the enrollees had no Race. This increased to 11.4% in Q2 FY 2014 and 14.7% in Q3 FY 2014. We found a similar pattern in reporting ETHNICITY-CODE. The percentage of enrollees with an 'Unknown' Ethnicity increased from 3.1% in Q3 FY 2013 to 7.6% in Q2 FY 2014. It increased further to 10.8% in Q3 FY 2014. The state indicated that MSIS processing has not changed. However, roughly two-thirds of the clients who enrolled in Medicaid via the New York State of Health [NYSoH] Marketplace reported no Race or Ethnicity information. The field is not mandatory on the HIPAA 834 transaction form. This raised the overall percentage of enrollees with no Race or Ethnicity.	12/5/2014
NY	Eligibility	Restricted Benefits Flag	Effective Q3 FY 2002, most of the persons assigned restricted benefits code 5 were in MASBOE 34 and 55 and state groups 68-69 (Family Health Plus). They qualified for a more restricted benefit package (no LTC, for example). When NY moved to a new data system in Q1 FY 2005, the number of individuals assigned RBF 5 increased substantially. About 4,000 children and 11,000 adults in MASBOE 14-15 were assigned this code. The state coverage codes indicate that in addition to Family Health Plus, enrollees receiving other capitated services receive RBF 5. Some persons in the medically needy group also receive RBF 5. The state assigns RBF 5 to persons in several limited benefit coverage codes. Information about types of benefits restrictions are included in NY's 2-byte category codes. NY is looking into adding these codes.	9/8/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
NY	Eligibility	Restricted Benefits Flag	NY assigns RBF '6' to enrollees in the state's Family Planning program. Between Q4 FY 2010 and Q4 FY 2013, total FP enrollment has been in the 37,000 – 43,000 range. Prior to Q1 FY 2013, NY assigned virtually all of these enrollees to SSG '56', MASBOEs '54' or '55', and Waiver Type 'F'. In Q1 FY 2013, the state began reporting them to SSG '5618'. It still maps them to MASBOEs '54' or '55' and Waiver Type 'F'.	11/15/2013
NY	Eligibility	Restricted Benefits Flag	NY has reported some inconsistent mapping of RBFs and Dual Codes since at least FY 2010. The state assigns about 5,000 Full Duals each month to RBF '3' (restricted – Medicare dual). It assigns about 1,500 to 2,000 Partial Duals each month to RBF '1' (full benefits). NY believes that this coding reflects the way that claims are processed for QIs and QDWIs.	11/15/2013
NY	Eligibility	Restricted Benefits Flag	NY received a Money Follows the Person Federal Rebalancing Demonstration grant in January 2007. The state began to enroll individuals in the program in December 2008. It started reporting them to MSIS in February 2009 (Q2 FY 2009). Initial enrollment in Q3 FY 2009 was low, about 24 per month. Enrollment increased to about 190 per month by Q4 FY 2011. Average enrollment for Q4 FY 2013 was about 275 per month. MFP enrollees are individuals with long-term care needs who are transitioning from an institution to the community. Qualified home and community-based services for these enrollees receive an enhanced FFP.	11/15/2013
NY	Eligibility	Restricted Benefits Flag	Between Q2 and Q3 FY 2014 enrollment in RBF '2' declined substantially. The number of enrollees in RBF '2' fell 24.1%, from 60,500 in January 2014 to 45,400 in June 2014. According to the state, it derives RBF from the client's Medicaid Coverage Code with values of '07' for 'Emergency Services Only'; '11' for 'Legal Alien – Full Coverage'; and '24' for "Comm Cov No LTC Alien 5 Yr Ban'. The state says that the numbers it reported are accurate. The drop is almost exclusively due to a decline in clients with Coverage Code '11'. Enrollment in Coverage Codes '07' and '24' has been nearly constant. Right now NYSoH [New York State of Health], the state's health exchange, does not assign anyone to Coverage Code '11'. It assigns enrollees to '01' [Full coverage] or '30' [Managed Care].	12/5/2014
NY	Eligibility	Sex	Each quarter the state assigns about 60,000 – 65,000 enrollees to SEX-CODE 'U' (Unknown). This group makes up less than 1.5% of the state's total Medicaid population. We understand that the group includes unborn children.	11/15/2013
NY	Eligibility	SSI	Relative to the number of aged SSI recipients, New York is reporting about 15 to 20 percent more eligibles under MAS/BOE 11. NY has a state administered SSI supplement program for some SSI recipients, which may account for some of the difference.	NA
NY	Eligibility	State-Specific Eligibility	New York began to report Eligibility Group '8926' to MSIS in April 2013. In December 2013 it assigned about 18,400 enrollees to this aid category. The SSG includes incarcerated	5/21/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			individuals who are temporarily released to a hospital, when a prison infirmary cannot provide necessary treatment. The state pays for these services only when they are provided in an inpatient hospital setting. This includes medical services provided in an inpatient hospital and physician services coded with Place of Service '21' [Inpatient Hospital].	
NY	Eligibility	State-Specific Eligibility	According to information from the state, New York's Eligibility Group is a composite of Client Category of Eligibility [COE] Aid Category Code, COE Medicaid Coverage Code, and two filler characters. Based on this explanation, New York should be reporting Eligibility Group as a 6-character Alpha-Numeric value. However, our DQ & validation only show it as 4-character Alpha-Numeric with no filler. For example, Eligibility Group '6934' = Aid Category Code '69' [PHP Parents / 19 – 20 year olds / 150% FPL FP] + Medicaid Coverage Code '34' [Family Health Plus (U)]. The state sent tables with current values for Aid Category and Medicaid Coverage Codes in May 2014.	5/23/2014
NY	Eligibility	State-Specific Eligibility	The number of individuals eligible and enrolled in Medicaid increased 9% between Q1 and Q3 FY 2014. Total enrollment, excluding MASBOE '00', went from 5,240,000 in December 2013 to 5,710,200 in June 2014 [+470,200]. Enrollment in MASBOEs '34' [Poverty-related / Child] and 35 [Poverty-related / Adult] rose sharply [+809,200], while enrollment in MASBOE '55' [1115 Demo / Adult] fell by 340,000. Concurrent with the increase in enrollment noted above, we found a large number of new State Specific Groups [SSGs]. Most of the new groups had only a few enrollees. However, eight of them accounted for nearly all new enrollment: 'H001', 'H030', 'H101', 'H130', '4301', '4330', '9101', and '9130'. There were 294,600 enrollees in SSGs beginning with 'H'. There were 30,600 in SSGs starting with '91' and 21,900 in those starting with '43'. According to the state, the first two characters of the SSG are the Client Aid Category, while the second two are the Client Medicaid Coverage Code. Aid categories 'H0' and 'H1' were added as part of the state's implementation of the New York State of Health exchange and '91' was added as part of a follow-on project later in the year. The state indicated that SSGs '4301' and '4330' were not new.	12/5/2014
NY	IP	DRG	New York uses a DRG reimbursement methodology except for certain psychiatric and rehabilitation services that NY pays using per diem.	8/22/2005
NY	IP	DRG	The DRG reported on many managed care encounters, increasingly since at least FFY2010Q1 when the state first implemented APR-DRG reimbursement, contains a suffix that likely represents an APR-DRG severity modifier.	11/12/2014
NY	IP	Service Tracking Claims	There are a large number of service tracking claims in the IP files. These are mostly Lombardi program payments. In 1999-2001 the Type of Claim was changed to 9 (Unknown) during the Valids processing because the MSIS IDs did not start with an "@" as required for service tracking claims. These claims can be	12/10/2004

State	File Type	Rec/Issue Type	Issue	Recorded
			identified with a Type of Claim of 9 and an Adjustment Indicator of 5 (Gross Adjustment).	
NY	LT	Adjustments	On some original and resubmittal claims, the Medicaid Amount Paid is negative. Likewise, on some voids and credit adjustments, the Medicaid Amount Paid is positive. This is OK according to the state, who notes: "Under our system, Long Term Care claims may be negative due to presence of a patient participation amount on our recipient master file. The patient participation amount is the amount a recipient is responsible for toward payment of his long term care services. If, for example, a nursing home submits a claim for $500 and the patient participation amount on our file is $600, the paid claim amount will be a negative $100. The same applies to resubmittals and debit adjustments. As far as voids and credit adjustments, we agree that they should generally be negative, but there may be some exceptions with long term care claims."	12/15/2004
NY	LT	Adjustments	In 2005, there is a big increase in LT claims for NY. We believe that the reason why the MSIS LT claim counts are so varied is due the increase in the number of adjustment claims. They tend to do rate adjustments for many facilities periodically. In Q1 and Q2FY2004 there were about 2.5 million original FFS LT claims per quarter. From Q3FY2004 to Q3FY2008 there are between 2.7-2.9 million claims per quarter.	4/28/2013
NY	LT	Admission Date	LT claims with TYPE-OF-SERVICE = 05 or 07 are not reported with a valid admission date.	12/27/2012
NY	LT	Bundled Payment	The New York bundled nursing home rate includes maintenance drugs. Therefore claims for those drugs do not appear separately in any file.	3/3/2005
NY	LT	Covered Days	Most LTC non-crossover claims are billed weekly.	6/9/2009
NY	LT	Covered Days	Some LT claims properly do not have covered days as they are claims for non-bundled services. Until Q1FY11 about 50 percent of all nursing facility claims were reported with zero covered days. After Q1FY11 fewer than 10 percent, sometimes less than 2 percent were reported with zero covered days.	4/28/2013
NY	LT	Covered Days	Through at least Q3FY2014 NY does not report covered days on managed care encounters.	11/12/2014
NY	LT	Crossovers	Until Q2FY05 New York consistently reported more than 30,000 crossover claims paid a total of about $20 million each quarter in the LT file. From roughly Q3FY05 through Q1FY07 there were about 1,500 crossover claims paid a total of $2 million each quarter. From Q2FY07 through Q4FY09 there were more than 30,000 crossover claims paid a total of about $20 million each quarter. From Q1FY10 through Q2FY12 there were about 1,500 crossover claims paid a total of about $2 million each quarter. From Q3FY12 to present there are more than 30,000 crossover claims paid a total of about $20 million.	1/15/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
NY	LT	Medicaid Amount Paid	Some original claims have a negative amount paid. This was the result of a system problem that deducted too much money from the claim payment amount when an individual's Net Available Monthly Income (NAMI) is more than the amount owed to the nursing facility. This situation was corrected using adjustment claims. It does mean that special rules are needed to be developed to properly adjust LT.	12/6/2012
NY	LT	Medicaid Amount Paid	Payment amounts for FFS original claims are often very high relative to LT claims in other states. The Data is correct as reported. The higher than expected maximum values are due to long stay Inpatient Psychiatric or Mental Hospital claims.	7/30/2014
NY	LT	Medicaid Amount Paid Avg	The per diem rate paid for Rate Code 4100, which is the primary rate for State Operated ICF DD Facilities, was cut by > 60% effective for Dates of Service of 4/1/2013 and after. Due to lag in claim submission Q3 of 2013 was only down slightly, but Q4 of 2013 and Q1 of 2014 show substantial decrease. Overall ICF-DD Expenditures for the State Fiscal year 2013-04-01 - 2014-03-31 were down by 36.7% from previous year with Expenditures for State Operated Facilities down by 63.4% for the same period.	7/30/2014
NY	LT	NPI	Through at least FFY2014Q1 New York reported claims for assisted living facilities in the LT file. These types of providers are not required to obtain or use an NPI. In FFY2014Q1 there were over 300,000 LT claims missing NPI. The state confirmed that there were over 300,000 claims for assisted living facilities in that quarter as well.	11/13/2014
NY	LT	Patient Liability	The percent of claims with Patient Liability is much lower than expected. When nursing facilities report NAMI in the incorrect fields on a claim, the NAMI amount is not reported as PATIENT-LIABILITY in MSIS.	12/10/2004
NY	LT	Supplemental Claims	From FY01 through Q1FY10 all supplemental claims were for non-bundled Aged Mental Hospital for the Aged and Inpatient Psychiatric Care for individuals < 21. In prior quarters these supplemental claims are reported as service tracking claims. In Q1FY10 NY began reporting a large number of supplemental payments for nursing facilities.	4/28/2013
NY	OT	Crossovers	There are no claims with MEDICARE-COINSURANCE-PAYMENT greater than zero dollars ($0).	1/24/2013
NY	OT	HCBS Waiver	From at least FY2007 through FY2013Q3 there are consistently between 30,000 and 40,000 MSIS IDs that are reported in the EL file with an HCBS waiver enrollment but not reported in the OT file on any HCBS waiver claims, though they are reported on claims with types of service "Other" (often used to represent HCBS, HCBS waiver, and other atypical services), transportation, personal care, and targeted case management. The state appears to have addressed the issue in the FY2013Q4 OT file as the total number of HCBS waiver enrollees stayed the same and the percentage of HCBS waiver enrollees with HCBS waiver	6/26/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			claims increased. Average paid for individuals with HCBS waiver enrollment and no HCBS waiver claims also decreased.	
NY	OT	Managed Care Capitation	In Q1-3FY2006 NY reported some HMO capitation claims as PHP capitation. This was corrected in Q4FY2006. They also appear to be using provider identification numbers instead of plan numbers in the PLAN ID field.	12/22/2006
NY	OT	Managed Care Capitation	NY's Primary Care Partial Capitation Program's (PCPCP) capitation payments have always been reported with TYPE-OF-SERVICE=20 indicating an HMO capitation. They should have been identified as either TYPE-OF-SERVICE = 21 or 22. Individuals enrolled in this program are enrolled in PLAN-TYPE = 07 (PCCM) because the program is identified by CMS as a PCCM program but the capitation covers primary care and case management. The capitation payment for PCCMs in other states usually only covers case management. PCPCP capitation payments can only be identified by their unique plan IDs which represented organizations rather than individual primary care providers. NY also submitted encounters for PCPCP unlike PCCM programs in other states. Since at least 2009 and likely before, the PCPCP represented a very small portion of NY's managed care program. On August 31, 2012, NY ended the PCPCP.	12/5/2012
NY	OT	Managed Care Encounters	NY reported encounters with PACE plan IDs. The plan IDs are unique to PACE plans. PACE plan IDs are not associated with any other types of managed care in NY. The number of encounters with PACE plan IDs seems appropriate for the number of people enrolled in PACE. Historically, it has been rare for a state to collect encounters from PACE providers and even more rare for those encounters to be reported in MSIS.	12/6/2012
NY	OT	Managed Care Plan IDs	NY has always submitted an eight-digit plan ID in claims files and a ten-digit plan ID in the EL file. The last two digits of the EL plan ID indicate the benefit package for a particular managed care enrollment. The first eight digits of the EL plan ID match the plan ID that appears on claims. In Q3FY12 more than half of all capitation claims and encounters were reported with a 10-digit plan ID. The percentage of capitation claims and encounters reported with a 10-digit plan ID rose after Q3FY12.	12/4/2013
NY	OT	Place of Service	The Place of Service is 12 (Home) on 44 percent of the claims, which appears to be correct since most of these claims are for Home Health and Personal Care Services.	12/10/2004
NY	OT	Service Code	Roughly 80% of the FFS Non-crossover Original Claims have "local" service codes (SERVICE-CODE-FLAG = '10' or '12'). Most of them are state-specific rate codes.	4/22/2011
NY	RX	Total Non-Crossover FFS claims	NY has carved-out many pharmacy benefits from managed care as far back as FY2000. On October 1, 2008, NY expanded their managed care pharmacy carve-out causing the number of fee-for-service RX claims in MSIS to substantially increase and managed care RX encounters to substantially decrease. On October 1, 2011, NY carved the majority of Medicaid pharmacy	12/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			benefits back in to managed care plan benefits causing the number of fee-for-service RX claims to substantially decrease and the number of managed care RX encounters to substantially increase. The ability to collect drug rebates for managed care pharmacy benefits, a component of the Affordable Care Act which became effective in 2010, influenced this shift from managed care carve-out to carve-in.	
OH	Claims	Data System Change	The new OH MMIS was implemented August 2, 2011. Q4FY2011 MSIS files were the first to be reported with NPI and taxonomy. It was also the first quarter that managed care encounters were reported.	NA
OH	Claims	NPI	NPI is missing on all claims through Q3FY2011 when the state implemented a new MMIS.	2/24/2014
OH	Claims	Provider Taxonomy	Provider Taxonomy is missing on all claims through Q3FY2011 when the state implemented a new MMIS. The percentage of claims with taxonomy after Q3FY2011 is low (<20 percent).	2/24/2014
OH	Eligibility	CHIP	Ohio has an M-CHIP program, but no S-CHIP program. Ohio reported some M-CHIP (about 5,000) children to MAS/BOE 12 (as well as MAS/BOE 34) through Q3 FY11. When the new MITS system was implemented in Q4 FY11, Ohio began no longer reporting to M-CHIP to MAS/BOE 12 and reporting M-CHIP children to MASBOE 34 and 44 (<150-200% FPL). Since Ohio is a 209(b) state, some disabled children do not qualify for Medicaid through the SSI-related provisions. However they are able to qualify for M-CHIP	4/10/2012
OH	Eligibility	Data System Change	OH implemented a new MMIS system (called MITS) on August 2, 2011. The Q3 FY2011 file was generated from the legacy system, but files from Q4 FY2011 and on will be generated from MITS.	9/9/2011
OH	Eligibility	Dual Eligibility Codes	OH has partial duals reported to MASBOE 11-12 because they are a 209(b) state.	11/17/2009
OH	Eligibility	Dual Eligibility Codes	It appears that some dual code changes were implemented when OH moved to the monthly dual code reporting in Q1 FY06 causing shifts from Q4 FY05. (We believe these new counts are more reliable than prior quarters as OH restored reporting to code 01 and the distribution of counts is somewhat more consistent with the monthly MMA counts for January 2006, but the state has not confirmed). The state made changes to its MMA reporting, which made the two sources more consistent by Q3 FY08 (some differences remain in the individual counts of 04 and 08, but total counts compare very well). In FY2009, MSIS counts for dual codes 03 and 04 are substantially different from MMA. The state believes this may be a timing issue related to the submission schedule of the MSIS and the MMA file in addition to the timing of when a consumer meets their spenddown.	12/20/2010

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State	File Type	Rec/Issue Type	Issue	Recorded
OH	Eligibility	Dual Eligibility Codes	Starting in FY06, the percent of aged enrollees reported to be duals dropped to about 85%, a much lower rate than reported in previous time periods. OH indicated that this count is more accurate and is low because the state does not require enrollment in Medicare as a condition of Medicaid enrollment; however, the state has been making efforts to encourage aged enrollees to get enrolled in Medicare, so OH expects this rate to increase.	3/18/2011
OH	Eligibility	Dual Eligibility Codes	In Q1 FY07, from month 2 (November) to month 3 (December), about 6,000 enrollees (most in MASBOE 31) shifted from dual code 04 to code 03. Then, in Q2 FY07, it appears about 3,000 duals in code 03 shifted back to code 04. The counts of duals in codes 03 and 04 stayed at consistent levels throughout the rest of FY07. The same pattern occurred in OH's Q1-2 FY08 data. The state has not clarified why this pattern occurs or if it might be related to how OH reports its spenddown enrollees.	4/6/2012
OH	Eligibility	Dual Eligibility Codes	Starting in Q4FY11, about 3,500 individuals in MASBOE 35 were assigned dual code 02. Enrollment increases through Q1FY13 to about 8,500, then begins to decrease through Q4FY13 to about 5,000. These duals are primarily coming from code 1013. Additionally, each month there are about 2,700 individuals in MASBOE 35 assigned dual code '08'. Enrollment increases to about 4,000 in Q1FY13, then decreases through Q4FY13 to about 3,000. These duals are primarily coming from program code 3013. OH explained that this is because eligibility is first determined using the CRISE system (being replaced Jan 1, 2014) by a county eligibility case worker, then the case is transferred into MITS (the state Medicaid processing system). These duals in MB 35 are when the county worker enrolls a person under 65 and assigns them a MA C classification, enrolling them in Healthy Start. Then, when they are transferred into MITS, they are run through the EDB match (and found to be Medicare eligible), therefore giving them a Healthy Start program and Medicare eligible assignment. The information is sent to the county but the fix is not immediate.	5/16/2014
OH	Eligibility	Family Planning	In 2011, Ohio started providing family planning-only services to enrollees under a state plan amendment. About 3 enrollees were incorrectly reported to MASBOE 44-45 in Q4FY11. The state correctly remapped these individuals to MASBOE 34-35 by Q1FY12. Enrollment increased to about 153,000 by Q1FY14.	6/11/2014
OH	Eligibility	Managed Care	PACE enrollees have been reported in CMS MC data since FY03, but not identified in MSIS managed care enrollment reporting (Plan Type); however, through Q4 FY06, OH mistakenly flagged PACE enrollees with a "Z" in the Waiver ID field even though PACE is not a waiver. Therefore, all enrollees reported with a "Z" Waiver ID should have been reported with Plan Type 6 (PACE) instead. (The state has two PACE plans, but there is no way to assign the correct plan ID to these enrollees.) Since "Z" is not a Waiver ID, the state fixed this reporting in Q1 FY07 and stopped assigning enrollees to 'Z', however, OH was not able to	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			include the Plan Type 6 assignment in its MSIS data. So, there is no way to identify PACE enrollees during FY07. OH started correctly reporting PACE enrollment in MSIS when the state implemented its new MMIS system in Q4 FY11.	
OH	Eligibility	Managed Care Plan IDs	OH accidentally started reporting the managed care plan's (Wellcare) NPI instead of their state-assigned plan ID. They continued to report the state-assigned plan ID in the capitation claims files but reported the NPI as the plan ID on encounters. Each month, any enrollee assigned to Plan ID '1871750208' should have it changed to '2659476'. OH did not carry any NPIs in their old MMIS which was replaced in August of 2011. They reported the state-assigned plan ID for Wellcare before that and the NPI after that.	5/16/2014
OH	Eligibility	MASBOE	All Years: OH has an unusually large proportion of children and adults in MASBOE 44-45, raising the possibility that some 1931 enrollees are being reported there in error. We have questioned the state about this and gotten no response.	NA
OH	Eligibility	MASBOE	All Years: Ohio is a 209 (b) state, using more restrictive rules for Medicaid eligibility than SSI. Until FY08, the number of SSI eligibles reported into MAS/BOE 11 and 12 was lower than the number reported by the Social Security Administration. However, OH corrected this problem in FY08 and its MSIS data began to show that most SSI recipients appear to be enrolled in MSIS although some are partial duals. In addition, most SSI disabled over 65 appear to be mapped to MASBOE 12.	NA
OH	Eligibility	MASBOE	In Q1 FY08, OH started reporting to MASBOE 3A.	10/16/2009
OH	Eligibility	MASBOE	2006 - 2008: Due to the decrease in reporting to MASBOE 11-12 in July 2006, the MSIS and SSA comparison for December 2006 (Q1 FY07), shows that the count in MSIS was about 57% lower. This comparison was more consistent again starting in Q1 FY08 (after the state made a shift in reporting from MASBOE 41-42 back to 11-12).	3/18/2011
OH	Eligibility	MASBOE	In Q1 FY08, OH started reporting about 5,300 individuals under age 65 to MASBOE 11 and about 4,000 individuals under age 65 to MASBOE 41. These enrollees should probably be reported to MASBOE 12 and 42, respectively. This reporting improved by FY09; however, in Q4FY11, this issue reoccurred. About 900 individuals under 65 were reported to MASBOE 11 and 500 to MASBOE 41.	5/20/2011
OH	Eligibility	MASBOE	In Q1 FY11, the number of foster children (MASBOE 48) fell from 38,746 in month 1 to 29,439 in month 2 of Q1; enrollment remained around 29,000 through Q2. The decline was seen across all 4 state eligibility groups in which foster children are enrolled (17 N, 18 N, 37 N, ad 38 N). We have asked the state to explain.	5/26/2011
OH	Eligibility	MASBOE	Starting in Q1 FY07, all enrollees assigned to dual codes 03, 04, and 06 had their state-specific code assignment changed to a	5/26/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			new group of codes that contain 'L1' in bytes 1-2. Since 'L1' is mapped to MAS 3, this change caused the MASBOE assignment to be 31-32 for these enrollees (the majority of enrollees in dual codes 03 and 06 were previously in MAS 3, but this caused enrollees in dual code 04 to switch from MAS 4 to MAS 3). Therefore, most SLMB plus enrollees were reported to MASBOE 31-32 by mistake. OH revised its crosswalk so that dual code 04 enrollees in 'L1' will be mapped to MASBOE 41-42 and corrected the data starting in Q2 FY2011.	
OH	Eligibility	MASBOE	In Q1 FY08, OH moved about 26,000 children in state eligibility code ''J4 N' (mostly ages 15-18) from MASBOE 34 to MASBOE 35 causing a large shift in MASBOE counts. These children should have been in MASBOE 34. The state made this fix starting in Q3 FY10, causing a shift of enrollees from MASBOE 35 back to MASBOE 34.	7/8/2011
OH	Eligibility	MASBOE	In Q1 FY2011, the number of foster children (MASBOE 48) fell from 38,746 in month 1 to 29,439 in month 2. The state explained that this occurred because the state investigated and corrected duplicate records as part of the transition to MITS. The Office of Child Support had transitioned systems, creating problematic spans. Nearly all of the foster children decline was due to clean-up of 9,097 duplicate and invalid eligibility spans that were created during conversion from the FACSIS to the SACWIS system.	9/9/2011
OH	Eligibility	MASBOE	In Q4 FY11, OH implemented a new MASBOE crosswalk. OH's new crosswalk generally looks good and the state feels its mapping and data is reliable, but the following shifts occurred: MASBOE 11 increased by about 2,700 MASBOE 12 decreased by about 16,000 MASBOE 14 increased by about 350,000 MASBOE 15 increased by about 219,000 MASBOE 34 increased by about 112,000 MASBOE 35 increased by about 131,000 MASBOE 44 decreased by about 460,000 MASBOE 45 decreased by about 290,000 In addition, Q4FY11 had no individuals reported to MASBOEs 16 or 17. OH indicated that this was because the new system does not include employment data and these MASBOEs are not included in the new xwalk.	6/21/2013
OH	Eligibility	MASBOE	In Q3FY12, there was a decrease of about 101,000 in MASBOE 14 between months 2 and 3. The decrease occurred in program code 4013. During this same time, there was an increase of about 120,000 in MASBOE 34. The increase occurred in program code 4014. In Q3FY12, there was a decrease of about 59,000 in MASBOE 15 between months 2 and 3. The decrease occurred in program code 4013. During this same time, there was an increase of about 25,000 in MASBOE 35. The increase occurred in program code 4014. The state explained that these shifts occurred because of state-enacted changes to both policy and the eligibility-determination system. There was a change in budgeting methodology going from a "two-step to a one-step budgeting methodology" so individuals ended up falling into another group.	5/15/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
OH	Eligibility	MASBOE	After steadily decreasing from ~ 797,800 in October 2013 to ~ 788,400 in December 2013 [mostly in SSGs 4017, 4018, and 4020], MB 34 began increasing from ~ 801,700 in January 2014 to ~ 834,600 in March 2014 [mostly with the addition of SSGs 4100, 4102, 4103, 4104, and 4121]. Similarly, after steadily decreasing from ~ 577,200 in October 2013 to ~ 564,300 in December 2013 [mostly in SSGs 4022 and 5013], MB 35 began increasing from ~ 652,600 in January 2014 to ~ 723,800 in March 2014 [mostly with the addition of SSGs 4108, 4110, 4112, and 4113]. This is consistent with Medicaid expansion in OH.	2/4/2015
OH	Eligibility	Race/Ethnicity	Starting in Q4FY11 through Q1FY14, OH only reports race code 7 (Hispanic/Latino & 1+ races) to ethnicity code 1 (Hispanic or Latino). OH does not include Race = 5 (Hispanic or Latino) to Ethnicity = 1. Therefore, Ethnicity =1 is under reported from about 160 to 50. We have asked the state to correct this issue and we expect to see a correction in upcoming quarters.	5/16/2014
OH	Eligibility	Restricted Benefits Flag	OH has not been assigning Restricted Benefit Flag Code '2' (individual is eligible for Medicaid but only entitled to restricted benefits based on alien status) to any enrollees. These individuals are included in OH's MSIS data; however, the state is not able to separately identify them; however, they are trying to make this fix as part of the MMIS system that will be implemented towards the end of 2009.	10/29/2008
OH	Eligibility	Restricted Benefits Flag	In 2008, OH began implementation of a Money Follows the Person (MFP) program, and enrollment is reported beginning in June 2008. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. MFP enrollees are assigned RBF code 8 in MSIS.	12/20/2010
OH	Eligibility	Restricted Benefits Flag	OH started incorrectly reporting enrollment in waiver IDs 'HH' and 'HM' in December 2008 to indicate that the consumer was in the MFP program. These "waivers" were used in addition to RBF 8. However, these individuals were not enrolled in actual waivers, so in Q3 FY2010, OH ceased reporting MFP enrollees to these waiver IDs and instead reported them to RBF 8 only.	5/20/2011
OH	Eligibility	Restricted Benefits Flag	Ohio has a sizeable group of eligibles (about 8,000 in Q4 FY06) in MAS/BOE 11 - 12 and 41-42 with restricted benefits related to Medicare. OH had earlier indicated this is related to the state's 209(b) coverage. This assignment improved greatly in Q1 FY07, but about 3,500 restricted benefit duals are still reported to MASBOE 11-12, which increased to about 9,000 in Q1 FY08.	4/6/2012
OH	Eligibility	SSN	A review of SSN reporting in OH's Q4 FY05 file for MSIS showed that OH is submitting what appear to be valid SSNs (9 digit numeric data) for 98.5 percent of Medicaid enrollees each quarter. We generally expect to see the SSN field 9-filled for at least 2-3 percent of enrollees, given that SSNs are not always available for some enrollees, such as newborns, younger	3/18/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			children, or undocumented aliens. OH reports about 1.4 percent of records with the SSN field 9-filled. For the 98.5 percent of records reported with SSNs, we've asked the state if this SSN data is completely reliable or if any numbers are being entered that are not SSNs.	
OH	Eligibility	State-Specific Eligibility	In FY2009, OH was incorrectly mapping state specific eligibility group 'K4 N' (CHIPS II 151% - 200% of poverty, ADCR /not spend-down) to MASBOE 44. They corrected reporting and remapped this group to MASBOE to 34 in the FY 2009 files, but the FY 2010 Q1 and Q2 files still mapped some K4 N beneficiaries to MASBOE 44. Additionally, OH determined that Healthy Start children age 19 and older (groups K4 N and K5 N) who are not eligible for Medicaid due to pregnancy should be re-mapped from MASBOE 35 to 34. Both issues were fixed in the submission of Q3 FY2010 eligibility files.	4/6/2012
OH	Eligibility	TANF/1931	The TANF flag for Ohio has some limitations. Ohio is only able to update this data element quarterly, not monthly. As a result, if eligibles leave TANF and move from MAS 1 to MAS 3 or 4 during the quarter, they will still be coded as receiving TANF benefits. That explains why quite a few MAS 3 and 4 persons have TANF. The state reports that it will correct TANF reporting when the new MMIS system is live.	12/20/2010
OH	Eligibility	Waivers	In Q1-2 FY2011, OH reported 10-40 individuals each month with blank Waiver ID and Wavier Type fields. These individuals were mapped to MASBOE 12 and 42. We have asked the state whether these individuals should be enrolled in a waiver and to fix reporting accordingly.	5/26/2011
OH	Eligibility	Waivers	Between M3 Q3 FY10 and M1 Q4 FY10 enrollment in the Individual Options Waiver (Waiver ID HB) and RBF 8 each dropped by about 75 individuals (well over half of previous enrollment). The state explained that the drop in enrollment occurred because a number of consumers reached the end of their Money Follows the Person participation period.	7/8/2011
OH	Eligibility	Waivers	In Q1 and Q2 FY2011, OH reported 10-40 individuals each month with blank Waiver ID and Wavier Type fields. These were individuals who were formerly enrolled in Waiver ID HH, but are no longer enrolled in a waiver.	4/6/2012
OH	Eligibility	Waivers	In Q4FY12, OH began reporting a new 1915c waiver, SELF Waiver (waiver ID '10'). From Dan Hecht: The SELF Waiver (Self-Empowered Life Funding) is a much-awaited waiver offering services that allow individuals with developmental disabilities who receive support on the waiver to direct where and how they receive those services -- for individuals this is known as 'self-direction.' DODD estimates up to 2000 individuals will be enrolled on the waiver by the third year it is in effect. The SELF Waiver has an overall annual cost cap of up to $25,000 for children and up to $40,000 for adults. These individuals are reported to MASBOEs 12 and 42 (based on	5/16/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			receipt of SSI), generally assigned to codes 4009 and 4009SI, and should be assigned RBF 1.	
OH	IP	Covered Days	Beginning in Q2FY2012 the number of claims with inpatient covered days missing or over 1,000 increased substantially.	3/24/2014
OH	IP	Crossovers	Of claims where MEDICARE-COINSURANCE-PAYMENT and/or MEDICARE-DEDUCTIBLE-PAYMENT are not equal to 8-fill (known as crossover), the sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT is greater than the MEDICAID-AMOUNT-PAID on about 70 percent of claims reported after Q4FY2011 when a new MMIS was implemented. MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT are supposed to represent the amount Medicaid paid towards the Medicare coinsurance and/or deductible therefore their sum should equal MEDICAID-AMOUNT-PAID on the majority of crossover claims allowing exception for rounding MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT up or down to the nearest dollar. Please explain why the sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT do not equal the MEDICAID-AMOUNT-PAID on crossover claims.	3/24/2014
OH	IP	DRG	According to changes in the frequency of DRG values it appears as though Ohio transitioned from CMS-based DRGs to APR-DRGs in FY2013Q4.	3/24/2014
OH	IP	DRG	DIAGNOSIS-RELATED-GROUP (DRG) and DIAGNOSIS-RELATED-GROUP-INDICATOR were always 8-filled when not applicable/available before 2011Q4 when a new MMIS was implemented. Beginning in 2011Q4 DRG is either 9-filled when it is presumably not applicable (reported with DIAGNOSIS-RELATED-GROUP-INDICATOR = "9999") or 0 (zero) when not available (reported with DIAGNOSIS-RELATED-GROUP-INDICATOR = "HG15", "HG99", "HG30", or "HG31"). In general 8-fill is used when something is "not applicable" to the situation and 9-fill is used when something is unknown, possibly because it may be applicable but is not available.	3/24/2014
OH	IP	Family Planning	OH stopped reporting Family Planning in the IP file from Q4FY2011 through Q4FY2012 resuming in Q1FY2013.	2/24/2014
OH	LT	Admission Date	Admission date is missing on most claims through Q3FY2011 when the state implemented a new MMIS.	2/24/2014
OH	LT	Covered Days	In 2006-2007 Covered Days are not reported for ICF/MR.	10/16/2008
OH	LT	Crossovers	There was a sharp drop in the total number of LT Crossover claims in Q1FY2010. This is the result of a budget initiative (effective 8/1/2009) that was put into place that rolled up most, if not all, outpatient therapies into Nursing Facility per diem.	2/9/2011
OH	LT	Patient Status	Patient status is missing on most claims though Q3FY2011 when the state implemented a new MMIS.	2/24/2014

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
OH	OT	HCBS Waiver	HCBS waiver enrollment-to-claims linkage: Until 2011Q4, more than 10 percent of HCBS waiver claim recipients did not have an HCBS waiver enrollment in the corresponding EL file. This improved dramatically in 2011Q4, the first quarter containing data from Ohio's new MMIS.	3/24/2014
OH	OT	Managed Care Capitation	OH reports PACE capitation claims as FFS claims with procedure code Y9999.	6/20/2011
OH	OT	Service Code Flag	Each quarter there were over 2 million claims that had a Service Code format of HCPCS that were reported with a CPT Service Code indicator. This was corrected in the Q1FY2009 and has not occurred again.	4/30/2014
OH	OT	Servicing Provider ID	The Provider ID Number Servicing fields are not filled in through Q3FY2011 when the state implemented a new MMIS.	2/24/2014
OH	OT	Specialty Code	Physician specialty codes are missing on all claims through Q3FY2011 when the state implemented a new MMIS.	12/10/2013
OH	OT	Type of Service	Almost 50% of the FFS claims are for waiver services and reported with a Type of Service of Other Services. This is the result of most people being enrolled in an HMO and that the state reports line item waiver services.	5/9/2011
OH	OT	Type of Service	There were no OT claims for OH with type of service 31 (TCM) through at least Q3FY2011 though procedure code Z9999, a local procedure code representing TCM for IID/DD population, appears in large quantities in the OT file. Refer to Ohio administrative code 5101:3-48-01 and Appendix DD to 5101:3-1-60. A request to have Z9999 reported as TOS=31 was made after the review of their Q3FY2011 OT file.	12/13/2011
OH	OT	Type of Service	In Q4FY2011 the number and percentage of claims with outpatient hospital type of service and laboratory revenue codes increased substantially.	1/4/2014
OH	OT	Type of Service	The percentage of claims with an outpatient hospital type of service that were paid zero dollars increased more than 10 percent in Q4FY2011.	1/4/2014
OH	OT	Type of Service	In Q4FY2011 the number of claims, average paid, and total paid for claims with laboratory type of service decreased substantially. Total paid for claims with laboratory type of service decreased by 90 percent from $35 million in previous quarters to about $3.5 million in Q4FY2011.	4/30/2014
OH	RX	Days Supply	Days supply is missing in the 1999-2011 files.	10/16/2008
OH	RX	Family Planning	OH stopped reporting Family Planning in the IP file in Q4FY2011 when a new MMIS was implemented.	2/24/2014
OH	RX	Medicaid Amount Paid Total	There is a large decrease in FFS RX claims from Q1 to Q4FY2007 as a result of increased HMO enrollment.	6/9/2009
OH	RX	Medicaid Amount Paid Total	In February 2010, Ohio carved out pharmacy benefits from managed care. On October 1, 2011 pharmacy benefits once	12/7/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			again became the responsibility of the managed care plans and their pharmacy benefit managers.	
OH	RX	New Refill	New/Refill Indicator is missing through at least Q1FY2011.	6/1/2011
OH	RX	Quantity	Until Q2FY10 QUANTITY-OF-SERVICE was missing on about 10 percent of all original (ADJUSTMENT-INDICATOR = 0) FFS (TYPE-OF-CLAIM = 1) RX claims. Between Q2FY10 and Q4FY11 (when a new MMIS was implemented) the percentage of FFS original claims with missing QUANTITY-OF-SERVICE was about 3 percent. Beginning in Q4FY11 QUANTITY-OF-SERVICE was missing on less than 1 percent of all original FFS claims and managed care encounters (TYPE-OF-CLAIM = 3). QUANTITY-OF-SERVICE was missing on all FFS claims and managed care encounters in the Q1FY13 RX (S1) file and a small percentage of claims in the Q2FY13 RX (S1) file. QUANTITY-OF-SERVICE was missing on less than 1 percent of original FFS claims and managed care encounters thereafter.	11/26/2013
OH	RX	TPL	Other Third Party Payment (or Third Party Liability/TPL) is missing through Q3FY2011 when the state implemented a new MMIS.	2/24/2014
OK	Claims	Adjustments	The date of payment on voids is the date of payment of the original claim, not the date it was adjusted. This means that many of the void claims have payment dates prior to the quarter. In the 2010 files, this is true only for crossover claims.	3/25/2011
OK	Claims	Managed Care Capitation	Oklahoma has a high number of PHP and PCCM capitation payments for PACE (Plan type = 6) managed care. Plan ID 100699800W has just under 100 enrollees a month, but has over 15,000 PCCM capitation payments. Plan ID 100699800X has under 50 enrollees, but has over 21,000 PHP capitation payments and over 110,000 PCCM capitation payments.	4/29/2015
OK	Eligibility	0-filling	OK had reported about 800 individuals in MASBOE 00 with valid values (08 or 8-filled) in the Plan Type and Plan ID managed care enrollment fields. We've asked the state to reviews its reporting so that individuals in MASBOE 00 have all monthly data elements 0-filled for those same months. This error was fixed in Q3 FY09.	8/11/2011
OK	Eligibility	1115 Waivers	OK implemented its 1115 SoonerCare waiver (waiver ID 'WF', waiver type '1') in October 1995. This waiver is used to operate a Primary Care Case Management model. The program is partially capitated in that primary care providers are paid a monthly capitated rate for a fixed set of services with non-capitated services compensated on a fee-for-service basis. In September 2005, the state added a HIFA amendment to this waiver (waiver ID 'WF', waiver type '5') to expand eligibility up to residents with incomes at or below 185 percent of the Federal poverty level (FPL) through enrollment in the State's Employer Sponsored Insurance (ESI) program Insure Oklahoma. Eligible populations include adult working disabled persons aged 18-64 years of age who, have income up to 200 percent of the FPL	4/16/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			and non-disabled low income workers and spouses aged 18-64 years) who work for small employers, the self-employed or unemployed (and seeking work) and have income above the Medicaid standard, but no more than 185 percent of the FPL. Also in 2005, the state added family planning only coverage (state group 29FP reported to MASBOE 55), until it moved to a state plan amendment in 2011.	
OK	Eligibility	1115 Waivers	Effective 2006, OK's Employer Partnership for Insurance Coverage (O-EPIC) program became part of the state's 1115 Sooner Care waiver. O-EPIC is a health plan premium assistance demonstration program that became effective January 2006 (Q2 FY06). For some enrollees in O-EPIC Employer Subsidized Insurance (ESI), the program pays part of the insurance premiums for employers and their employees of companies with <= 25 employees. These people are assigned health insurance flag 3, restricted benefits flag 1, and state group 30H1 or 30H2. In addition, starting in March 2007 (Q2 FY07), OK implemented the O-EPIC Public Product Health Care Plan (PUB) that allows various groups to buy coverage directly from the state. O-EPIC PUB clients are reported with health insurance flag 1 and state codes 31H1 through 31H9. All O-EPIC clients are reported to MAS 5. Finally, in 2008, OK expanded coverage to include college students ages 19-22 with incomes up to 200% FPL (state groups 30HC or 31HC) This program appeared in the MSIS EL files in Q3 FY09. All three programs (ESI, PUB, and College Kids) allow for childless adults. Due to new enrollment among college students and increased public outreach about the program, enrollment in this program (and in MASBOE 55 overall) grew in Q3-4 FY09.	3/18/2011
OK	Eligibility	1115 Waivers	In Q1FY13, SoonerCare (waiver ID 'WF') increased dramatically from around 506,000 to 570,000. The state believes this was caused by general fluctuations in the economy and agency outreach. This waiver is managed care, therefore also causing an increase in PCCM.	6/30/2014
OK	Eligibility	CHIP	Oklahoma reports its M-CHIP children (codes A7 and A8 in bytes 3-4 of the state specific code) in MSIS.	6/3/2010
OK	Eligibility	CHIP	In Q4 FY08, OK added an S-CHIP program for unborn children called Soon-To-Be-Sooners (STBS) that provides prenatal care to noncitizen mothers. These children/mothers are not included in the MSIS data. These enrollees are included in SEDS data reporting (about 8,000 in Q4 FY08).	1/3/2011
OK	Eligibility	CHIP	MSIS CHIP counts remain consistent from Q4 FY 10- Q1 FY 11, but SEDS counts drop substantially in Q1 FY 11. The MSIS CHIP counts are consistent with other external data (e.g. Kaiser).	12/6/2012
OK	Eligibility	CHIP	In Q1FY13, MCHIP increased by about 9,000 between months 1 and 2. This increase was caused by a systems issue. The eligibility system did an income verification with OESC. When the employer listed by the applicant was not an exact match to OESC, the income from OESC was added to what the applicant	6/30/2014

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			reported, thereby inflating the applicant's income. This affected poverty level status and moved several thousand into the CHIP poverty type that should not have been. The clients were corrected in August. OK resubmitted Q1FY13 and the MCHIP issue was addressed. There is still an increase in months 2 and 3; however, it was not as large (from about 67,800 to 71,300 instead of 77,500).	
OK	Eligibility	CHIP	Between October 2013 and March 2014 MCHIP enrollment increased by about 16,900 (24.1%). OK had a problem with under reporting MCHIP enrollment, which they fixed. While investigating the problem, they found a few other system glitches and have now fixed the issue. OK believes that they are seeing higher than normal numbers because they were previously under reporting enrollment. Although they are dubious of the higher numbers, they are investigating the issue and do not believe it is a problem with the MSIS system.	2/24/2015
OK	Eligibility	Dual Eligibility Codes	Effective 11/99, OK covered all aged and disabled for full Medicaid benefits up to 100% FPL.	NA
OK	Eligibility	Dual Eligibility Codes	Oklahoma does not report any QDWIs as the information is stored in a separate manual system. OK also did not include QIs in its MSIS reporting until January 2003 when the state made changes to its systems.	NA
OK	Eligibility	Dual Eligibility Codes	Through Q4 FY05, OK's MSIS and MMA dual counts were not completely consistent. MSIS show about 5,000 more total duals (5%) compared to what is reported in OK's January 2006 MMA file. In MSIS, the count of 02 is significantly higher, while the count of 04 is lower. Starting in Q1 FY06, however, the state made significant improvements in its reporting of duals in MSIS to make the two sources more consistent. There continued to be some differences in reporting to dual code 04, but this improved over time and by FY08 the two sources were extremely close. In FY09, OK implemented some changes to its dual eligible reporting. They remapped full duals with incomes over 100 percent of FPL to dual code 08. The state had not applied this correction in MSIS through Q1 FY10. The state made this change in the Q1 FY10 file and submitted a crosswalk that applies the fix back to Q1 FY09.	4/6/2012
OK	Eligibility	Dual Eligibility Codes	In Q1 FY10, OK recoded dual eligibles with incomes over 100 percent of the FPL from dual code '02' to dual code '08.'	10/19/2012
OK	Eligibility	Dual Eligibility Codes	In Q2FY12, dual code 08 increased from about 12,000 to over 15,000. Enrollment returned to about 12,000 in Q3FY12. The state did not know of any policy changes that would cause this increase but believes that the MSIS counts are correct. A similar pattern occurred in Q2FY13. Dual Code 08 counts were at about 12,000 in Q1FY13, then increased to about 14,000 in Q2FY13, and went back down to 11,000 in Q3FY13.	6/30/2014
OK	Eligibility	Family Planning	OK's Family waiver (waiver ID 'WH', SoonerCare Family Planning) expired on 8/30/11. The state last reported individuals	2/27/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			in this waiver in Q1FY11. The state correctly maps shifted these enrollees from MASBOE 55 to MASBOE 35.	
OK	Eligibility	Managed Care	There were some changes to OK's managed care reporting in FY07 when the state implemented new dental services to its O-EPIC II program. We noticed that starting in Q2 FY07, the state started reporting to new Plan IDs and there were increases in both PCCM and "other" enrollment as O-EPIC II enrollment expanded. Enrollment continued to grow through 2008. (This also caused the MSIS data to contain several new managed care Plan IDs that are not included on the most recent version of our managed care Plan ID list for OK; however, since one of OK's "other" (Plan Type 08) plans acts like a PCCM, the state provides all of the individual provider IDs. Usually we don't require states to submit all the PCCM-related IDs to MSIS, but it appears that OK has been able to do so in the past. At this point, however, the list is starting to get unwieldy so we have chosen not to ask for an updated list at this time.)	4/9/2009
OK	Eligibility	Managed Care	In Q1FY13, managed care plan type 07, PCCM, increased by about 38,000. Additionally, plan type 08, Other, increased by about 35,000. The state believes that these increases are caused be fluctuations in the economy and agency outreach. Most people enrolling in Medicaid, SoonerCare in particular, will be enrolling in PCCM. Plan type 08 is the NET Transportation and almost anyone who qualifies for Medicaid also qualifies for NET, with a few exceptions. Therefore, the increase in NET is slightly less than the increase in PCCM.	6/30/2014
OK	Eligibility	Managed Care	In Q1FY13, managed care plan type 07, PCCM, increased by about 38,000. Additionally, plan type 08, other, increased by about 35,000. The state believes that these increases are caused by general fluctuations in the economy and agency outreach. Most people enrolling in regular Medicaid, SoonerCare in particular, will be enrolled in PCCM. Plan type 08 is NET transportation. Almost anyone who qualifies for Medicaid also qualifies for NET, with a few exceptions, hence the slightly lower increase in NET.	6/30/2014
OK	Eligibility	MASBOE	All Years: Effective 11/99, OK provides full Medicaid benefits to 100% FPL for aged and disabled.	NA
OK	Eligibility	MASBOE	All Years: Oklahoma is a 209(b) state, using more restrictive rules for Medicaid than SSI. This makes the comparison to SSI data difficult. In addition, OK has a state-administered SSI supplement. Generally, fewer individuals are reported to MASBOE 11-12 than are reported to receive federally administered SSI benefits.	8/21/2007
OK	Eligibility	MASBOE	2006 - 2007: In Q2 FY06, OK started reporting two new state-specific groups (30H1 and 30H2) to MAS 5 as part of the state's O-EPIC II program. Additional state groups (31H1-31H9) were added to MAS 5 in Q2 FY07 as part of the state's new O-EPIC PUB program.	6/10/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
OK	Eligibility	MASBOE	2004 - Present: OK had an 1115 waiver for FP services approved Q4 FY04 and started reporting enrollment in January 2005 (Q2 FY05) to MASBOE 55 (state group 29FP). These enrollees are assigned restricted benefits flag 6. Enrollment in the FP group grew dramatically in Q3-Q4 FY05. The FP waiver ended in 2011 and coverage moved to a state plan amendment, causing a shift of enrollees from MASBOE 55 to 35.	9/30/2009
OK	Eligibility	MASBOE	All Years: OK's SoonerCare 1115 waiver mostly sets up a managed care system for OK's Medicaid enrollees. Only the O-EPIC coverage is an eligibility expansion, therefore, only this group (along with the family planning waiver enrollees through 2011) are reported to MAS 5.	9/17/2010
OK	Eligibility	MASBOE	In Q3-4 FY09, OK reported declines in MASBOE 48. The state contact believes that the declines were among child clients in custody. He is unaware of any policy changes that occurred to cause the decline, but eligibility was completely determined by another agency.	9/17/2010
OK	Eligibility	MASBOE	Enrollment in MASBOE 14 increased by about 20,000 from Q4 FY2009 to Q1 FY2010. Most of this increase was in state specific eligibility group '15M', but there were some increases in groups '01M' and '16M' as well. The state believes that a time lag or retroactive updates since the last approved 2009 Q4 file may have caused the increase.	10/7/2011
OK	Eligibility	MASBOE	In OK's Q1 and Q2 FY2010 files, there were about 60,000 enrollees<65 incorrectly mapped to MASBOE 11. These individuals were reported to MASBOE 12 in Q4 FY2009 and are enrolled in state groups 01E, 01I, 15E, 15I, 16E, 16I, 18I, 28I, and 32I. The state is working to debug its age coding and corrected reporting by Q4	4/25/2012
OK	Eligibility	MASBOE	Through Q2FY11-Q1FY13, there was a steady increase in MASBOE 34, specifically in codes '01N' and '15N'. The state believes that this increase is caused by general fluctuations in the economy and agency outreach. These eligibility groups are the most populous (regular Title 19 or Title 19 with SoonerCare); therefore, when increase in Medicaid in general occur, they will appear in these groups.	6/30/2014
OK	Eligibility	MASBOE	Through Q2FY11-Q3FY12, there was a steady decrease in enrollment in MASBOE 14. In Q1FY13, enrollment began to increase again. The change occurred mostly in '01M', '15M', '15N', and '16N'. Additionally, there was a steady increase in MASBOE 34 from Q2FY11-Q2FY12. In Q3FY12, enrollment begins to decrease. The decrease is occurring in '01N' and '15N'. The state believes that these changes were caused by fluctuations in the economy or agency outreach. These are the most populous eligibility groups (regular Title 19 ('01M') or Title 19 with SoonerCare ('15M', '15N'), and to some extent SCHIP Children ('16N')); therefore, when there is any change in enrollment in Medicaid, they will most likely occur in these groups.	6/30/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
OK	Eligibility	MASBOE	Between December 2013 and January 2014, enrollment in MASBOE 55 fell sharply, from about 25,700 to 19,700, then steadily declined through Sept 2014. The decrease occurred mostly in SSGs 31H3, 31H5, and 31H6, which are part of the Insure OK group. If their employers do not offer insurance and they meet certain income and size qualifications, they could pay a premium and receive Medicaid. OK explained that the program was set to sunset on 12/31/15, and it was highly publicized. OK believes that with the ACA enrollment beginning around that time, it may have caused these beneficiaries to find other options so they could get coverage before the deadline. Recently, the program was extended and the state expects enrollment to increase again.	2/24/2015
OK	Eligibility	Private Health Insurance	Individuals in OK's ESI program (operated as part of the state's 1115 waiver) are assigned to health insurance code 3.	9/17/2010
OK	Eligibility	Private Health Insurance	In the Q3-4 FY09 review, we asked about fluctuating enrollment in health insurance code '2' and about the increase in health insurance code '3'. The state investigated these changes and believes that they are the result of the timing of when the files were submitted. Also, starting January 2010, OK has a new contractor gathering and improving this info and believes that they are going back to 2009 and improving that reporting as well. Insurance reporting gradually increased through 2010.	4/25/2012
OK	Eligibility	Restricted Benefits Flag	Beginning in FY05, FP only enrollees are assigned restricted benefits flag 6.	NA
OK	Eligibility	Restricted Benefits Flag	From May 2007 (Q3 FY07) through Q2 FY08, OK reported about 14,000 enrollees to state-specific group "32P1" and restricted benefits flag 7 (alternative package of benchmark-equivalent coverage). The RBF assignment was incorrect. These enrollees are mapped to MASBOE 35 and are pregnant women that had dental services added to their package of benefits. They should have received RBF 1, which was fixed in OK's Q3 FY08 file.	9/24/2008
OK	Eligibility	Restricted Benefits Flag	OK's Money Follows the Person (MFP) program was approved in June 2008 (Q3 FY08). MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. Starting in Q3 FY09, MFP enrollees are assigned to RBF code 8 in MSIS and to state-specific eligibility groups 36-38.	4/6/2012
OK	Eligibility	Restricted Benefits Flag	Restricted benefits code 5 (other) was generally assigned to medically needy enrollees, which ended in FY03 when the program was terminated. OK also reports individuals in a Tuberculosis program (Elig Group 19L, mapped to MAS 2) to RBF 5. These individuals receive benefits limited to TB-related services.	4/6/2012
OK	Eligibility	SSN	Beginning in FY1999, about 3,000 to 5,000 SSNs were assigned to more than one record each quarter. By Q1 FY03, this improved and by Q4 FY05 there were less than 1,000 SSNs with	3/18/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			duplicate records. The state believes that these duplicates primarily involve newborns, twins, and mothers and their children. The state is unable to correct all the duplicate SSNs, but believes that many of the duplicates assigned to newborns are resolved in future files.	
OK	Eligibility	TANF/1931	Oklahoma TANF data were not reliable until Q2 FY03. The MSIS counts of TANF recipients compared well with the counts reported to the Federal ACF report through FY04; however, starting in FY05, the counts diverged again. MSIS counts were about 20-30 percent higher than the ACF report. The state believed that the MSIS counts were more accurate; however, the difference between the two counts increased to almost 50% in FY07 forward. The state reviewed these counts again, but they are received from a different agency and they were not able to double-check who is being included. The state began 9-filling this field in Q3 FY09.	4/6/2012
OK	Eligibility	Waivers	In FY06, OK reported invalid waiver combinations for individuals enrolled in more than one waiver during the quarter. In addition, some waiver IDs repeated in a waiver combination for any one month. For example, some enrollees were reported twice to Waiver ID "WA" in month 1. The state indicated that this was happening for individuals that enrolled, disenrolled, and then reenrolled back into the same waiver during the month. This was fixed starting in Q4 FY07.	1/2/2008
OK	Eligibility	Waivers	The OK NET waiver (Waiver ID 'WG', Waiver Type '2') converted to a State Plan authority in June 2006; however the state mistakenly continued to report enrollment in this waiver through Q2 FY09.	6/3/2010
OK	Eligibility	Waivers	In OK's Q1 and Q2 FY2010 files, there were about 100 HIFA enrollees (Waiver Type '5') each quarter mapped outside of MAS 5. The state explained that their MMIS system is incorrectly reporting these individuals as enrolled in a TXIX program and a HIFA program. Because this issue affects such a small number of people, we've told the state that we can revisit a possible system workaround when OK is more current with MSIS file submissions.	9/27/2011
OK	Eligibility	Waivers	It appears that OK has not been reporting monthly waiver enrollment data according to the hierarchy established by CMS to prioritize reporting for certain types of waivers for individuals enrolled in more than 3 waivers. The state will work to adjust this reporting starting in Q3 FY09; however, the state does not believe that anyone is enrolled in more than 3 waivers, so there should not be any underreporting of waiver enrollment in earlier quarters.	4/6/2012
OK	Eligibility	Waivers	Starting in Q1 FY07, there was a minor waiver hierarchy error. It appears the state 8-filled the waiver type 1 field and the waiver ID 1 field by mistake for about 2,300 enrollees who were enrolled in two waivers. OK entered the waiver enrollment information for these individuals in the waiver type 2 and 3	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			fields and the waiver plan ID 2 and 3 fields. Since enrollment can be reported in up to three waivers per month per enrollee, if an individual is enrolled in one or two waivers, the remaining waiver type and waiver ID field(s) should be 8-filled. The waiver type 1 field and the waiver ID 1 field should only be 8-filled (type "8" and ID "88") if the individual is enrolled in Medicaid, but not enrolled in any waivers for the month. This was fixed in 2008.	
OK	Eligibility	Waivers	Through Q2 FY09, OK reports all SoonerCare 1115 waiver enrollees (waiver ID "WF") with waiver type '1'. Starting in Q3 FY09, however, the state assigned those SoonerCare enrollees who are enrolled in the HIFA Employer/Employee Partnership for Insurance Coverage (O-EPIC) component of this waiver to Waiver Type '5' (and corresponding waiver ID 'WF'). All other SoonerCare enrollees remain with Waiver Type '1'.	4/6/2012
OK	Eligibility	Waivers	1115 Family Planning waiver enrollees (waiver ID 'WH', waiver type 'F') were not reported with any waiver enrollment from January - August 2011. These enrollees can be identified by State-specific group '29FP' and MASBOE 55. The waiver expired in August 2011 and these enrollees shifted from MASBOE 55 to MASBOE 35.	3/5/2013
OK	IP	DRG	There aren't any DRGs as Oklahoma does not use them for reimbursement.	12/10/2004
OK	IP	Indian Health Services	Program Type of 5 (Indian Health Service) appears to be under-reported in the IP file.	12/10/2004
OK	OT	Diagnosis	Some of the diagnosis codes may have an extra zero or two because this field is not edited by the state. Mathematica checks only the 50 most frequent diagnosis codes, and these appeared to be correct.	12/10/2004
OK	OT	Managed Care Capitation	The Type of Service on capitation claims is PHP for people flagged as enrolled in a PCCM because it is a "PCCM plus" program and includes some other services.	12/10/2004
OK	OT	Managed Care Capitation	There are approximately 19,000 capitated claims (Type of Claim=2) per quarter with a TOS=99 (unknown). OK says these are payments for their PUB benefit plan. This is part of the Insure Oklahoma program where they cover employees without any employer contribution. The state plans to change to TOS to 21 in Q3FY2011 files so the TOS=99 will disappear.	9/12/2011
OR	Claims	CHIP	OR began reporting S-CHIP claims in 2012 Q3 claims files.	12/18/2012
OR	Claims	Type of Service	Because so many people are enrolled in managed care, the distribution of FFS services is sometimes unusual.	12/10/2004
OR	Eligibility	0-filling	In Q2 FY 2012, Oregon began reporting additional data fields (waiver, health insurance, managed care, etc.) for SCHIP (CHIP CODE = 3, MASBOE = 00) enrollees. As a result, the 0-filling of the MASBOE field and these other fields will not match.	10/15/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
OR	Eligibility	1115 Waivers	1999 - current: Beginning in 1999, OR had a family planning only waiver (called FPEP by state); however, these individuals are not reported in MSIS. Their enrollment and claims are handled in a separate system operated by OR's public health department. OR implemented a new MMIS in fall 2008, but did not include these enrollees as expected.	12/15/2011
OR	Eligibility	1115 Waivers	OHP enrollees are divided into two different types of coverage: (1) 'OHP Plus' which serves most previous Medicaid enrollees eligible through more traditional categories; and (2) 'OHP Standard' services some previously eligible parents and other adults with incomes below poverty, and possible expanded enrollment in the future to more parents and other adults based on state funding. A third coverage group is included in the Family Health Insurance Assistance Program (FHIAP) which covers parents and other adults 100-170% FPL who were previously covered under a state-funded program, as well as OHP Plus and OHP Standard enrollees who chose to enroll in FHIAP.	12/15/2011
OR	Eligibility	1115 Waivers	OR's section 1115 waiver, the 'Oregon Health Plan (OHP)', was implemented in February 1994 and expanded eligibility, prioritized health benefits, and relied heavily on managed care. In February 2003, OR began operating under a new section 1115 waiver (that also included HIFA components) that allowed it to make changes to OHP, creating what is now called 'OHP2'. The waiver gave the state the authority to make reductions and expansions in coverage, which included using some S-CHIP (Title XXI) funds for some additional expansions, including parents of S-CHIP children, depending on the availability of state funding. OR implemented several reductions approved under the new waiver (reduced benefits and increased premiums and cost-sharing). OHP2 also approved a small eligibility expansion for pregnant women and children with incomes between 170-185% FPL (we are verifying with the state whether this was actually implemented). However, due to budget cutbacks, the larger expansion for parents and other adults with income between 100-185% FPL was delayed indefinitely. OR began expanding its OHP enrollment to Standard clients (MASBOE 55) around April 2010, at which point enrollment in the expansion population began to increase substantially.	4/6/2012
OR	Eligibility	1115 Waivers	In July 2012, CMS approved Oregon's request to extend and amend its Section 1115 waiver to launch new Coordinated Care Organizations (CCOs) to replace the current managed care delivery system. Oregon has modeled the CCO approach based on an ACO construct. CCOs are managed care entities that will operate on a regional basis with enhanced local governance. CCOs will integrate physical, mental and dental health services and also provide care coordination and a menu of flexible non-medical services under a global budget. Long-term services and supports will not be included initially. The waiver amendment includes a global budget payment system for CCOs based on a	11/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			hybrid of capitated and non-capitated payments. The payment system includes quality outcome-based incentives and, eventually, shared savings between the state and contracted entities. The waiver also allows the state to pay for the services of non-traditional health care workers, such as community health workers, doulas, client navigators and peer wellness workers, in Medicaid.	
OR	Eligibility	CHIP	Oregon reports its child S-CHIP data in MSIS. Its adult S-CHIP program, which began in 2/03 was never reported in MSIS and appears to have ended with the expiration of the 'HIFA' component of the state's 1115 waiver in 2007 (the adult coverage is not mentioned in the Title XXI state plan (2007)). The state does not have an M-CHIP program.	3/22/2011
OR	Eligibility	CHIP	In April 2008, OR added S-CHIP coverage for unborn children. The 'CX' state-specific group captures this new S-CHIP coverage.	4/6/2012
OR	Eligibility	CHIP	In Q2FY12, OR started reporting SCHIP data for some additional fields (Private Insurance, Waiver Type and ID, Plan Type and ID, etc.). By Q2 FY 13, it appears that OR is reporting these data for all SCHIP enrollees.	1/31/2013
OR	Eligibility	CHIP	Between September and December 2014, SCHIP enrollment decreased from 79,045 to 71,954. It is likely that this is related to the corresponding increases we see in MASBOE 34 over this timeframe as more children (including some S-CHIP children) become eligible for Medicaid with the revised income standards.	6/10/2015
OR	Eligibility	Dual Eligibility Codes	Oregon reports about 100-300 aged and disabled partial duals each month to managed care plans. Generally, we would not expect partial duals to be receiving any type of managed care, but the state reviewed these enrollees and indicated that the majority are duals who had a retroactive change to their eligibility after enrolling in a managed care plan. The managed care enrollment continues until the end of the month thereby causing a small number of duals to show managed care enrollment during this change in eligibility.	12/4/2007
OR	Eligibility	Dual Eligibility Codes	Through Q3 FY11, OR had a lower than expected percentage of duals with a valid HIC number. This could potentially signal a problem with OR's dual mapping in MSIS. This issue was corrected in Q4 FY11.	12/20/2011
OR	Eligibility	Dual Eligibility Codes	FY 10-15: OR reports several hundred partial duals to MAS 1 and 4 each month. This issue is related to the issue where Oregon is reporting partial duals to Restricted Benefits Flag = 1 (see that anomaly note for an explanation).	4/6/2012
OR	Eligibility	Dual Eligibility Codes	The CMS Innovations Center is implementing the Comprehensive Primary Care Initiative, a set of demonstrations designed to foster effective organization and delivery of primary care across payers including Medicare and Medicaid. OR was awarded funding for one of these demonstrations in August	11/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			2012. It is unclear whether impacts will be seen in the MSIS data.	
OR	Eligibility	Dual Eligibility Codes	In Q2-Q4 FY 2012, OR's MSIS data showed a 16% enrollment discrepancy from MMA for SLMB+ enrollees. We asked the state for an explanation but have not received a response. In Q1 FY 2015, OR's MSIS data showed a 27% enrollment discrepancy from MMA for Other Full Duals (Dual Code '08'). We have asked the state for an explanation.	1/31/2013
OR	Eligibility	Dual Eligibility Codes	Each month, OR assigns about 100-150 partial duals (Dual Codes 01, 03, or 06) to Restricted Benefits Flag '01' (Full Benefit Duals). We have asked the state to assign these individuals to RBF '3' (if these individuals are truly partial duals); or to Dual Code 02, 04, or 08 (if they are actually Full Benefit Duals). The state researched the issue and was not able to find any such record in their system. It is possible that these types of discrepancies get resolved after the fact; since Oregon doesn't submit retro or correction records, there is no way for the state to update these records after they submit their quarterly file.	3/8/2015
OR	Eligibility	Managed Care	FY 2010: PACE enrollment drops from about 500 to 200 enrollees from Q1 to Q2 and persists through Q4 FY 2010 because OR had a problem with tracking its PACE enrollment. The problem was resolved in the FY 2011 submissions.	12/15/2011
OR	Eligibility	Managed Care	In 2009, Managed Care enrollment comparisons between MSIS and CMS data showed discrepancies of greater than 10% for HMO enrollment, PCCM enrollment, dental, behavioral, and PACE plans. OR confirmed that this was because the numbers in the MSIS data do not reflect CHIP clients whereas the CMS data include these individuals. OR reported that this issue will be fixed once OR's new MMIS is implemented. However, it appears that the June 2010 MSIS and CMS numbers compare well and all enrollment for all plan types is within 10%, with the exception of PACE (see anom about this).	12/15/2011
OR	Eligibility	Managed Care	The 2005 CMS June managed care enrollment report showed over 370,000 individuals being reported to a non-emergency transportation program. This is a 1915(b) waiver program, which started in 1994, and is not really considered managed care since the state pays a fixed amount for each ride--not a fixed amount per enrollee. Therefore, these enrollees are not included in OR's MSIS managed care reporting in the eligibility files, but the claims are included. This program is no longer reported in the June 2010 CMS Managed Care Summary, presumably because it is not really considered a managed care plan.	12/19/2011
OR	Eligibility	Managed Care	In Q4 FY 2010 through Q3 FY 2011, Oregon showed rapid enrollment increases in plan type = 1 (HMO), plan type 2 (Dental), and plan type 3 (Behavioral). It appears that this is tied in part to the state's rapid enrollment increase for the expansion population (MASBOE 55).	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
OR	Eligibility	Managed Care	Oregon implemented Coordinated Care Organizations (CCOs) in August 2012 and simultaneously began to phase out the state's existing managed care plans. CCOs are community-based organizations that provide and coordinate medical, dental, and behavioral health services for enrollees. CCOs receive a fixed global payment and be held accountable for certain quality outcomes and metrics. From July to March 2013, behavioral health plan enrollment drops substantially from nearly 600,000 to 59,000. Oregon has said that this is because of the CCO implementation and associated phase-out of old plans. Accordingly, many new plan IDs are reported starting in August 2012. Oregon reports that the first enrollments into the new CCOs began 8/1/2012 and are continuing. In July 2013 Oregon brought on the first CCO that includes medical, behavioral, and dental. In Q1 FY 2015, dental, behavioral, and HMO enrollment begins to stabilize.	5/8/2012
OR	Eligibility	Managed Care	Starting in Q1 FY 2013, Oregon capitation claims for PCCM increase sharply (from about 1,000/month in December to 30,000/month in January 2013), but PCCM enrollment in the EL file does not increase (it hovers around 800/month). It appears that the EL PCCM enrollment is complete and accurate through February 2013, while the increase in claims during this period was in error. The state initially said that there was an error in the EL files and they failed to report enrollment in their PCPCH program as PCCM, but this program is not in fact PCCM or any type of managed care - instead, providers are paid per patient visit. However, the state later implemented the Alternate Payment Method (APM) program in March 2013 that is not reported in the EL files. This program pays providers a PMPM fee to cover all of a patient's primary care. We will ask the state to correct their files back to either Q1 FY 2014 or Q1 FY 2015 (pending CMS feedback) by adding this program to their EL files as Managed Care Plan Type '08' (other managed care).	11/13/2014
OR	Eligibility	Managed Care	During Q4 FY 2014, OR began to assign approximately 6,000-10,000 enrollees per month to Plan Type '01' more than once. This figure was much lower in Q1 FY 2014 (M1 = 1,700 / M2 = 1,100 / M3 = 700). According to the state, clients can be enrolled in more than one Coordinated Care Organization (CCO) due to the level of care each CCO provides. In many cases the Plan Type for both CCOs is Plan Type '01'.	3/8/2015
OR	Eligibility	Managed Care Plan IDs	Through Q1 FY12, OR had reported different Managed Care Plan IDs in the claims and EL files. As of Q2FY12, OR updated the plan IDs in the EL file to match those in the claims files.	1/31/2013
OR	Eligibility	MASBOE	All Years: Oregon maps most SSI disabled age 65 and older to MASBOE 11.	NA
OR	Eligibility	MASBOE	1999 - Present: A handful of people in FY 1999 and FY 2000 were incorrectly mapped to MAS/BOE= '99'. Then, again in FY03 and FY04, OR reported from 17 to 467 persons to MASBOE '99' each month. This was corrected in Q1 FY05, but reporting to	10/1/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
			MASBOE= 99 occurred again starting in Q3 FY05 for a very small number of individuals (<5) each month. The state is unable to fully correct this issue and continues to report 1-2 individuals to MASBOE= '99' in most months.	
OR	Eligibility	MASBOE	OR began reporting individuals to MASBOE 55 in April 2010, due to the expansion of its OHP enrollment to Standard clients (MASBOE 55). Enrollment increased rapidly to about 70,000 individuals by June 2011. In FY 2014-2015, MASBOE 55 enrollment is phasing out as Oregon's former 1115 expansion adults (under the 1115 Adult Demonstration Medicaid Expansion, which ended 12/31/2013) become eligible for Medicaid under MAGI rules. These recipients are now enrolled as Newly Eligible MAGI Adults and are included in MAS/BOE 42 and 45.	4/6/2012
OR	Eligibility	MASBOE	In 2009-2012, Oregon has been busy implementing various aspects of the Affordable Care Act. Oregon is projected to experience a nearly 50 percent increase in Medicaid enrollment with the ACA Medicaid expansion in 2014.	5/8/2012
OR	Eligibility	MASBOE	Oregon's 1115 waiver (OHP2) expands Medicaid coverage to low-income individuals, including childless adults, parents, pregnant women > 170% FPL, and children > 170% FPL. Medicaid expansion enrollees are reported to MASBOE 55. Until 2007, the waiver covered the parents and pregnant women through SCHIP funding, but as of 2007 began covering these individuals under Medicaid instead.	10/2/2012
OR	Eligibility	MASBOE	In FY 2012, Oregon implemented several enrollment process changes to increase help decrease barriers to enrollment. These include express lane eligibility, implementing other electronic data matches, and administrative renewals.	11/6/2012
OR	Eligibility	MASBOE	OR reportedly planned to implement a childless adult coverage expansion in FY 2012; however, according to the state, this expansion was not implemented.	11/6/2012
OR	Eligibility	MASBOE	In Q2 FY 13, 1 SCHIP enrollee was reported to MB 44. In addition, OR has been reporting about 40 individuals/month with CHIP CODE '0' to MB 44. We may follow up with the state if this pattern persists.	10/15/2013
OR	Eligibility	MASBOE	Enrollment in MASBOE 16 declined from 11,600 to 17 between September 2013 and September 2014. The state said that this decrease is expected. Oregon doesn’t have deprivation requirements for the MAGI PCR program. They eliminated the deprivation eligibility requirement effective 10/1/14, which means that they didn’t use it for MAA/MAF clients approved last year effective 10/1/13 and later, resulting in very few enrollees currently enrolled in MASBOE 16.	3/8/2015
OR	Eligibility	MASBOE	Enrollment in MASBOE 34 increased from 151,600 to 228,400 between September 2013 and September 2014. The state has said that this increase was expected. The state noted that "With	3/8/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
			the implementation of the 2014 Medicaid Expansion some of the income requirements have changed. This has resulted in an increased number of recipients in this category."	
OR	Eligibility	MASBOE	Enrollment in MASBOE 55 declined from 62,100 to 25 between September 2013 and September 2014. The state said that this decrease was expected. The Standard Population (1115 Adult Demonstration Medicaid Expansion) ended on 12/31/2013. These recipients are now enrolled as Newly Eligible MAGI Adults and are included in MAS/BOE 42 and 45.	3/8/2015
OR	Eligibility	MASBOE	Enrollment in MASBOE 16 declined from 11,600 to 17 between September 2013 and September 2014. The state said that the decrease was expected, and occurred because Oregon eliminated the deprivation eligibility requirement for the MAGI PCR program effective 10/1/14, which means that they didn't use it for MAA/MAF clients approved last year effective 10/1/13 and later. For the holdover MAA/MAF from 2013, the state uses the same process used in prior years	6/10/2015
OR	Eligibility	MASBOE	Enrollment in MASBOE 34 increased from 151,600 to 228,400 between September 2013 and September 2014. With the implementation of the 2014 Medicaid Expansion, income requirements have changed, resulting in additional children gaining Medicaid eligibility.	6/10/2015
OR	Eligibility	Private Health Insurance	In Q1 FY09, OR started reporting a small number of individuals with state purchased insurance (Health Insurance = '3') each month. The state clarified that with its new eligibility system implemented in October 2008, it is better able to identify these enrollees.	12/15/2011
OR	Eligibility	Race/Ethnicity	Through Q4 FY14, OR reported 6,000 individuals with "1 or more races", in combined race/ethnicity field, but no individual is reported to more than one race in the five RACE fields. OR identified a problem in the program logic for the combined race/ethnicity field and has corrected the issue as of Q1 FY 2015.	4/24/2012
OR	Eligibility	Race/Ethnicity	OR reports about 130 partial duals monthly with full benefits (RBF= '1').	1/31/2013
OR	Eligibility	Restricted Benefits Flag	Oregon reported one individual to restricted benefits code 9 (an invalid code) in FY06 Q1-4. This problem was fixed beginning in Q1 FY07; however, the state does not seem to be able to fully correct this issue and continues to report 1-2 individuals in some (but not all) months.	10/1/2008
OR	Eligibility	Restricted Benefits Flag	Through 1/03, persons with restricted benefits code 5 (other) were generally medically needy enrollees. Beginning with 2/03 data (after the medically needy program ended), restricted benefits code 5 was used for most, but not all, 1115 expansion adults in MASBOE 55.	4/6/2012
OR	Eligibility	Restricted Benefits Flag	In June 2008, OR's Money Follows the Person (MFP) program was approved by CMS. MFP enrollees are individuals with long	4/16/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. MFP enrollment began in MSIS starting in June 2008, and these enrollees are assigned RBF code 8 in MSIS. As of late 2010, the program has been suspended indefinitely. Current enrollees are running out their 365 days, but the state is not enrolling anyone new. As a result, enrollment has decreased from 131/month in October 2010 to 10/month in September 2011. By Q3FY12, enrollees are no longer reported to MFP (RBF= 8).	
OR	Eligibility	SSN	Each quarter, several hundred SSNs are assigned to more than one record.	NA
OR	Eligibility	SSN	The percentage of SSNs that are 9-filled has always been a bit high in Oregon, in part because the state does not submit retro or correction records. Percentage of SSNs that are missing (9-filled) spikes in FY 2010, rising from 6.9% in Q1 FY 10 to 7.5-8% in Q2-Q4 FY 10; however, the percentage for the calendar year improves to 5.4% for CY 2010. FY 11 shows only about 6% 9-filled in MSIS. In FY 2013- FY 2014, the percent of 9-filled SSNs remained steady at about 4.9- 5.9 percent. (Additionally, starting in July 2012, SSNs with a leading 8 were issued by SSA; therefore, these SSNs are now considered valid).	4/6/2012
OR	Eligibility	State-Specific Eligibility	Through Q1 FY 2013, OR did not map Medicaid Buy-In (MBI) participants to MBI-specific eligibility groups. This is because OR used a separate field to track these beneficiaries, and this field is not included in MSIS data. In Q3 FY 13, the state added an MBI-specific code ('EPD') to the 3rd-5th byte of the state specific eligibility group field in MSIS for all MBI enrollees. The first two bytes are the enrollee's PERC code (internal eligibility group code).	10/7/2011
OR	Eligibility	TANF/1931	In December 2012, the number of TANF recipients reported in MSIS (83,000) differed from the number reported in ACF data (68,000) by 21 percent. We asked the state to verify whether TANF counts in MSIS were accurate, but did not receive a response.	10/15/2013
OR	Eligibility	TANF/1931	The percentage of individuals assigned to MASBOE 14, 15, 16, 17 who receive TANF (TANF Flag '2') declined from about 50% in Q3 FY 13 to less than 1% in Q4 FY 14 and beyond. The state said that the change is due to a systems issue causing an inability to report TANF data in MSIS. The state expects that individuals receiving TANF will be correctly assigned once the DCS system is implemented in 2017.	3/8/2015
OR	Eligibility	Waivers	OR is not reporting people with the correct waiver reporting hierarchy since at least Q1 FY 09. Since all 1915c waiver enrollees are also enrolled in the 1115 waiver and the 1915b waiver, this will cause inaccurate enrollment counts for individuals enrolled in multiple 1915c waivers. The state fixed this issue starting in Q1 FY 2015.	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
OR	Eligibility	Waivers	In Q1 FY 2011, only about 38% of OR's 1915c waiver enrollees have HCBS waiver services reported in the claims files (cause unknown). This percentage increases to 70% in subsequent quarters. OR did not provide a reason for this but verified that the 70 percent figure is correct.	9/18/2013
OR	Eligibility	Waivers	The MSIS files show large enrollment increases in waivers A7 and A8 in Q4 FY 2013. The state has said that this is expected and is because CHIP had been carved out in the past but are now included. The state has also said that going forward, effective Q1 FY 2014, the A8 Non-Emergency Medical Transportation (NEMT) services are included in the A7 Oregon Health Plan Section 1115 Demonstration and therefore not reported separately as waiver A8.	4/15/2014
OR	IP	DRG	There are nine state-specific DRGs that aren't flagged as state codes.	12/10/2004
OR	IP	Patient Status	There are no FFS Non-crossover Original Claims with a PATIENT-STATUS = '30' (Still a Patient). There are a small percentage (< .5%) of Encounters with a PATIENT-STATUS = '30'.	4/22/2011
OR	LT	Admission Date	In Q1FY1999 files, the beginning date of service was put in the Admission Date field as admission date was not available. After Q1, the field will be coded as missing.	8/22/2005
OR	LT	Covered Days	The Average Amount Paid per Covered Day for TOS 02 (Aged/Mental Health) fell 43% between Q4FY2010 ($623 Day) and Q1FY2011 ($350). Previously the State operated on a 'pay and chase' basis. Oregon now requires providers to bill third-party insurers prior to billing Medicaid.	4/20/2011
OR	LT	Leave Days	Leave Days are not covered.	NA
OR	LT	Patient Liability	The Patient Liability field contains both TPL and Patient Liability. This can't be corrected until the whole system is revised.	12/10/2004
OR	LT	Type of Service	Beginning in Q1FY2009, OR made several changes in its long-term care program. This caused several changes in the data. 1. The number of FFS Non-crossover Original claims for TOS = 07 (NFs - All Other) fell dramatically, Prior to Q1FY2009, the State paid about 300,000 claims per quarter. The average has fallen to roughly 18,000 - 20,000 per quarter. 2. The number of FFS Non-crossover Original claims for TOS = 05 (ICF/IID declined substantially. The State previously paid about 5,000 - 6,000 claims per month. The total fell to zero by Q2 2010. 3. The State tightened its criteria for IP Child Psychiatric Services. It now authorizes an average of only 1 - 3 children per month for these services. 4. All FFS IP Child Psych claims (TOS = 04) are for Children's Psychiatric Residential Treatment Services. These claims appear in the file with an IP Covered Days Indicator = 0 Days.	6/2/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
OR	OT	FQHC	There aren't any FFS claims with Program Type of 4 (FQHC) although Oregon has an FQHC program until 2005 when they started reporting a very small number.	6/9/2009
OR	OT	Managed Care Capitation	During Q3FY2010, Oregon corrected a system problem that allowed some recipients to be enrolled in a managed care plan without issuing a cap payment for them. This issue for prior months was resolved in April - June 2011. The State made the missed cap payments periods during this time. Additionally, due to budget issues, the capitation payments for July 2011 were made during the period June 29, 2012 - June 30, 2012. These actions are clearly visible in the OT data. The average number of all cap payments for April, May, August and September 2011 was roughly 1.6 million per month. However, the State made 3.3 million payments in June 2011. It made only 73,000 payments in July 2011.	2/28/2012
OR	OT	Type of Service	About one-third of the FFS Non-crossover Original Claims have a TYPE-OF-SERVICE = '26' (Transportation).	4/22/2011
OR	RX	NPI/Taxonomy	The percentage of FFS RX Claims with PROVIDER-TAXONOMY = "DME/Medical Supplies" is significantly higher than expected (Average = 13.5% for Q2FY2010 - Q1FY2011)). Oregon has determined that the default taxonomy for some pharmacy providers was assigned to the wrong Taxonomy Code. The State has indicated that it is working on the problem. It should be corrected before its submission for Q2FY2011.	4/20/2011
PA	_All	Waivers	Historically, PA has reported a relatively high number of 1915(c) waiver enrollees who had no HCBS claims. In particular, in calendar year 2007 75 percent of people enrolled in HMOs AND in HCBS waivers had no HCBS claims. The number of enrollees with no claims dropped notably in Q4 FY08. The state reported that FFS claims for waiver services Q3 FY08 were classified as "county paid" and not paid through MMIS and therefore were not included on MSIS CLAIMOT files. PA began to pay some services through MMIS after July 2008. All services after July of 2009 were to be paid through MMIS and should be included on MSIS CLAIMOT files.	3/21/2011
PA	Claims	Adjudication Date	The percent of claims paid each month is uneven because the adjudication flow is not always even.	12/10/2004
PA	Claims	Adjustments	The PA MMIS includes claims for both Medicaid and State Only programs. Claims are selected for MSIS based on the value in the FFP field. Sometimes people are enrolled into Medicaid who were on General Assistance retroactively (such as a delivery). When this happens the FFP on the claim(s) are not changed in the state MMIS, so they will not be included in MSIS.	3/2/2005
PA	Claims	ICN	Prior to Q3FY2013, ICNs for FFS claims and managed care encounters were 14 characters. Starting in Q3FY2013, Pennsylvania began removing an extra character (trailing null) from the ICN making it 13 characters.	12/6/2013

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	Claims	Managed Care Encounters	PA began submitting encounter data to MSIS in 2013 Q3. PA indicated that the data include encounter records for enrollees in the General Assistance program, which is a state-funded program and NOT Medicaid. They are working to filter out these encounter records for T-MSIS implementation.	11/26/2013
PA	Claims	Managed Care Encounters	The majority of PA's Medicaid eligibles are enrolled in comprehensive managed care but PA did not report any managed care encounters (TYPE-OF-CLAIM = 3) through Q2FY2013. Most of those not enrolled in comprehensive managed care are enrolled in some other kind of managed care including BHO plans.	1/8/2014
PA	Eligibility	1115 Waivers	PA implemented a new Family Planning 1115 waiver on June 1, 2007 (Q3 FY07). A very small number of enrollees were reported starting in Q1 FY08 with enrollment increasing throughout FY08. These enrollees are assigned state-specific eligibility group "PSF00" and mapped to MASBOE 54-55 with a restricted benefits flag of 6; however, PA did not assign these enrollees the FP waiver ID and type 'F' through Q3 FY08. The state fixed this reporting in Q4 FY08.	1/30/2012
PA	Eligibility	CHIP	Pennsylvania has an S-CHIP program, but no M-CHIP program. The state does not report its S-CHIP enrollment in MSIS.	1/30/2012
PA	Eligibility	Dual Eligibility Codes	PA provides full benefits for aged/disabled individuals to 100% FPL. This explains the low number of QMB plus (dual code '02') duals and the high number of Other Full (dual code '08') duals.	3/21/2011
PA	Eligibility	Dual Eligibility Codes	We generally expect partial duals to be reported to RBF 3; however, PA reports over 100 aged non-dual enrollees and about 50 disabled non-dual enrollees flagged with RBF 3. The state confirmed this mapping is correct.	4/6/2012
PA	Eligibility	Dual Eligibility Codes	In Q1FY14, approximately 200 individuals in eligibility codes PG 00, TA 65, TA 67, TJ 65, and TJ 67 were incorrectly assigned dual code '00' The state confirmed that these codes should be correctly mapped to: PG 00 dual 01 TA 65 dual 03 TA 67 dual 06 TJ 65 dual 03 TJ 67 dual 06	9/16/2014
PA	Eligibility	Family Planning	PA reports the State Eligibility Group, MASBOE, Dual Eligible code, and Restricted Benefits code for which the individual has the most Medicaid-Eligible days in the month. About 2.5% of the women enrolled in the Family Planning waiver were assigned to State Eligibility Group PSF00 for days enrolled waiver but, because there are more days in the month with another State Eligibility Group, the coding for the "other" State Eligibility Group is used on the MSIS record. This explains the number of eligibles outside of MASBOE 55 and RBF '6' who are reported to Waiver ID 'FP', Type 'F'.	4/6/2012
PA	Eligibility	Managed Care	The vast majority of PA Medicaid enrollees (including dual eligibles) have mandatory assignment to Health Choice HMOs and BHPs, as approved under a 1915(b) waiver. However, this waiver is not yet statewide.	8/8/2007

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	Eligibility	Managed Care	PA's 1915(c) HealthChoices waiver (waiver ID 'HC') requires most Medicaid enrollees to enroll with an HMO in counties where enrollees have a choice of Medicaid HMOs. While we would expect enrollment in Plan Type 01 (HMO) to be similar to enrollment in waiver ID 'HC' each month, more enrollees are reported to plan type 01 (~70,000 in FY08) than the count reported to waiver ID 'HC'. The state explained that in some counties, some enrollees (outside the HealthChoices waiver) are offered the option of enrolling in an HMO instead of the traditional FFS program, causing a larger HMO enrollment count compared to HealthChoices count.	1/7/2010
PA	Eligibility	Managed Care	PA's Access Plus 1915(b) waiver was implemented 1/1/05 (Q2 FY05) and started showing increased enrollment by March 2005 as the program continued to grow. This waiver is a PCCM program and essentially replaces the Family Care Network (FCN) waiver, except that Access Plus is intended to expand the categories of children eligible and provide a Disease Management component. Enrollment is mapped to Plan Type 07. Although both children and adults are enrolled in the Access Plus PCCM, only children (age < 21) are included in the Access Plus waiver.	1/7/2010
PA	Eligibility	Managed Care	Each quarter, PA reports about 500 partial duals to behavioral health plans. The state confirmed that partial dual eligibles should not be enrolled in behavioral health plans and that as the state identifies that these persons are enrolled in BHPs they are removed from these plans. The number of partial duals in BHPs will continue each month but the state is confident that as they are identified as duals they are subsequently removed from the plan.	6/25/2010
PA	Eligibility	Managed Care	The 2008 CMS data show about 34,000 individuals enrolled in a transportation PAHP plan (Logisticare Solutions); however, we did not see this enrollment reported in PA's MSIS data. We believe this plan might have been implemented in 2006. The state confirmed that PA offers a non-emergency medical transportation plan to its Medicaid enrollees and included this enrollment in MSIS starting in Q1 FY09 (Plan Type 08); however, the state reported about 400,000 enrollees per month, which is much higher than the count reported to the CMS report. The discrepancy occurs because the state reports the number of people who actually receive transportation services in the CMS report (about 40,000), while they report the total number of eligibles in MSIS. The state confirmed that they pay monthly capitation payments for each person eligible for transportation benefits (and they report these cap payments in the Claims OT file).	12/2/2010
PA	Eligibility	Managed Care	In June 2008 (Q3 FY08) PA reported about 292,000 individuals with PCCM (Access Plus Program) enrollment in MSIS compared to about 261,000 individuals in the CMS report. This 12 percent difference was slightly larger than expected.	3/21/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	Eligibility	Managed Care	Starting in the CMS June 2006 report, PA reported 33,127 individuals in a Disease Management (DM) PAHP. The state indicated that the DM program is a component of the state's Access Plus HMO (Plan ID 80). Therefore, enrollment in this program is not separately reported in MSIS. Some, but not all, of the enrollees in this plan receive the DM component.	3/21/2011
PA	Eligibility	Managed Care	In Q1FY13, there was a decrease of about 89,000 enrollees in the PCCM plan. This was caused by the termination of the Access Plus Waiver (AP) on 12/31/12. Components were covered (for a period 1/1/13-2/28/13) with CMS approval under the expanded and renewed 1915(b) HC waiver. PA moved to state-wide managed care on 3/1/13, causing the PCCM decrease. In month 3 of Q2 FY13, PCCM enrollment disappears.	7/16/2013
PA	Eligibility	MASBOE	All Years: Pennsylvania provides full Medicaid benefits for the aged and disabled up to 100 percent FPL, (state groups PS40, PS70, PS90, PH00, PH80), explaining why many people in MASBOE 31 - 32 have full Medicaid benefits. In addition, SSI disabled age 65 and older are mapped to MASBOE 11.	4/6/2012
PA	Eligibility	MASBOE	There are up to several thousand children (ages<18) reported to BOEs other than 4 and adults (age 19-64) reported to BOEs other than 5. The state has explained that this is a timing issue that they are unable to fix. Expect to see continued noise.	4/6/2012
PA	Eligibility	MASBOE	In Q1FY14, there were several unexpected changes in MASBOE reporting. PA stopped reporting some eligibility codes 10/1/13 and introduced new codes, causing several shifts. Specifically: -Decrease in MASBOEs 14 and 15 is due to the reporting end date of PC 27 (10/1/13). -Decrease in MASBOEs 16 and 17 is due to the reporting end date of PU 27 (10/1/13). -Increase in MASBOEs 24 and 25 is due to some eligibility codes being end dated and beneficiaries are transferred to TC 00 and TU 00. Additionally, the implementation of PA's MAGI codes (MG 00 and MG 27) on 10/1/13 caused increases in MASBOEs 34 and 35.	8/19/2014
PA	Eligibility	MASBOE	Between Q2 and Q3FY13, enrollment in MASBOE 44 declined from about 82,000 in January 2014 to about 52,500 in June 2014 (36.6%). The change mainly occurred in PC 00, PC 23, PC 71, and PU 71. The state explained that these enrollees were migrated over to the 'early implementation MAGI codes' (1115 demonstration prior to the change to Healthy PA (1115 demo).	3/26/2015
PA	Eligibility	MASBOE	Enrollment in MASBOE 45 increased from about 55,400 in October 2013 to 74,800 in March 2014 (35%). Then, it declined to 30,800 (-58.8%) in June 2014. The state originally ran Q2 using an outdated chartbook and needs to resubmit.	3/26/2015
PA	Eligibility	MASBOE	Enrollment in MASBOE 55 declined from about 94,000 in October 2013 to about 85,500 in June 2014 (-9%) The change occurred mainly in PSF00 (-41,400) and PSF10 (+36,896). The state explained that these plans represent the Select Plan for women. PSF 00 was end dated and PSF 10 replaced it.	3/26/2015

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	Eligibility	Restricted Benefits Flag	Effective FY03, PA assigned restricted benefits flag 5 to all medically needy aged, disabled, and adults (but not many children). Nevertheless, from 700-2,200 persons in MASBOE 31-32 are assigned restricted benefits code 0 or 9 by mistake. Persons in state specific groups PA 40, PH 00, PH 80, PH 95, PI 00, PS 40, PS 70, PS 90, PS 95, PW 00, PW 66, PS 80 (all these groups have a space in byte 3) should be assigned restricted benefits flag 1. Persons in groups PA 86, PG 00, PL 00, PM 86, TA 65, TA 67, TA 68, TJ 65, TJ 67, TJ 68 (all these groups have a space in byte 3), and B 80 (space in bytes 2 and 3) should be assigned restricted benefits code 3.	NA
PA	Eligibility	Restricted Benefits Flag	Through the end of FY05, PA assigned RBF 2 to very few enrollees in MSIS (none in Q3 FY05). PA started more complete reporting to this code starting in Q1 FY06. However, in each month over 200 aged and disabled duals (both partial and full) were mapped to restricted benefits code 2 (emergency services only for unqualified aliens). This reporting was greatly improved starting in Q3 FY08.	8/31/2009
PA	Eligibility	Restricted Benefits Flag	In Q1 FY09, PA started reporting MFP enrollees to RBF 8.	4/5/2010
PA	Eligibility	Restricted Benefits Flag	RBF 4 is assigned to people in state group PS 17 (presumptive eligibility for pregnant women).	6/17/2010
PA	Eligibility	Restricted Benefits Flag	PA assigns RBF 9 to about 600 individuals each month in MASBOE 31-32. The state indicated that this is due to a data problem it is not able to fix.	7/8/2011
PA	Eligibility	Restricted Benefits Flag	PA reports about 2,000 more individuals mapped to RBF 6 and MAS 5 than Waiver Type F. The state explained that MAS 5 includes some women who have alien status and are assigned RBF 2. Additionally, women who are assigned family planning eligibility during a month but spend more days that month in a non-FP state eligibility group will report to Waiver ID FP but not RBF 6.	4/6/2012
PA	Eligibility	SSN	PA appears to submit valid SSNs (9 digit numeric data) for 99 percent of Medicaid enrollees each quarter, which is a higher proportion than expected. We generally expect to see the SSN field 9-filled for at least 2-3 percent of enrollees, given that SSNs are not always available for some enrollees, such as newborns, younger children, or undocumented aliens; however, PA 9-fills the SSN field for about 0.5% of total records. The state verified that the SSN data is reliable and it is able to report actual SSNs for such a high percent of the Medicaid enrollees. Since MSIS data has been delayed in its submission, the state has extra time to ensure SSNs are included for as many records as possible (as the MSIS data become more timely, there might be a slight increase in the number of 9-fills). Additionally, PA has a specific program that creates a database for missing SSNs and requires counties to research and correct the records for these individuals. Finally, PA's newborn program provides for an SSN application while still in the hospital.	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
PA	Eligibility	TANF/1931	In general, reporting of TANF enrollment has been consistent between MSIS and ACF; however, in December 2007 (Q1 FY08) the counts diverged. The MSIS count remained relatively consistent with earlier years, but the ACF count shows a significant drop from December 2006 to December 2007 causing enrollment to be about 46% higher in MSIS. The state confirmed that they believe the MSIS reporting is still reliable. Differences continued through Q1FY2012 (December 2011). MSIS and ACF counts matched again in Q1FY2013.	4/5/2010
PA	Eligibility	Waivers	Through Q3 FY08, PA reported its PA's AIDS/HIVD waiver (waiver ID '80') as a 1915(c) waiver (waiver type '3'); however, this waiver is a combination 1915(b)(c) waiver and should have been reported to waiver type '4'. This reporting was fixed in Q4 FY08.	12/6/2009
PA	Eligibility	Waivers	In Q1 FY08, PA started reporting its new family planning waiver enrollment (state-specific eligibility group 'PSF00') to RBF 6 and to MASBOE 55; however, these enrollees were not reported with the correct assignments in the waiver enrollment data fields. The FP enrollees should have also been assigned to waiver ID 'FP' and to waiver type 'F'. The state fixed this reporting in Q4 FY08. (A small number of individuals are reported to waiver ID 'FP', but with different eligibility and/or RBF assignments--the state explained that there will be a little noise in the data due to the way the state system assigns eligibility codes and because a small number of women in the group are aliens and assigned to RBF 2.) Enrollment in the family planning waiver increased starting in Q1 FY 2009 and increased through FY 2010 to about 85,000 enrollees.	3/21/2011
PA	Eligibility	Waivers	Since at least Q1FY10, about 1,000 individuals in MASBOE 55 have been assigned to the Health Choices waiver (waiver ID 'HC', waiver type 2). Enrollment has increased to about 2,000 by Q1FY13. The assignment of waiver ID 'HC' for MAS/BOE 5 5 beneficiaries appears to be due to the fact that the beneficiaries were enrolled in multiple eligibility categories/program statuses during the reporting period. While they had days enrolled in waiver ID 'FP', waiver type F, they also had other days when they were enrolled in managed care as represented by waiver ID 'HC', waiver type 2. Technically, when a beneficiary was enrolled in waiver ID 'FP', waiver type F, the beneficiary is not eligible for 'HC' enrollment on the same days, but through the reporting month, it is possible the waiver enrollment(s) change, and the waiver IDs are reflecting those multiple waiver codes.	7/16/2013
PA	Eligibility	Waivers	Waiver ID '78' (PA - Michael Dallas HCBS for Persons Dependent on a Medical Device) expired 9/28/10; however, one person was still reported through Q1FY14. The state said they would stop reporting to waiver ID '78'.	8/19/2014
PA	IP	Adjustments	The Charge on void adjustment claims is positive instead of negative.	8/22/2005

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	IP	Covered Days	There is an issue with Covered Days for two (2) FFS Claims in the State's Q1FY2009 and Q2FY2009 IP files. They are both the result of problems in the Claims History. In Q2FY2009, there is a single claims with 5,903 Covered Days. The claims was actually for 2 Covered Days. In Q1FY2009, there is also a single claim with 67,292 Covered Days. The correct number of days is still undetermined.	4/19/2011
PA	IP	DRG	In March 2011, PA Medicaid implemented the All Patient Refined Diagnosis Related Groups (APR DRGs) in its MMIS payment system, retroactive to discharges on and after July 1, 2010. For that reason, the Q2 2011 IP file shows that the volume of non-crossover claims processed in March 2011 is approximately 30,000 more than in other months. This is the result of a mass adjustment of previously paid hospital inpatient claims. Nearly 30,000 records processed in the month were for services with the BEGINNING-DATE-OF-SERVICE between July and October 2010. The DRG value was zero-filled on all IP claims adjudicated between March 2011 and September 30, 2011 because of an error retrieving the data for MSIS. These types of mass adjustments to trailing quarter claims and the error in retrieving the APR-DRG value continued through Q4FY11. APR-DRG values began appearing in PA's Q1FY12 IP file.	3/29/2013
PA	LT	Adjustments	PA performed a mass rate adjustment on LT claims in March and April 2009. Beginning in Q1FY2009 PA began replacing claims by submitting a void and a new original claim that replaces the old original claim. This resulted in a very large increase in the number of FFS Originals and Voids submitted for Q2 and Q3FY2009. The State reported 65,000 FFS Original claims in February 2009, compared to 225,000 in March and 401,000 in April. It reported 8,600 FFS Voids in February 2009, compared to 168,000 in March and 304,000 in April. Almost all of the "Replacement Originals" (97.1%) had an END YYYYMM from 200801 through 200909. PA performed similar mass adjustments in Q1FY2011, Q4FY2011, and Q1FY2012.	1/24/2013
PA	OT	Crossovers	Prior to Q1FY2009, Pennsylvania significantly under-reported FFS Crossover Claims. The claims extraction process failed to pull in a majority of the records. In Pennsylvania, Crossover Claims are paid at the header-level. However, the extraction code looked for records at the detail-level. Since detail-level date were unavailable, it did not include most Crossover Claims in the OT file. Pennsylvania reported only 13,900 FFS Crossover Claims in Q4FY2008. It reported 516,300 in Q1FY2009 and 494,400 in Q2FY2009. The State is now reporting FFS Crossovers correctly.	4/19/2011
PA	OT	Crossovers	PA reports the full Medicare coinsurance and deductible on crossover claims rather than the portion of the coinsurance and deductible paid by Medicaid. For this reason, the sum of MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT do not equal the MEDICAID-AMOUNT-PAID on the majority of claims.	11/20/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
PA	OT	Diagnosis	The diagnosis code on some EPSDT screens is "EPSDT."	12/10/2004
PA	OT	Field Formatting	Beginning in Q1FY2009, PA began to report some OT claims with the following fields incorrectly formatted: (1) MSIS-IDENTIFICATION-NUMBER; (2) PROVIDER-ID-NUMBER-BILLING; (3) PROVIDER-ID-NUMBER-SERVICING; (4) PLAN-ID-NUMBER; (5) INTERNAL-CONTROL-NUMBER-ORIG; and (6) INTERNAL-CONTROL-NUMBER-ADJ. The State right-padded these fields with 'Null' values. They should have right-padded them with Spaces. This can cause problems in linking OT claims with EL records. The linkage rate will be substantially lower than expected.	9/29/2011
PA	OT	Managed Care Capitation	The Maternity Care payment is for each live birth outcome. A live birth outcome is defined as one or more live deliveries. For example, if a recipient of a managed care plan delivers twins, the managed care plan is paid for one live birth outcome. Each managed care plan is paid an amount that is negotiated in advance between the Commonwealth and each managed care plan. The negotiated rate must be within the rate range of actuarially sound rates that the Commonwealth's actuary develops. These rate ranges are developed for different geographical rating areas in which the managed care plans operate. The rate ranges cover dates of service for a given length of time, typically in increments of 1 year. The rate ranges are based on an estimate of the costs the managed care plan can be expected to incur for a pregnancy, with an additional allowance for administrative costs and profit. Separate claims must be submitted by the managed care plan for each live birth outcome. The payment is to compensate the managed care plan for all services received by the woman during the period 5 months prior to delivery, the delivery itself, and 2 months after the delivery. These payments are reported as capitation payments.	3/10/2005
PA	OT	Managed Care Capitation	Starting with Q1FY2004, PA will report maternity care payments to managed care plans as cap claims (type of claim 2), and TOS 21. These claims are essentially a global payment to the managed care plan for any live delivery, and include 5 months of prenatal care and 2 months of post-natal care as well as the delivery. The plan ID will be included, as will their system's provider ID. State proc codes of W1871 and W1872 identify these semi-service semi-cap claims.	3/30/2005
PA	OT	Managed Care Capitation	Until Q2FY2004 all PACE capitation claims were reported with a type of service of 20 (HMO capitation payment). However, there are 2 levels of PACE - full PACE and partial or pre-PACE. Starting with Q2FY2004 the full PACE capitation claims will have a type of service of 20 and the partial PACE capitation payments will be reported with type of service 21.	4/12/2005
PA	OT	Managed Care Plan IDs	PA began reporting managed care plan 42 (United Healthcare of PA) in the OT file in Q2FY2011. Enrollments with this plan ID did not appear in the EL file until Q4FY2012.	12/17/2012

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
PA	OT	Medicaid Amount Paid Total	The total Medicaid Amount Paid for Original Non-crossover FFS claims increased sharply between Q3 and Q4FY2009. Total expenditures increased from $462.5 million in Q3FY2009 to $718.5 million in Q4FY2009. While the total number of claims rose about 9.4%, the total Medicaid Amount Paid increased more than 55%. During the same period, the average Medicaid Amount Paid per Original Non-crossover FFS claim rose substantially. It was $88 in Q3FY2009, compared with $125 in Q4FY2009. After a reviewing the data, the State determined that there was a marked increase in the number of claims with Specialty Codes 510; 512 - 516; 521 - 522; 524; 531; and 540 - 541. According to PA, these Specialty Codes are used frequently in the Pennsylvania Consolidated HCBS Waiver. CMS approved this Waiver effective July 2007. Before July 1, 2009, providers billed each county's MH/IID program directly; not through the State's MMIS. After July 1, 2009, the Department implemented a change in billing based on a recommendation from CMS. Providers began to bill for waiver services through the State's system. The claims associated with the Specialty Codes noted above accounted for over $263 million in Original Non-crossover FFS claims processed during Q4FY2009, compared with $7.8 million in Q3FY2009. The average Medicaid Amount Paid on claims with these Specialty Codes was roughly $359. The increase contributed to a concurrent rise in the average Medicaid Amount Paid between Q3 and Q4FY2009.	8/22/2011
PA	OT	MSIS ID	Beginning in Q1FY2009, PA began to report some PHP (TOS 21) cap payments with an incorrectly formatted MSIS ID. The IDs appear in the DQ and Validation Reports as 20-Character Alpha-Numeric values. They should appear as 9-Character Numeric values. The State formatted these IDs as 9 Numeric Characters followed by 11 Null Characters. The 11 Nulls should be 11 Blanks. The State indicated that the incorrect MSIS IDs are for PHP payments with PLAN-ID-NUMBER = 'MATP51'. They are extracted from a separate source than the other cap claims. They are then merged into the final file OT file. After reviewing the claims in question, PA confirmed that the first 9 Numeric Characters are the correct MSIS IDs.	9/28/2011
PA	OT	Type of Service	There are a large number of claims with a Type of Service of 19 (Other Services) and a Place of Service of 12 (Home). According to Pennsylvania, these are not Home Health services and are being correctly reported.	12/10/2004
PA	OT	Type of Service	DME and supplies billed by LT facilities are reported in the OT file (as approved by CMS)	10/7/2011
PA	OT	Type of Service	In Q1FY2012 total lab/x-ray expenditures decreased by about $14 million and outpatient hospital services increased by about $14 million. In Q2FY2012 lab/x-ray and outpatient hospital service expenditures were nearly identical to Q1FY2012 lab/x-ray and outpatient hospital service expenditures, respectively. Expenditures for lab/x-ray and outpatient hospital remained stable after Q1FY2012.	4/24/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
RI	Claims	Adjustments	When a claim is adjusted, Rhode Island voids the original claim itself and therefore there isn't any original claim. If a claim is adjusted in the same quarter as the original, then Rhode Island will create a "dummy" original claim. If the claim is adjusted in a later quarter, the original claim will be have been submitted in the MSIS files, so the state will not need to create a "dummy" original. The voided original claims will be flagged as "voids" and the Medicaid Amount Paid will be a negative amount.	12/10/2004
RI	Claims	Adjustments	The date of payment on void adjustments is the date of payment of the original and not the date the void was adjudicated.	3/25/2011
RI	Claims	NPI	RI began using NPIs in its legacy provider ID fields beginning with its Q4FY2010 submissions	3/25/2011
RI	Eligibility	1115 Waivers	RI's Global Consumer Choice Compact 1115 waiver proposal was approved by CMS in January 2009 and implemented in July 2009. RI is providing all Medicaid services through this one 1115 waiver beginning in Q4 FY 09. Distinct populations within this 1115 waiver are still reported to separate (but new) waiver IDs in MSIS.	4/1/2011
RI	Eligibility	1115 Waivers	In Q1-Q3 FY 2009, all non- Family Planning RiteCare Waiver enrollees (Waiver 'RC') had a corresponding 88-filled Waiver Type. These enrollees should have been assigned to Waiver Type '1'. This issue was corrected in Q4 FY 2009.	4/15/2011
RI	Eligibility	1115 Waivers	RI's 1115 also added a RIte Share program effective 2001. This program is a premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance/ESI. These participants can be in several different aid categories and can also be counted as adult M-CHIP enrollees. RI's RIte Share enrollment level was estimated at about 6,400 in March 2007 (per CMS section 1115 waiver documentation). State officials indicated that most of these participants were incorrectly assigned health insurance code 2; however, this was fixed in Q1 FY08 when the state started assigning either codes 3 or 4. RIte Share claims for these participants are included in MSIS.	7/8/2011
RI	Eligibility	1115 Waivers	Beginning in 1994, Rhode Island implemented an 1115 program for children and adults. This 1115 plan has always covered infants 185-250% FPL, children 1-5 years 133-250%, children 6-7 years 100-250% FPL, and family planning only recipients 250%. Until January 1997, it also covered children 8-19 years 100-250%, but then that group also became the first M-CHIP population. Until January 2001, it also covered pregnant women 185-250% when this group was transferred to M-CHIP as well. However, in November 2002 RI switched to covering "unborn children" < 250% FPL under a separate CHIP (S-CHIP) plan. From January 1998 to January 2001, RI covered parents 110-185% FPL under the state's 1931 provisions; however, this group was transferred to the 1115 program and M-CHIP effective January 2001. Beginning in July 2009, Rhode Island	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			folded all existing waivers and Medicaid enrollees into its Global 1115 Demonstration waiver, through which all Medicaid services are provided.	
RI	Eligibility	1115 Waivers	In Q4 FY 2009, RI began reporting about 65,000 people monthly to Waiver Type = '1', Waiver ID= '88'. These individuals are receiving services funded via "Costs Not Otherwise Matchable" (CNOM) funding as of July 2009 through the Global 1115 Waiver. Beginning in Q1 FY 2010, the state began reporting these individuals to a new Waiver ID ('19').	4/6/2012
RI	Eligibility	1115 Waivers	RI's MASBOE crosswalk lists several adult groups (ranging from 100-185% FPL) as 1115 expansion population groups, reported to state-specific eligibility groups C1, C5, and C7. These may be RIteShare (ESI/HIPP) enrollees, but we have asked RI to clarify who is included in these eligibility groups.	1/23/2013
RI	Eligibility	CHIP	Beginning January 1997, Rhode Island covered children 8-19 years 100-250% FPL as an M-CHIP group. Then, in January 2001 it added pregnant women 185-250% FPL and parents 110-185% FPL as M-CHIP groups. The child M-CHIP groups were all previously covered as expansion populations under the state's section 1115 program while the parents were previously covered under the state's section 1931 provisions. Then, effective November 2002, RI added an S-CHIP program covering unborn children up to 250% FPL (including undocumented aliens). This S-CHIP group of unborn children is not reported in MSIS. RI does not have a child or adult S-CHIP component.	2/14/2012
RI	Eligibility	CHIP	RI's M-CHIP adults are not reported in SEDS. Additionally, counts of M-CHIP children age 19 and under consistently remain lower than the counts in SEDS. The two systems use slightly different methods of counting, but the state believes that the MSIS counts are more precise.	9/25/2012
RI	Eligibility	CHIP	RI's M-CHIP enrollees have always been mapped to MAS 5 as originally this group was granted coverage as an 1115 expansion population. Similarly, eligibility groups '58', '59', and '61', pregnant and postpartum groups 185%-250% FPL, initially covered via expansion and mapped to RBF= 4, are reported to MASBOE 55. Both of these populations are covered by M-CHIP.	10/23/2012
RI	Eligibility	County Codes	Rhode Island has always had a larger than expected number of persons with County Code = 000. These individuals live out of state, so do not receive a valid FIPS code. In addition, the percentage with a missing county code (County Code = 999) started to increase in Q2 FY 2009. By Q3 FY 13, 70% of enrollees had a missing county code. The state has said that this is because county code is no longer a required field on the medical assistance application.	2/14/2012
RI	Eligibility	Dual Eligibility Codes	The percent of aged enrollees (those age 65+) who are duals dropped substantially in Q4 FY 09 (from 96% in Q3 FY 09 to 84% in Q4 FY 09) (cause unknown). It remained low (in the 83-87% range) from Q1 FY 10- Q1 FY 11. It appears this may have	2/14/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			to do with the fact that many (70-80%) of expansion beneficiaries (MAS 5) with BOE 1 are non-duals. It appears that many of these individuals (approximately 2000) are duals according to the EDB, but not MSIS. We have asked the state to investigate.	
RI	Eligibility	Dual Eligibility Codes	Effective by at least 2001, RI extended full Medicaid benefits to all aged/disabled up to 100 percent FPL. However, it is unclear where these enrollees are being reported as there are no full duals being reported to MASBOE 31-32 (cause unknown). The state has said that these enrollees are included in the MSIS data, but it is unclear where they are being reported (we've asked the state about this multiple times, but have not received a response).	4/6/2012
RI	Eligibility	Dual Eligibility Codes	In Q2-Q3 FY 13, partial dual enrollment showed a 18-19% discrepancy from MMA. We have asked the state to verify that the MSIS counts are accurate	1/23/2013
RI	Eligibility	Managed Care	Enrollment in MC plan type 02 jumps about 10% from October to November 2009. We have asked the state if this was expected but did not receive a response. Enrollment jumps again more than 20% between December 2012 and January 2013 from 44,000 to 55,000. We have asked the state about the reason for the increase.	2/14/2012
RI	Eligibility	Managed Care	In 2010 and 2011, a small PCCM is reported in the CMS Managed Care Summary but not in the MSIS data. It is named the "Connect Care Choice" PCCM, according to the CMS Managed Care Summary. We have asked RI if this plan is still active, and if so, to begin reporting it in MSIS.	2/14/2012
RI	Eligibility	Managed Care	RI's MSIS FY07-08 reporting does not include any dental managed care enrollment, whereas the 2007 June CMS managed care report included about 33,000 individuals enrolled in United Health Care Dental - Rite Smiles. The state began reporting these enrollees to MC plan type = '2' and plan ID= 'DB60072' in MSIS in Q1 FY 09. Additionally, these individuals were transitioned to the Global 1115 Waiver starting in January 2009, and reported to Waiver Type = '2' with an 88-filled Waiver ID beginning in Q1 FY 09 (we have asked the state to assign a Waiver ID to this population, and to re-map this group to waiver type = '1', but they have not done so).	2/14/2012
RI	Eligibility	Managed Care	Most (over 80%) of RI's Family Planning waiver enrollees are reported to an HMO. This seems unusual, and we have asked the state to clarify whether this is accurate.	10/23/2012
RI	Eligibility	MASBOE	FY 2010 - Q1 FY2011: In the state's first submission of these files, 5,000 - 7,000 people in MASBOE 55 were age 65+ and about 400-500 people each quarter were reported to MASBOE 31 that are less than 65 years of age. This issue was fixed in the state's resubmission of Q1 FY 10- Q1 FY 12.	4/6/2012

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RI	Eligibility	MASBOE	There was a 30% drop in MASBOE 51 in March 2010 (from about 4,000 to 2,800). We have asked the state about this.	4/6/2012
RI	Eligibility	MASBOE	Through Q4 FY 2009, RI reported about 200-300 persons under age 65 to MASBOE 31. This issue was corrected in Q1 FY 2010.	4/6/2012
RI	Eligibility	MASBOE	Enrollment in MASBOE 3A, which corresponds to eligibility group 'CA', drops by about 45% from October to November 2009 (526 to 292). We included a question about this in our MSIS review to the state, but did not get a response on this particular issue. Additionally, the state continues to report a very small number of individuals in group 'CA' to MB 39 via retro-correction records.	9/25/2012
RI	Eligibility	MASBOE	RI had a CHIPRA-related SPA approved to lift waiting period for children subject to 5-year bar effective 7/1/09 for both Medicaid and CHIP. We may see this lead to an enrollment increase for children (BOE = 4) after this time.	9/25/2012
RI	Eligibility	MASBOE	Y 2010- FY 2013: About 500-600 QI-1s (Dual Code = '06') per month (all assigned state-specific eligibility group 'Q1') are mapped to MASBOE 35. We have asked the state to re-map these individuals to MASBOE 31 or 32.	10/4/2012
RI	Eligibility	MASBOE	2010: Enrollment in MASBOE 15 drops by about 10% in October, then increases by about 10% in November 2010 (cause unknown). Enrollment in MASBOE 44 drops by over 10% in October 2010.	10/23/2012
RI	Eligibility	MASBOE	RI plans to increase income and/or asset limits for long-term care or medically needy groups in FY 2012. This may lead to increased enrollment in these groups.	11/6/2012
RI	Eligibility	MASBOE	2011 there was a substantial increase in percent of people with claims, but with missing Medicaid eligibility. Specifically, the percent with claims but missing Medicaid eligibility grew from approx. 1 percent in 2009-2010 to 6 percent in 2011 (to 15,000 people), with $62 million in Medicaid paid for people with missing eligibility.	10/29/2013
RI	Eligibility	Medically Needy	Until FY 2009, medically needy enrollees were reported to MAS 2, but were shifted to MAS 5 in Q1 FY 2009 when the state made a programming change. However, this issue was corrected as of Q1 FY 2010, with medically needy enrollees correctly mapped to MAS 2 again.	4/6/2012
RI	Eligibility	MSIS ID	Beginning in FY 2010, the number of enrollees with duplicate records is rather high (1,000-1,600 per quarter) and growing. State has explained that this is because the new Medicaid eligibles (who were formerly state-only groups, but now receive federal funding under the global 1115) have two separate IDs for internal tracking purposes, creating two separate records in the MSIS files. RI has said that they do not have a fix for this issue.	4/6/2012
RI	Eligibility	Private Health Insurance	RI's HIPP program, called RIteShare, was implemented in 2001. These enrollees are receiving wraparound services in addition to	4/7/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			premium assistance. Participants were reported to health insurance code 2 initially, but were correctly reassigned to health insurance code 3 (or 4 if an employer also pays part of the premium in addition to the state) in Q1 FY 08. (The ~50 enrollees assigned to HI code 3 prior to Q1 FY08 are not RIteShare participants.) Due to RIteShare, an unusually high percentage of Medicaid enrollees have private insurance (17 percent in 2009).	
RI	Eligibility	Race/Ethnicity	RI has had an unusually high percentage with unknown race. RI has indicated that this is because race is not a required field on the medical assistance application.	2/1/2012
RI	Eligibility	Restricted Benefits Flag	A small but growing number of non-dual enrollees (about 70 per month in Q4 FY 12) are assigned restricted benefits flag 3 each month. We have asked the state to investigate.	2/14/2012
RI	Eligibility	Restricted Benefits Flag	In Q3-4 FY08, RI reported about 2,900 individuals each month with the RBF field 9-filled. These were state only enrollees in state groups EI and G1 that should not have been included in RI's MSIS reporting. The state corrected this reporting in Q1 FY09. However, these groups, along with several other formerly state-only groups, became eligible for federal funding in July 2009 under the global 1115 waiver. Additionally, beginning in Q3 FY 12, RI begins to report about 300 people with RBF= 9 monthly. We have asked the state to review and correct.	2/14/2012
RI	Eligibility	Restricted Benefits Flag	Medically needy enrollees are assigned restricted benefits code 5 ("other"). Until FY 2009, these medically needy enrollees were also reported to MAS 2, but were shifted to MAS 5 in Q1 FY 2009 when the state made a programming change. Medically needy enrollees were correctly shifted back to MAS 2 in Q1 FY 2010. However, the state still assigns many individuals in MAS 5 to RBF= 5. We have asked the state to clarify what this additional group represents.	2/14/2012
RI	Eligibility	Restricted Benefits Flag	Women in state groups 71, 73, and 74 only qualify for family planning services. They were assigned restricted benefits flag 4, along with pregnant women. These FP groups were assigned RBF 6 starting in Q2 FY05. The state also reported these individuals to Waiver ID= 'RC', Waiver Type= '1' until Q4 FY 08, but began correctly reporting them to Waiver ID= 'RC', Waiver Type= 'F' in Q1 FY 09.	4/6/2012
RI	Eligibility	Retroactive/ Correction Records	Beginning in FY 2001, Rhode Island submits an unusually high number of correction records. The state explains that, prior to FY 2001, a programming error caused only 1/5 of its correction records to be included in MSIS. Analysis of Rhode Island's corrections shows that most are not changing key data elements (with the exception of the waiver fields through Q1 FY 2010).	3/21/2011
RI	Eligibility	Retroactive/ Correction Records	Retro-correction records submitted with the FY 2010 files were causing very large unexplained enrollment shifts in Waiver ID 'RC' through Q1 FY 2010.	10/4/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
RI	Eligibility	State-Specific Eligibility	In Q2 FY 2009- Q1 FY 2012, enrollment is reported to state-specific groups EI, G1, CM, CA, BZ, D1, and D2, which are state-only groups according to RI's crosswalk. The state has said that these groups are now covered by federal funds under the global 1115 waiver, and should be reported in MSIS. We have asked the state to submit an updated crosswalk.	4/6/2012
RI	Eligibility	State-Specific Eligibility	According to RI's MASBOE crosswalk, it appears that groups 'C1', 'C5', and 'C7' are "employer sponsored insurance" (RIteShare) groups, but we have asked the state to verify this.	9/17/2013
RI	Eligibility	State-Specific Eligibility	Between December 2012 and June 2013, enrollment in MASBOE 14 (state-specific eligibility group 'UM') drops from 8,747 to 7,146 (an 18 percent decrease). We have asked the state about this.	10/29/2013
RI	Eligibility	TANF/1931	MSIS showed about 14 percent more TANF recipients than ACF in FY02. By FY05, this difference increased to about 30 percent. RI indicated that enrollees in their state-run TANF program are also counted as TANF enrollees in MSIS as their system is not able to distinguish between the two programs. The state started 9-filling this field in Q1 FY08.	9/24/2009
RI	Eligibility	Waivers	RI's HCBS Habitation waiver (CMS control number 0379, Waiver ID 'W8') was approved in 2001 and is currently active in the state, and is reported under Waiver ID 'W4' until June 2009. In June 2009 and later, enrollment is reported under the new global 1115 waiver and Waiver ID '04', Waiver Type '1'.	4/1/2011
RI	Eligibility	Waivers	In FY 2009, there was an unexpected drop in enrollment for Family Planning waiver enrollees from about 800 to 500 per month (cause unknown).	6/13/2011
RI	Eligibility	Waivers	In July 2009 onward, all 1915c waivers were transitioned into RI's global 1115 waiver. Individuals formerly receiving HCBS services through a 1915c waiver are presumably receiving these services through the global 1115 waiver, but we will ask the state about this in our next review. RI is still reporting the HCBS claims for these individuals to program type = 6 or 7. As a result, 100 percent of HCBS services were provided to non-1915c waiver enrollees in July 2009 onward.	9/25/2012
RI	IP	DRG	There are no DRGs reported until Q4FY2010.	3/25/2011
RI	IP	Procedure Code	Very few procedure codes are included in the file as they are not required to be included by the providers, even though they use the UB-04 form.	3/25/2011
RI	LT	Leave Days	Leave Days are not covered in RI.	7/11/2011
RI	OT	Crossovers	Crossover claims account for over 50% of original, FFS claims	6/30/2011
RI	OT	Supplemental Cap Claims	RI bills supplemental payments to HMOs with Type of Claim = 5 and Type of Service = 20.	3/25/2011
RI	OT	Type of Service	A large percent of claims (9%) are for Type of Service 33 (Rehabilitation Services).	3/25/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
RI	OT	Type of Service	There aren't any claims with a Type of Service of 34 (PT and other therapies).	3/25/2011
RI	RX	Date Prescribed	Date Prescribed is always missing. They 9-fill the field.	3/25/2011
RI	RX	Family Planning	There aren't any claims with a Program Type of 2 (Family Planning).	NA
RI	RX	Quantity	The Quantity of Service on most claims was reported as 0 until Q2FY2008.	3/21/2011
SC	Claims	Crossovers	Starting in 2003, South Carolina's crossover claims will be reported with a summary record with the coinsurance and deductible amount for all line items and then separate line items with the coinsurance and deductible fields 0-filled.	3/21/2011
SC	Eligibility	1115 Waivers	Beginning in 1993, SC implemented a section 1115 program with family planning only coverage. Enrollees in this program Were reported to MASBOE 54-55. SC's family planning waiver enrollees are no longer covered under a waiver as of 1/1/2011, but are instead covered under the state plan. After the waiver's expiration, these enrollees can still be identified by state eligibility group __55. In the Q2 FY 2011-Q4 FY 2011 files, when family planning waiver enrollment was supposed to have ceased, the state incorrectly reported family planning enrollees to MAS 5 (though it ceased reporting them to Waiver Type = F and Waiver ID= WF). This issue was corrected starting with the state's Q1 FY 12 file.	4/9/2012
SC	Eligibility	CHIP	SC's S-CHIP program began in May 2008 but expired as of October 1, 2010. The S-CHIP program was called Health Connections Kids and covered children in families with 150 - 200% FPL. The S-CHIP Program experienced an enrollment increase of ~60 percent between September-December 2008. The state indicated this was expected. Upon expiration of the S-CHIP program, all children were moved into SC's M-CHIP program beginning in Q1 FY 2011.	4/3/2012
SC	Eligibility	Dual Eligibility Codes	No aged person (BOE=1) in SC's eligibility data is reported as a non-dual (dual code '00'). When asked about this, the state responded that it assigns the dual code based on the person's eligibility category and the presence of Medicare eligibility dates on file. EDB linking of 2008 data shows that approximately 1,200 of SC's 63,000 aged enrollees, all of which were reported as a dual in MSIS, did not link with the EDB, a relatively low percentage.	3/21/2011
SC	Eligibility	Dual Eligibility Codes	South Carolina does not report any eligibles with dual code 01 since the state extends full Medicaid benefits to all aged/disabled up to 100 percent FPL.	3/21/2011
SC	Eligibility	Dual Eligibility Codes	With CMS's approval, SC began assigning a small number of family planning waiver enrollees to dual code = 09. The state says it is doing this because MMA is using dual code 09 for this population, and they want the two to be consistent. However, beginning in March 2012, enrollees are no longer reported to	12/16/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			dual code = '09' in MMA. We have asked the state to cease reporting dual code '9' in the MSIS files, but as of Q1 FY 2015 this issue remains.	
SC	Eligibility	Dual Eligibility Codes	In many quarters beginning in FY 08, counts for dual code = '06' (QI-1s) show fluctuations from month-to-month, and discrepancies from MMA reporting. However, MMA anomalies note that there have been large fluctuations in the MMA data as well, due to frequent eligibility redetermination for this group, particularly at the beginning of a calendar year (Q2 of the fiscal year). Many of these large fluctuations are often corrected with retro records in subsequent quarters. It appears that SC often retroactively corrects its MSIS counts with retro records as well, and through CY 2008, SC's dual code= 06 counts have been very close to the EDB. When including retro-correction records, enrollment in CY 2008 was smooth from month to month. Additionally, in Q2 FY 2014, enrollment in Dual Code '8' shows a 19% difference from MMA; in Q3 FY 2014, this discrepancy grew to 69% (cause unknown).	4/6/2012
SC	Eligibility	Dual Eligibility Codes	Each month, SC reports about 5000 non-duals to MASBOE '32' (cause unknown).	3/1/2013
SC	Eligibility	Managed Care	PCCM (plan type '7') enrollment declines from 180,000 in December 2013 to 170 in January 2014. Two new comprehensive managed care plans with 170,000+ enrollees began during this same timeframe. The state reports that as of 1/1/14, PCCM is no longer an active Managed care plan option for SC Medicaid recipients and the only enrollees now are special cases. Most of the former PCCM enrollees were transitioned to these two new comprehensive managed care plans, while the rest were transitioned to Wellcare, HM3800.	4/7/2014
SC	Eligibility	Managed Care	In May 2007 (Q3 FY07), SC started reporting its new non-emergency transportation plan enrollment in MSIS. This caused enrollment in Plan Type 08 (other) to increase from about 5,000 enrollees per month to over 600,000. Through FY 2008, two non-emergency transportation plans were active-- Logisticare and MTM. These plans were reported as Transportation Prepaid Ambulatory Health Plans (PAHPs) in the CMS June 2008, 2009, and 2010 managed care summary. The number of PHP claims and payments in the OT file dropped substantially from 750,000 to 500 in March 2011. Claims documentation indicates that these plans reportedly left the market in 2011. However, the CMS Managed Care Enrollment report's 7/1/2011 enrollment figures, however, are consistent with the eligibility file. The state has also clarified that one of the plans (Logisticare) is still active through 2014.	6/5/2014
SC	Eligibility	Managed Care	SC's overall non-emergency transportation plan enrollment (Logisticare, plan ID 'TB1000', and MTM, plan ID 'TB2000' (active through December 2012)) is relatively steady throughout FY 2011-FY 2014. However, starting in March 2011, PHP capitation claims (Type-of-Claim = '2', Type-of-Service = '21')	10/14/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			drop from 750,000/month (consistent with enrollment) to just 500 per month. According to the state, the payment for these plans is no longer on a PMPM basis, but rather the broker is paid via gross adjustment. As a result, we do not expect these payments to show up in the claims files but enrollment will be reported in the EL files.	
SC	Eligibility	MASBOE	All Years: South Carolina exhibits a seam effect between the last month of one quarter and the first month of the next quarter. This problem also affects other fields, most notably Plan Type. It is resolved by their submission of retroactive records.	NA
SC	Eligibility	MASBOE	All Years: South Carolina provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.	NA
SC	Eligibility	MASBOE	All Years: SC reports many more aged SSI recipients to MASBOE 11 compared to the SSI administration data. Two factors may contribute. First, SC has a state-administered SSI supplementation program. Second, in FY00 and FY01, SC in some quarters reported all disabled SSI recipients age 65 and older as "aged." However, in later quarters, some disabled enrollees over age 65 are reported to MASBOE 12.	3/21/2011
SC	Eligibility	MASBOE	Between September and October 2010, there was a 10% increase in MASBOE 34. This increase was likely due to the state's transition of all S-CHIP to the M-CHIP program on October 1, 2010. In October 2012, there was a 14% increase in MASBOE 34 enrollment (cause unknown).	4/3/2012
SC	Eligibility	MASBOE	Enrollment in MASBOE 48 increases from 12,000 to 19,000 from July 2011- June 2012 (cause unknown).	3/1/2013
SC	Eligibility	MASBOE	Between December 2013 and March 2014, enrollment in MASBOE 15 increases from 68,000 to 80,000. We have asked the state to indicate the reason for this increase.	4/7/2014
SC	Eligibility	Private Health Insurance	South Carolina has a Medicaid premium assistance program which pays a portion of health insurance premiums for low-income (<200% FPL) employees of small businesses. Employer and employee are also required to contribute towards the premium. Premium assistance enrollees are reported to Private Health Insurance Code= '3'.	11/16/2012
SC	Eligibility	Race/Ethnicity	South Carolina does not assign any individuals with a Hispanic/Latino ethnicity code to a race code (either in the expanded 5-race variables or in the combined race/ethnicity field). Additionally, each quarter about 5 percent of South Carolina's eligibles have an "unknown" race. Additionally, in each quarter through Q1 FY 2011, individuals of 'Hawaiian/Pacific Islander' race are reported in the combined race ethnicity field (RACE-ETHNICITY-CODE) but not the race field (RACE-CODE). We asked the state to begin reporting individuals to the Hawaiian/Pacific Islander category in the race field ('RACE-CODE') so that the two are consistent. This issue was corrected starting in Q2 FY 2011 files, but with this coding	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			change appeared other changes to race reporting (increase in Hispanic/Latino, decrease in American Indian/ Alaskan native). Finally, there are 2000+ reported as "more than 1 race not Hisp/Latino" in combined race / ethnicity field but no one is reported to more than one race in the 5-race variables. We have asked the state to correct this so that reporting aligns between the two fields.	
SC	Eligibility	Restricted Benefits Flag	Beginning in Q3 FY07, SC began assigning RBF 5 to a small number (<150) of enrollees in MASBOE 41-42 and 44-45. The state indicated that this represents a small population of inmates who are covered for emergency services. However, all of these individuals are reported as full-duals in MSIS.	3/21/2011
SC	Eligibility	SSN	The number of current records reported with an SSN with a leading 8 (considered to be invalid) has risen steadily from 1,300 in Q1 FY 2012 to nearly 18,000 in Q2 FY 14 (1.6 percent of all current records). Effective July 2012, SSA began to issue SSNs with leading 8s, therefore, these SSNs are now valid.	4/7/2014
SC	Eligibility	State-Specific Eligibility	South Carolina reports MBI enrollees to state specific eligibility group '5040'. In Q1 FY 2010 through Q4 FY 2010, the state correctly mapped these enrollees to MASBOE 42, but in Q1 FY 2011, began again incorrectly mapping them to MASBOE 32. CMS has given the state permission to continue mapping this group to MASBOE 32.	4/9/2012
SC	Eligibility	State-Specific Eligibility	In October 2012, there was a sizeable increase in enrollment for State-specific eligibility group '3088' ("Partners for Health Children (PHC))" assigned to MASBOE '34') from 308,000 to 363,000. The state says that this increase is due to the state's implementation of the Express Lane Eligibility Program in October 2012. Authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA), Express Lane Eligibility (ELE) gives states the option to certify children for health coverage based on the findings of other government agencies. South Carolina (DHHS) chose the option to fully automate initial enrollment into Title XIX Medicaid using SNAP and TANF eligibility information. These children were made eligible in the eligibility group 3088, Partners for Healthy Children.	3/1/2013
SC	Eligibility	Waivers	Each year from 2009-2014 the percentage of SC 1915c waiver enrollees without any waiver claims has increased slowly to 26% in Q1 FY 2014. The comparable figure for Q1 FY 2009 was 11.0%. SC reports that they have reviewed the current waiver enrollment counts to see if there were persons still in the waiver that should have been terminated, but did not find any problems. The state thinks that perhaps the counts are off due to the considerable participant churn/turnover during the year compared to claims paid.	10/14/2014
SC	IP	Crossovers	The average Medicaid Amount Paid on crossover claims is higher than expected in some quarters.	2/1/2010
SC	IP	Crossovers	A large percent of the claims are for crossovers.	3/21/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
SC	IP	Patient Status	There aren't any claims with a Patient Status of 30 (Still a Patient).	12/10/2004
SC	IP	Service Tracking Claims	Through Q3 FY2011, the state submits very large expenditures on service tracking claims.	10/28/2011
SC	LT	Admission Date	Admission date is usually missing. This is still a problem as of 3/21/2011.	3/21/2011
SC	LT	Diagnosis	On the South Carolina LT files, diagnosis codes are only available on claims for Type of Service 04 (IP psych claims). (94% of claims have no diagnosis codes.)	2/1/2010
SC	LT	Leave Days	Leave days are usually missing. The field is usually '0' filled instead of '9' filled when the days are unknown.	2/1/2010
SC	LT	Patient Status	Patient Status is missing on most LT claims.	2/1/2010
SC	OT	Capitation	State shows a large drop in capitation payments starting in Q3 FY2011. According to the state, this is because two transportation brokers, plan IDs=TB1000 and TB2000, had terminated and were no longer Medicaid FFS vendors.	7/27/2012
SC	OT	Crossovers	The 2010 Q2 OT file had a 25% jump in the number of FFS crossovers, there were 200,000 additional claims compared to the previous quarter.	NA
SC	OT	Crossovers	Q4FY2011 shows a 20% decrease in the number of crossover claims over the previous quarter.	10/31/2011
SC	OT	Managed Care Capitation	The number of PCCM capitation claims is somewhat lower than expected based on the person months of enrollment in PCCM managed care.	12/10/2004
SC	OT	Medicaid Amount Paid	In Q4FY2011, a number of submitted original claims contained a negative Medicaid Amount Paid value.	10/31/2011
SC	OT	Service Tracking Claims	Transportation capitation claims were mostly submitted as service tracking claims until Q2FY2007. After that they are reported as individual FFS claims but actually should continue to be reported as Service Tracking. These claims can be identified as they all have service code C1000.	10/16/2008
SC	RX	Date Prescribed	Date Prescribed is always missing.	2/1/2010
SD	Claims	Crossovers	SD began reporting diagnosis codes on crossover claims in Q3FY2011.	8/18/2011
SD	Claims	Data System Change	SD canceled its first MMIS replacement contract in October of 2010 and changed vendors.	NA
SD	Claims	NPI/Taxonomy	The percent of claims reporting both NPI and Taxonomy is lower than expected. Neither Taxonomy nor NPI are used by SD's current MMIS system, so the data available to report is limited.	6/6/2011
SD	Eligibility	CHIP	South Dakota reports its M-CHIP children and S-CHIP children. However, the S-CHIP program was not implemented until Q4 2000.	3/22/2011

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SD	Eligibility	County Codes	In Q3 FY10, approximately 1,700 persons were assigned county code 999. SD indicated that this county code is used for children under the care of child protection or foster care. For these children, the system contains information about the county in which the Child Protective Services Office is located rather than the county in which the child resides. Therefore, county code 999 is used.	2/22/2011
SD	Eligibility	Date of Birth	In Q2 FY13, South Dakota began reporting enrollees with missing or unknown dates of birth (191 individuals). By Q3 FY13, the state was still reporting missing or unknown DOBs, although the number of individuals had improved to 152. The state was asked to improve its reporting in the future.	9/11/2013
SD	Eligibility	Dual Eligibility Codes	Starting in Q1 FY12, there were differences between MSIS and MMA reporting of enrollment in dual codes 04 (SLMB+), and 08 (Other full duals). The state indicated that these differences were due to errors in MMA reporting.	4/6/2012
SD	Eligibility	Managed Care	South Dakota began reporting dental managed care enrollment in FY 2000. By mistake, this enrollment was not reported in FY 1999. All Medicaid enrollees were reported as enrolled in dental care although the state has since said that they believe partial duals should not have been reported this way. The program ended as of July 2007, but the state continued to report enrollment in this plan anyway (through Q4 FY08).	3/21/2011
SD	Eligibility	Managed Care	Each quarter, SD reports approximately 30,000 PCCM enrollees with no PCCM capitation claims. For example, in Q1 FY10, the state reported approximately 254,000 person-months of PCCM (plan type 07) enrollment, but reported only approximately 150,000 person-months of PCCM capitation claims. SD explained that this occurs because the state reports PCCM enrollment (but no PCCM claims) for rural health center, federally qualified health center, and Indian Health Services patients. Additionally, SD indicated that some managed care recipients are not assigned PCPs due to retroactive eligibility, county transfers, grace periods, PRTFs, situations in which patients are attending out of state schools, and DSS error.	6/27/2011
SD	Eligibility	Managed Care	In March 2013 PCCM enrollment in SD was 87,044, but by April 2013, it had decreased to 78,060, and by December 2013, it had rebounded to 87,630. South Dakota implemented a Health Home program that was not added to MSIS in a timely manner. It caused a drop in enrollment that was corrected in Q1 FY2014.	2/10/2014
SD	Eligibility	MASBOE	In Q4 FY10, enrollment in MASBOE 48 declined from approximately 3,900 to around 3,600. The state explained that this decline in enrollment was due to Child Protection Services inadvertently closing about 220 foster care records. The records have been reinstated in SD's system and we have asked the state to submit them through retroactive and correction records.	12/2/2010
SD	Eligibility	MASBOE	SD was notified of age sort issues, particularly in MASBOE 11, in Q3 FY09. The state indicated that it will not change BOE	4/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			assignments to aged when individuals who originally qualify for Medicaid as disabled turn 65. Therefore, age sort issues will continue in SD.	
SD	Eligibility	MASBOE	Between Dec 2013 and Jan 2014 MASBOE 14 (Cash Child) decreased from 15,183 to 65. Reporting to MASBOE 14 ceased completely in March 2014. Between December 2013 and January 2014, MASBOE 34 (Poverty Related Child) increased from 43,669 to 60,491.	5/6/2014
SD	Eligibility	MASBOE	South Dakota is working to get the new T-MSIS eligibility groups incorporated into future MSIS quarterly files. However, they do not have an estimate of when this project will be completed at this time.	12/3/2014
SD	Eligibility	Private Health Insurance	More than 10 percent of the persons in the file are coded as receiving third party insurance. This number is higher than expected, but the state confirms that it is correct.	9/23/2011
SD	Eligibility	Restricted Benefits Flag	Starting in Q1 FY07, SD started reporting a small number of enrollees to RBF 2 (<10/month). The state confirmed that this small number is correct.	3/30/2011
SD	Eligibility	SSN	Until Q4 FY10, South Dakota had between 400 to 800 records on each file with duplicate SSNs. In Q4 FY10, this number decreased to less than 10 records, and it has remained low since that time.	9/23/2011
SD	Eligibility	State-Specific Eligibility	South Dakota is currently unable to identify its Medicaid Buy-In program enrollees. The state will attempt to do so when programming time becomes available.	11/5/2010
SD	Eligibility	TANF/1931	South Dakota cannot identify its TANF recipients. This field is 9-filled for all eligibles.	3/21/2011
SD	Eligibility	Waivers	2006 - 2008: Results of linking analyses of waiver-related eligibility and claims found that, due to an error in SD's eligibility reporting, enrollment in the state's Developmentally Disabled 1915(c) waiver (Waiver ID '02') was undercounted. SD acknowledged this. The error was fixed in the state's MSIS submissions as of Q1 FY09.	3/21/2011
SD	Eligibility	Waivers	SD indicated that a 2006 amendment to its "Elderly" waiver (waiver ID '01', waiver type '3') affected enrollment henceforth so that the waiver was no longer restricted to just the aged. As a result, the waiver now includes persons age 18 and older who would otherwise require an institutional level of care.	3/21/2011
SD	IP	Revenue Code	The UB-92 revenue codes are missing on many IHS claims.	3/21/2011
SD	LT	Covered Days	The number of claims with Type of Service 04 (Inpatient Psychiatric Services for those Under Age 21) and either zero or 9-filled covered days is consistently higher than average in SD. The state explained that these claims with either zero or 9-filled covered days are stored in their system with HCPCS T2048 and represent payments to in-state psychiatric residential treatment	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
			centers but do not have a value for covered days because they were billed on CMS-1500 forms. In Q4FY2011 covered-days was zero or 9-filled on all claims with TOS=04. This was corrected in Q1FY2012.	
SD	LT	Diagnosis	There are very few diagnosis codes reported on LT FFS non-crossover originals through Q2FY2011. This was substantially improved in Q3FY2011	11/9/2011
SD	LT	LTC Days	Inpatient psychiatric hospital services for individuals under 21 years can be provided in psychiatric residential treatment facilities (PRTF). Because of the unique billing format of psychiatric residential treatment facilities, inpatient covered days were not reported for some claims in MSIS until Q1FY2012 when SD began calculating inpatient covered days using the service from and through date on the claim.	5/9/2012
SD	OT	Crossovers	SD began reporting PLACE-OF-SERVICE on crossover claims in Q3FY2011.	8/18/2011
SD	OT	Crossovers	SD has not reported procedure codes or revenue codes on crossover claims through at least Q3FY2013.	8/2/2013
SD	OT	HCBS Waiver	Until Q1FY2012 many claims for people enrolled in the HCBS for the Aged and Disabled waiver were not correctly identified as HCBS waiver claims. That caused an underreporting of waiver claims until Q1FY2012.	5/8/2012
SD	OT	HCBS Waiver	Through at least Q4FY2010 waiver services are reported as FFS claims bundled as monthly payments with no procedure or revenue code.	1/25/2013
SD	OT	Managed Care Capitation	Dental managed care ended in late 2007 but the state continued to submit capitation and encounter claims and dental managed care enrollment through 2010.	NA
SD	OT	Managed Care Capitation	Each month about 30,000 beneficiaries enrolled in the PCCM program are assigned to PCCM providers in FQHCs, RHCs, and IHS clinics. FQHC, RHC, and IHS clinic providers do not receive the PCCM administration fee through the same monthly capitation payment process as other PCCM providers so the capitation payments for PCCM in MSIS appear to be artificially low.	12/12/2014
SD	OT	Service Code Modifiers	SD does not report any service code modifiers.	8/9/2013
SD	OT	Specialty Code	SD only reports a single state-specific provider specialty code and it is not reported on all claims. State-specific SPECIALTY-CODE cannot be used for analysis of SD MSIS data.	1/25/2013
SD	RX	Compound Drugs	SD uses NDC 09999200000 to represent compound drugs.	5/12/2011
SD	RX	Prescribed Date	The state put the fill date in both the Fill and Prescribed Date fields until Q4FY2005. In Q1FY2006 SD stopped reporting Prescribed Date.	3/21/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
TN	Claims	Managed Care	TN reported that they were going to code the managed care Plan ID on all claims paid on a FFS basis by the managed care plans that are currently acting as fiscal agents for their enrollees. With the return to risk-based managed care, TN still is reporting Plan IDs on FFS claims (Q1FY2009-Q1FY2010). The state has been asked to correct this beginning with Q2FY2010.	3/21/2011
TN	Eligibility	1115 Waivers	Tennessee operates its Medicaid program through the TennCare II Section 1115 Demonstration. TennCare II is a continuation of the state's 1115 Demonstration waiver, funded through Titles XIX and XXI of the SSA. All individuals eligible under the Medicaid state plan (except for those eligible only for payment of Medicare premiums) are enrolled in TennCare Medicaid. They receive most services through the Demonstration's delivery system. The program uses savings from managed care and the redirection of disproportionate share hospital (DSH) payments to fund enhanced services for adult Medicaid state plan eligibles and to expand eligibility to uninsured (SSG 087) or uninsurable (SSG 097) demonstration eligibles through the TennCare Standard program. TennCare II covers individuals in the following populations: 1) Those eligible under the Title XIX state plan, except for persons whose only coverage consists of Medicare premium payments; 2) Children who "rollover" into TennCare Standard coverage after losing eligibility under the Medicaid state plan. This includes Title XXI low-income children who are uninsured and younger than 19 years old with family income up to 200% of FPL, and Title XIX uninsurable children younger than 19 years old with family income at 200% or more of FPL; 3) a demonstration expansion population of non-pregnant adults aged 21 or older who would meet the state plan's medically needy rules; 4) persons eligible for long-term care services in a nursing facility or through HCBS.	3/5/2013
TN	Eligibility	1115 Waivers	TN assigns partial duals to its 1115 waiver, although this assignment is incorrect. The state confirmed in the past that partial duals should not be assigned to the waiver. However, it indicated previously that rewriting the code to fix this will take some. As of Q4 FY 2014, Tennessee was still assigning partial duals to the waiver.	3/24/2015
TN	Eligibility	CHIP	TN has a separate CHIP program known as Cover Kids. The state currently does not report enrollment to MSIS.	3/14/2013
TN	Eligibility	CHIP	TN assigns children in the following state aid categories (SSGs) to CHIP-CODE '2' (M-CHIP): '000027' (TennCare Disabled – Uninsurable), '000037' (TennCare Disabled – Uninsured), '000087' (TennCare – Uninsured), and '000097' (TennCare – Uninsurable). The number of M-CHIP enrollees reported by the state has declined considerably since Q3 FY 2011. The average monthly M-CHIP enrollment was about 27,900 in Q3 FY 2011. As of Q3 FY 2013, M-CHIP enrollment was about 17,700 per month.	11/11/2013

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State	File Type	Rec/Issue Type	Issue	Recorded
TN	Eligibility	County Codes	TN indicated that it uses County Code '999' for cases where a given county code is missing or otherwise does not match an existing county code.	1/3/2011
TN	Eligibility	Dual Eligibility Codes	Differences in MSIS and MMA dual codes may be explained by the fact that MMA calculates its totals on the 17th of each month, while MSIS uses the last day of each month. TN provided this explanation when asked about the recurring >10% discrepancy among those with dual code 04 (SLMB+) (in each instance more persons are counted in MMA versus MSIS).	10/12/2009
TN	Eligibility	Dual Eligibility Codes	TN assigns Qualified Individuals (QIs) to Dual Code '03' (SLMB-only), not Dual Code '6'. The state recognizes that this is an ongoing issue; but it has no plans to change this assignment methodology.	11/11/2013
TN	Eligibility	Dual Eligibility Codes	Starting in Q3 FY 2009, TN began to report a small number of enrollees [150 – 200 average] in Dual Codes '01' and '03' to MASBOEs other than '31' or '32'. This group included individuals in state specific groups '000012' [QMB-only], '000022' [QMB-only], '000042 [QMB-only], and '000099' [SLMB-only]. As of Q4 FY 2014, however, Tennessee has corrected most of the problem. Virtually all individuals in the state specific groups noted previously are now in Dual Codes '01' or '03' and MASBOE '31' or '32'.	3/24/2015
TN	Eligibility	Managed Care	As of 01Oct2013, DentaQuest USA Insurance Company is the Dental Benefits Manager (DBM) for Tennessee's Medicaid program (TennCare). DentaQuest administers benefits to about 740,000 children on TennCare. Unlike the fee-for-service contract that the state had with TennDent, the previous DBM, the contract with Dentaquest is risk-based.	11/11/2013
TN	Eligibility	Managed Care	TennCare Select is a program for special populations, like children in foster care, children receiving SSI, and children under 21 in a nursing facility or ICF-MR. Beneficiaries are assigned to a designated HMO and Primary Care Physician (PCP). Unlike other TennCare managed care plans, TennCare Select does not have a risk-bearing, capitated arrangement with the state.	11/11/2013
TN	Eligibility	Managed Care	TN began to move all enrollees to risk-based managed care in early 2007. It had completed the process for most of them by year-end 2011. Each enrollee is assigned to a single MCO which provides both comprehensive and behavioral health services. The state makes one monthly capitation payment per enrollee. As a result, TN should report all enrollees only to Plan Type '01' (comprehensive). As of Q4 FY 2014, however, it still assigns each enrollee to both Plan Type '01' and Plan Type '03' (behavioral). The state previously indicated that it would correct the error. However, as of Q4 FY 2014 it had not done so. Given current circumstances, TN will need to make the correction when it begins to submit T-MSIS files.	3/24/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
TN	Eligibility	Managed Care Plan IDs	In October 2013, Tennessee moved all of its dental managed care enrollees [~744,400 average per month] from Plan ID '000000071A' to Plan ID '000000072A. The state confirmed that the new plan is DentaQuest.	6/13/2014
TN	Eligibility	Managed Care Plan IDs	In June 2013, Magellan Health Services replaced Catamaran as TennCare's Pharmacy Benefits Manager [PBM]. The agency reports its PBM as Plan Type '08'. Catamaran was reported as Plan ID '000000062A'. Magellan is reported as Plan ID '000000063A'.	4/8/2015
TN	Eligibility	MASBOE	All Years: Many persons age 65 and older are mapped to MASBOE 12. However, since these are disabled SSI recipients, their MASBOE mapping was not changed.	3/21/2011
TN	Eligibility	MASBOE	All Years: TN has consistently reported a much higher number of eligible individuals than expected to MASBOE 11 and 12, given the number of SSI recipients in the state. Although this was known to be attributable to a lawsuit filed against the state, a 2009 injunction ended the ongoing eligibility of certain individuals. Nevertheless, a substantial gap still exists between the reporting of eligible individuals to MASBOE 12 and comparable data for SSI beneficiaries.	3/14/2013
TN	Eligibility	MASBOE	TN assigns about 29,000 disabled enrollees age >= 65 years per month to MASBOEs '12', '22', '32', and '42'. More than 75% of them are in MASBOE '12'. Another 23.5% are in MASBOE '42'.	11/11/2013
TN	Eligibility	MASBOE	Each month TN assigns about 340 enrollees to MASBOE '11' and DUAL-ELIGIBLE-CODE '00'. The state says that, "These individuals fall under our Old Age Assistance - Categorically Needy or Old Age Assistance - Categorically Needy and QMB. Using information at the time the EL file was created, the state did not have enough data to validate their Medicare Eligibility status.	11/18/2013
TN	Eligibility	Private Health Insurance	From Q4 FY 2007 to Q3 FY 2013, the number of enrollees reported with private health insurance (HEALTH-INSURANCE '2') grew from about 19,900 per month (1.5%) to 188,800 per month (13.7%). The state indicated that the increase coincided with an effort to increase third-party liability (TPL) recoveries. TN hired a private contractor to find and flag enrollees who appeared in private health insurance databases.	11/11/2013
TN	Eligibility	Race/Ethnicity	TN does not report the values '07' (Hispanic or Latino and one or more races) or '08' (More than one race [Hispanic or Latino not indicated]) for the field RACE-ETHNICITY-CODE. As a result all Latinos are reported with Number of Races = 0.	11/11/2013
TN	Eligibility	Race/Ethnicity	The number of enrollees who have not been assigned a Race Code of any kind has increased substantially between 2013 and 2015. In Q1 FY 2013, about 9.3% of all eligible individuals had an 'Unknown' Race. This increased to 11.4% in Q1 FY 2014 and 16.9% in Q1 FY 2015. In our Q1 FY 2015, we asked the state to explain this result. We are awaiting their response	4/8/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
TN	Eligibility	Restricted Benefits Flag	Beginning with Q3 FY09, TN mistakenly reported several hundred enrollees outside MASBOE 31-32 as having dual codes 01, 03, 05, or 06. However, these individuals were not assigned restricted benefits flag = 3 nor assigned state specific groups associated with partial dual groupings. In fact, these persons should have been assigned a full dual code and restricted benefits code = 1. TN has managed to reduce this problem over time and is committed to eliminating the problem.	3/22/2011
TN	Eligibility	Restricted Benefits Flag	Each month TN assigns about 400 enrollees not in MASBOEs '34' or '35' (eligible under Title XIX as low-income pregnant women) to RBF '4' (restricted benefits – pregnancy-related services). The state indicated that these enrollees have a basis of eligibility tied to something other than their status as low-income pregnant women. It still assigns them to RBF '4' to capture their pregnancy status.	11/11/2013
TN	Eligibility	Restricted Benefits Flag	CMS awarded TN a Money Follows the Person (MFP) Rebalancing Grant in September 2010. However, the state has not been able to report any enrollees to RBF '8'. TN indicates that its current MMIS has not integrated MFP into its eligibility categories. TN needs to implement special processing for MFP reporting to MSIS. The state added that it will initiate a work order in the future. As of Q4 FY 2014, it was not reporting MFP enrollment in MSIS. Given current circumstances, the state will need to correct this when it begins to submit T-MSIS files.	3/24/2015
TN	Eligibility	Restricted Benefits Flag	From October 2012 through December 2013, TN assigned 200 – 240 people per month to RBF '2' [Restricted benefits – Alien]. It reported just 23 in January 2014 and none thereafter. We asked the state to explain this result in our Q4 FY 2014 review. As of Q1 FY 2015, we have not received a response.	4/8/2015
TN	Eligibility	SSI	The count of persons TN reports to MSIS as aged, blind and disabled differs from the count of persons it reports as receiving SSA cash payments. When an individual loses his SSI eligibility, TennCare immediately begins a reverification process. That is, the state checks to see whether the person qualifies for Medicaid for another reason. The reverification process can take several months. During that time, TN continues to report the person as SSI-eligible. As a result, the count of aged, blind and disabled enrollees will always be higher than the number reported to SSI. The difference between TN's MSIS and SSA totals has declined dramatically since 2009. However, the difference will never be zero.	3/18/2013
TN	Eligibility	SSI	The difference between TN's MSIS and SSA totals has declined dramatically since 2009. However, it will never equal zero. The count of aged, blind, and disabled reported to MSIS will always be higher than the count reported to SSA. TN's reporting of aged, blind, and disabled differs from the number of persons receiving SSA cash payments, because once someone loses SSI eligibility, the state initiates a re-verification process. That is, it attempts to determine whether the person is eligible for	4/24/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Medicaid for a different reason. The re-verification process takes months to complete. During the re-verification process, TN continues to report them as SSI.	
TN	Eligibility	TANF/1931	TN 9-fills its TANF data.	3/14/2013
TN	IP	Covered Days	MEDICAID-COVERED-INPATIENT-DAYS is 8-filled on nearly all FFS Non-crossover Original Claims and Encounters.	4/22/2011
TN	IP	Covered Days	From FFY2013 Q2 onwards, Tennessee's mean covered days have been averaging more than 2000 days. Both the state and CMS are aware of this issue. The state is currently working towards a fix, but no timeline is given.	1/23/2015
TN	IP	DRG	TN does not report DRGs.	9/4/2005
TN	IP	FFS Claims	All IP claims are handled through managed care. There not be any claims for original FFS, non-crossover claims.	1/23/2015
TN	OT	Adjustments	There was a dramatic increase in the number of adjusted Capitation Payments in October 2010. There were approximately 173,700 debit adjustments to Cap Payments in September 2010 and 182,500 in November 2011. The comparable figure for October 2010 was 5.318 million. Tennessee indicates that this was the result of retroactive changes in the State's actuarial rates. According to the State, "In the October 2010 capitation payment cycle, new actuarially sound rates were loaded for the East and West region MCOs. These rates were to be effective July 1, 2010, so the prior capitation payments needed to be voided and replaced with the correct payments. The result was approximately 700,000 void and replace transactions for 3 months. 1.4 million adjustment transactions for 3 months would yield 5.2 million adjustment transactions in the month of October 2010."	5/24/2011
TN	OT	Capitation	TN stopped reporting original PHP capitation payments in FFY 2011 Q3.	4/2/2015
TN	OT	Managed Care Capitation	During the time when the managed care plans are providing services on a FFS basis, the state submits HMO capitation claims for about $10 per person per month as an administrative fee. This fee does not include any medical services. The managed care Plan ID is also put on these FFS claims. TN planned to correct this in Q3FY2010.	3/21/2011
TN	OT	Managed Care Capitation	Starting in Q3FY2007, the State began a transition from an Administrative Services Only (ASO) arrangement to a Risk-based Managed Care Model. The transition began with two new MCOs (AmeriGroup and AmeriChoice) in Middle TN on 01Apr2007. The State moved to Risk-based Managed Care in East Tennessee on January 1, 2009. It completed the transition in West TN on November 1, 2009. Only a small number of individuals with intellectual disabilities are still FFS recipients. Their care is managed across the entire State by TennCare Select (VSHP/BCBS).	4/22/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
TN	OT	Managed Care Capitation	Since at least Q3FY2006, TN has reported about 1.9 cap payments per person per month on the OT file. Total enrollment is about 1.2 million persons per month. The total number of cap payments is about 2.4 million per month. According to the State, "TennCare's capitation process creates a transaction for a medical managed care payment and behavioral health organization (BHO) payment for each enrollee each month in the new payment cycle. If the member is a priority BHO recipient, an additional capitation payment is made. If the member is not a priority BHO recipient, a zero dollar transaction occurs. As a result, two transactions are performed for each recipient. This explains the 2.4 million transactions per month for the new payment. The BHO transaction is tied to a separate vendor identification in the system that was established to capture the priority BHO capitation amounts when they were paid. This separate BHO payment ended in December 2010, so in future submissions, the number of new payment transactions should be closer to the number of enrollees. This change may or may not be reflected immediately. This is dependent on when system change gets promoted into the production environment."	7/8/2011
TN	OT	Managed Care Encounters	Type of Service is missing on about 10 percent of the claims and there are very few different Type of Service codes. File contains about 4,000 claims with a Type of Service of Inpatient Psychiatric Services for those Under Age 22. These claims should be reported in the LT file.	12/10/2004
TN	OT	MSIS ID	There are about 7,000 claims with '9' filled MSIS ID's between Q1FY2008 and Q1FY2009. They decrease to a very small number after that.	NA
TN	RX	Adjustments	From October 2008-May 2009 the new TN pharmacy benefits manager (PBM) incorrectly reported the RX claims in the MSIS files. In the Q3-4FY2009 files, TN will void those claims and resubmit the corrected claims as original claims (not resubmittals).	3/21/2011
TN	RX	Managed Care Encounters	The Fill Date is missing, only the Prescribed Date is populated from Q1FY1999-Q2FY2002.	12/30/2004
TN	RX	Medicaid Amount Paid Total	On July 1, 2003 all pharmacy services were 'carved out' to a single Pharmacy Benefits Manager.	4/22/2011
TX	Claims	All	Texas has a large number of state agencies responsible for the administration and processing of Medicaid claims for different parts of the program, making it difficult for them to collect and report Medicaid services uniformly in MSIS.	12/15/2004
TX	Claims	Crossovers	Most crossover claims have Medicare coinsurance/deductible amounts, but have a $0 amount paid.	2/11/2006
TX	Claims	Patient Liability	Texas initiated a co-payment program for Medicaid in December 2002. These co-payments cannot be included in the IP, OT or RX files as there isn't a Patient Liability variable.	3/21/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
TX	Eligibility	1115 Waivers	Texas stopped operating the Texas Medicaid Women's Health Program 1115 waiver [CMS Waiver ID 11-W-00233/6] on 31Dec2012. The state implemented the Texas Women's Health Program, which is entirely state-funded, on 01Jan2013. TX should not report enrollment in Waiver 'H1' after Q1 FY 2013. 4-16-2015 update: The state continues to report to this waiver through September 2013, even though it previously indicated that it withdrew from this waiver effective December 31, 2012. Between December 2012 and September 2013, enrollment declined by about 16,000, but remains sizeable (about 105,300) as of September. The state indicated this is a defect of the new TIERS system, which did not correctly suspend WHP (H1) reporting. Changes were made in regard to coding that affects the funding stream, moving this program from federal funding to state general revenue, but the waiver indicator was not addressed. Their production team has addressed this and will be removing this population from TMSIS reporting, since TX is no longer making changes to the MSIS process.	8/22/2014
TX	Eligibility	1115 Waivers	The Texas Health Care Transformation and Quality Improvement Program [CMS Waiver ID 11-W-00278/6] is an 1115 waiver that replaces the STAR and STAR+PLUS waivers. It is designed to expand managed care statewide. Texas completed its move to statewide managed care in March 2012. HHSC indicated that it will use Waiver ID 'F5' for MSIS reporting. As of Q2 FY 2012, the state has not reported enrollment to MSIS. 4-16-2015 update: The Texas Healthcare Transformation and Quality Improvement Program (F5) Demonstration Approval Period is from December 12, 2011 through September 30, 2016. The approval letter from which these dates were report was dated October 24, 2014. From the approval letter: "The STAR and STAR+PLUS managed care programs will cover most beneficiaries statewide through three geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities, and the second expansion occurred in March 2012, under section 1115 authority. A third expansion of STAR+PLUS will occur September 1, 2014 under section 1115 authority as a result of an amendment to the demonstration." The state does not think the necessary changes have been made to insure the expansion under section 1115 authority is reported accurately. The data reflects the expansion within STAR and STAR+PLUS (F1 and E9) but F5 reporting should have begun March 2012. TX is addressing this currently (April 2015) but has yet to determine the disconnect that is preventing correct reporting.	8/22/2014
TX	Eligibility	CHIP	The state does not report separate CHIP [CHIP-CODE 3] enrollment to MSIS. Due to the T-MSIS project, CMS agreed to allow Texas to delay CHIP reporting until TMSIS is live.	9/5/2014
TX	Eligibility	Dual Eligibility Codes	Between FY07-FY09, the number of 1929(b) enrollees reported to dual code 09 was 15+% greater in MSIS than MMA; the counts for all other dual groups were very close. We suspect the 09 counts are different because the MMA counts only include	3/3/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			those enrollees reported to dual code 09 who are confirmed duals.	
TX	Eligibility	Dual Eligibility Codes	In Q2 FY06, TX changed its programming so that 1929(b) waiver enrollees are assigned to dual codes 01 or 03 if they qualify as QMB only or SLMB only (appears some went to dual code 06 as well), while the remaining 1929(b) enrollees who are duals are assigned dual code 09. This resulted in an increased count for partial duals. These 1929(b) enrollees, who are partial duals, continue to be reported to MASBOE 41-42.	3/21/2011
TX	Eligibility	Dual Eligibility Codes	Texas acquired a new eligibility system in June 2011. Shortly thereafter Mathematica began to find substantial differences between MSIS and MMA reporting. We continued to see these differences through Q1 FY 2012, the last quarter for which we have a file. As of Q1 FY 2012, Texas reported 640,000 duals to MSIS; but only 530,000 to MMA. We found similar differences for nearly every dual code. For example, in Q1 FY 2012, the state reported 300,000 QMB+ enrollees to MSIS; but only 205,000 to MMA. We were previously notified that we should continue see these differences through the beginning of 2012.	4/11/2014
TX	Eligibility	Dual Eligibility Codes	Between December 2011 and January 2012 SLMB-only enrollment increased ˜ 13% while QI-1 enrollment declined ˜ 38%. Then between December 2012 and January 2013 SLMB-only enrollment increased again by ˜ 10% while QI-1 enrollment declined further by ˜ 27%. The state noted there are several of issues directly related to the SAVERR main frame to TIERS database conversion (SAVERR was retired in December 2011). The QI-1 issue is one the state has been contending with since it was first discovered and subsequently delayed its eligibility reporting. (TIERS was not reporting this client group at all.) The state is finding several flaws/defects that are directly affecting the accuracy of reporting. TX reviewed the MMA data for this period and the QI-1 and SLMB population does not align with what TIERS is reporting. The state indicated changes in the numbers are not reflective of changes in population but a defect in the system reporting the population. Reporting should improve in T-MSIS.	4/16/2015
TX	Eligibility	Managed Care	Due to the state's 1915(b) (c) Star+Plus waiver, TX reports aged and disabled persons (including dual eligibles) with HMO and behavioral managed care arrangements. As of Q2 FY11, the state began reporting this waiver to Waiver Type '2' 1915(b), per CMS's instruction: in 2011 report as 1915(b) recipients those persons enrolled in the Texas Star+Plus combination 1915(b)(c) waiver who do not receive home and community-based services.	3/8/2011
TX	Eligibility	Managed Care	TX indicated that an increase to PCCM enrollment during Q1 FY10 (from ~730,000 to ~795,000) was expected due to the economic downturn. Moreover, this program will decrease in September 2011 because of counties dropping out and end altogether sometime in March/April 2012.	7/29/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
TX	Eligibility	Managed Care	Texas has at least two PACE programs (Bienvivir Senior Health Services and the Basics at Jan Werner), but PACE enrollment was not included in the EL files until Q1 FY09. PACE enrollment is included in the June Medicaid Managed Care Report maintained by CMS.	4/6/2012
TX	Eligibility	Managed Care	TX has a disease management plan that is reported in the annual CMS managed care data; however, the state has indicated that managed care enrollment in this plan cannot be reported in MSIS because the data reside in a separate system.	4/6/2012
TX	Eligibility	Managed Care	Enrollment in comprehensive managed care [Plan Type '01'] grew from roughly 1,800,000 to about 2,100,000 between April and December 2011, up 14.8% over the period. According to HHSC, increases in Comprehensive Managed Care enrollment during 2011 are the result of expansion of the STAR and STAR+PLUS programs into additional counties. In February 2011, HHSC expanded STAR+PLUS into the Dallas and Tarrant [Ft Worth] service areas. In September 2011, HHSC further expanded STAR and STAR+PLUS into 28 counties contiguous to already existing service areas. STAR expanded into 17 counties around the Bexar [San Antonio], El Paso, Lubbock, Nueces, and Travis [Austin] service areas. STAR+PLUS expanded into 10 counties surrounding Bexar, Harris [Marshall], Nueces, and Travis service areas. STAR and STAR+PLUS also expanded into the newly formed Jefferson [Beaumont] service area, which includes 11 counties around the Harris [Marshall] service area. The main difference between STAR and STAR+PLUS is that STAR serves children and young adults mainly in northern and central TX, while STAR+PLUS serves aged enrollees mostly in the Houston area. An 1115 waiver [The Texas Healthcare Transformation and Quality Improvement Program; CMS ID "TX-W-00278/6] will replace both STAR and STAR+PLUS and will operate statewide (effective date still pending on CMS's website).	9/5/2014
TX	Eligibility	Managed Care	In Q3-Q4 FY 2011 EL files there was a marked increase in the number of cash-recipient adults and children in Program Types 01 [Money Grant & Medicaid] and 61 [AFDC Unemployed Parent]. Enrollment in the combined groups increased 170,000 over the year. Enrollment in the Breast and Cervical Cancer Treatment Program fell from 2,500 to 1,700 between June and July 2011. HHSC suggested the simultaneous expansions of certain Medicaid activities during the time under consideration are responsible for enrollment increases in several plans/categories (e.g., Behavioral Health, MC, TANF), including those in Program Types 01 and 61.	9/5/2014
TX	Eligibility	Managed Care	Texas ended its PCCM program as of March 1, 2012. The state stopped reporting enrollment in Plan Type '07' [PCCM] in March 2012 in MSIS. PCCM enrollment was ˜ 807,300 in February 2012 and 0 in March 2012. These individuals were transitioned into managed care (specifically STAR and STAR+PLUS Medicaid managed care programs, which at the same time were	9/5/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			expanded into the counties around Fort Worth, San Antonio, Austin, and several other service areas).	
TX	Eligibility	Managed Care	In March 2012, Texas began reporting three dental managed care plans ('1G' [Delta Dental], '1J' [Managed Care of North America Dental], and '1M' [DentaQuest]), including a combined ~2.3 million enrollees. However, the state inadvertently coded them to PLAN-TYPE '01', but they should be in PLAN-TYPE '02'. The state plans to correct this beginning with Q3 FY2012, but will not correct and resubmit prior files.	9/29/2014
TX	Eligibility	Managed Care	The Texas Health and Human Services Commission (HHSC) announced in September 2012 that HHSC and Delta Dental had agreed to end Delta Dental's contract to provide CHIP dental services effective November 30, 2012. The state stopped reporting to Delta Dental plan [Plan ID '1G', Plan Type '01'] in December 2012, with the exception of <5 per month.	2/10/2015
TX	Eligibility	MASBOE	All Years: Most disabled SSI recipients age 65 or older are reported to MASBOE 11.	NA
TX	Eligibility	MASBOE	TX reports enrollees who were initially certified into Medicaid as disabled in BOE 2 after they turn 65.	10/6/2009
TX	Eligibility	MASBOE	All Years: TX has a so-called 1929(b) waiver group. These aged and disabled individuals only qualify for a very limited set of personal care services (and no prescription drugs) under Medicaid. The waiver is no longer active, but TX was able to "grandfather" Medicaid eligibility for this group. These individuals are assigned program type code "T" in byte 5 of the state specific eligibility code. In Q4 FY04, about 42,000 persons were in this group, all mapped to MASBOE 41-42. Many 1929(b) enrollees are also reported as partial duals.	3/3/2011
TX	Eligibility	MASBOE	There was a noticeable decrease in the number of people assigned to MASBOE 25 [Medically Needy/Adults] between October and December 2011. Enrollment in this group declined 52.3%, from 4,500 in September to 2,200 in December. Based on information we received previously, we know that the state was 'phasing out' its medically needy program at this time.	4/11/2014
TX	Eligibility	MASBOE	From October 2013 through June 2014 (Q1-Q3 FY14) there were substantial changes in reporting the following MASBOE groups: '14' declined by 116,000 [-59.4%], '15' increased by 16,000 [+16.1%], '16' declined by 8,000 [-77.4%], '17' declined by 8,000 [-76.7%], and '34' increased by 231,700 [18.0%] (i.e., cash recipients and children eligible due to their poverty status). Each of the eligibility groups in which these changes occurred includes children or adults in families with dependent children, who receive regular Medicaid benefits, and are at either <100% or <133% FPL. Because these groups enroll similar beneficiaries, we suspect there may have been some program changes, possibly as a result of the Affordable Care Act, that affected these individuals' Medicaid enrollment status in 2014. However we have not yet received confirmation from the state.	5/29/2015

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
TX	Eligibility	Restricted Benefits Flag	Through FY06, Texas assigned code 5 ("other") to all aged and disabled persons in the so-called 1929(b) waiver program in MAS/BOE 41 - 42 who are living at home. These persons used to be in a HCBS waiver program. They do not qualify for prescription drug benefits, but get a limited set of home care services. However, beginning in Q1 FY07, TX switched from RBF 5 to RBF 3 for 1929(b) enrollees who are also partial duals. Thus, these 1929(b) enrollees in MASBOE 41-42 are partial duals assigned RBF 3, but they also qualify for some additional home care services.	3/21/2011
TX	Eligibility	Restricted Benefits Flag	TX's Money Follows the Person (MFP) program was approved in January 2008 (Q2 FY08). MPF enrollees are assigned RBF code 8 in MSIS and began reporting this value as of Q4 FY08. Also, MFP data were missing for Q2 FY09. The state indicated this was a mistake and would be fixed where possible using correction records.	7/29/2011
TX	Eligibility	Restricted Benefits Flag	Starting in Q1 FY2011, there was substantial change in reporting Full Duals to RBF '3' [Restricted benefits – Medicare]. Prior to Jan 2011, the state did not assign any Full Duals [Dual Code '02', '04', and '08'] to RBF '3'. In January 2011 it began to assign ~ 15,300 Full Duals per month to RBF '3'. States should only assign Partial Duals [Dual Codes 01, 03, and 06] to RBF '3' and Full Duals [Duals Codes '02' '04' and '08'] to RBF '1'. HHSC indicated that it did not understand the distinction between Full Duals [QMB Plus, SLMB Plus, and Other] and Partial Duals [QMB-only, SLMB-only, and QI-1]. HHSC is reporting dual eligible enrollees in MSIS, indicating they are coding them in TIERS. If these enrollees are in fact both fully eligible for both Medicaid and Medicare, they should be assigned an RBF = '1'. 11/3/2014 update: The state informed us clients with RBF '3' and Dual-Eligible-Code 4 were coded the incorrect RBF because they were not interpreting the dictionary definition appropriately in regard to the RBF. When examining the clients under this review, it became clear the RBF was wrong for SLMB Plus when the correct interpretation was applied. Enrollees in SSEG ending in "RB" should be assigned Dual Code '04', RBF '1' (not RBF '3'). The SSEG code identifies these clients as SLMB clients receiving full Medicaid. The "R" indicates full Medicaid and the "B" indicates SLMB. The state plans to correct this for T-MSIS but not for MSIS. CMS has agreed to this plan.	9/5/2014
TX	Eligibility	Restricted Benefits Flag	TX assigns RBF '5' to Special Duals (Dual code 09), which are 1929b Partial Duals. They are assigned SSEG '1401T8', '1403T8', '1404T8', MASBOE 41-42.	2/10/2015
TX	Eligibility	SSN	Texas reports about 500 duplicate SSNs each quarter. The state is aware of the problem and periodically works at reducing it. As of Q3 FY14, the number of SSNs with duplicate records is about 2,900.	NA
TX	Eligibility	State-Specific Eligibility	In TX, individuals who belong to the state's 1929(b) program have a program type "T" in byte 5 of their state code.	12/12/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
TX	Eligibility	TANF/1931	TX's TANF reporting in MSIS began to diverge with ACF's numbers in FY2006. The state maintains that the MSIS counts are accurate, although it cannot provide an explanation for the discrepancy. The MSIS count was 49% higher than the ACF count in Q1 FY09.	3/21/2011
TX	Eligibility	Waivers	TX has not been adhering to the requested waiver reporting hierarchy. As of Q4 FY09, the state has said that it would approach IT staff about the issue as soon as other, more important issues were resolved.	3/21/2011
TX	Eligibility	Waivers	2008-present: Home and Community-Based Eligibility and Claims data link at a less-than-expected rate because of 1929(b) enrollees who have claims with a program type = 6 or 7 but otherwise lack enrollment in a section 1915(c) waiver. Linkage analyses indicated that this problem concerned approximately 44,000 individuals, which TX researched and later identified as being chiefly due to 1929(b) enrollees. Subsequent independent analyses confirmed this to be true.	11/28/2011
TX	Eligibility	Waivers	TX has two distinct 1915(c) waivers as part of its Integrated Care Management Program, one serving an SSI population, the other serving a MAO (Medical Assistance Only) population. Both waivers have never been reported in MSIS, despite recurring requests for this to be done. In addition, we anticipated reporting of a 1915(c) Integrated Care Model waiver (which was assigned Waiver ID H3) but this never took place. Instead, the state replied that the data for this waiver was provided in a manner that did not allow for identifying SSI and MAO participants, and the program ended in May 2009. This response implied that the former waivers were components of the latter and therefore ended at the same time. However, the CMS waiver renewal spreadsheet lists the SSI/MAO waivers as active during 2011.	11/29/2011
TX	Eligibility	Waivers	TX's Star+Plus waiver (Waiver ID E9, Waiver Type 4) was known to have some recipients who did not receive 1915(c) services. When asked whether these enrollees could be reported separately, the state responded that all enrollees assigned Waiver ID E9 are strictly 1915(b) enrollees, and that those with 1915(c) services are instead assigned to the state's Home and Community-Based Services waiver (Waiver ID E2, Waiver Type 3). Because this has implications for how these waivers are coded and reported, we've asked for a meeting with the state to clarify.	4/6/2012
TX	Eligibility	Waivers	The Texas Medicaid Wellness Program [CMS Waiver ID TX.0022.R01.00] was called the Texas Disease Management Program from 2004 through August 2005. It became the Texas Medicaid Enhanced Program in September 2005 and remained so through February 2011. On 01Mar2011 it became the Texas Wellness Program. The 1915b waiver covers people with "long-lasting or serious health conditions". The first program period [PP1] ran from 01Mar2011 through 29Feb2012. During that	8/22/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			time, HHSC announced that it would end PCCM enrollment in March 2012, since the Texas Health Care Transformation and Quality Improvement 1115 waiver would expand managed care to the entire state. This appears to have occurred on schedule. The state reported no PCCM enrollment for March 2012. As of Q2 FY 2012, HHSC is not reporting enrollment in this waiver to MSIS. HHSC previously told us that it is working with its program vendor, McKesson, to gather the information it needs to begin reporting in MSIS.	
TX	Eligibility	Waivers	Enrollment in Waivers 'F1' and 'F2' increased noticeably between April and December 2011. Both are 1915b waivers [Waiver Type 2], which are often called 'freedom of choice' waivers. Waiver 'F1' is the Texas Access Reform STAR MMC Consolidated Waiver. Enrollment grew 11.7%, from 1,526,000 to 1,705,000. The state confirmed that this waiver is no longer 'active' but has provided an expiration date for the waiver. The stated indicated the increased enrollment in is likely a result of the STAR/STAR+PLUS expansion. Waiver 'F2' is the Texas NorthStar Behavioral Health Waiver. Enrollment in waiver 'F2' increased 13.3% between April and December 2011, from 400,000 to 453,000. The state indicated that on 20Dec2013 CMS renewed the waiver through 31Aug2015. HHSC indicated that it did not expect or observe in its own sources the expansion of this waiver and cannot provide an explanation for the increase seen in MSIS. This waiver was renewed on December 30, 2013 and expires on August 31, 2015.	9/5/2014
TX	Eligibility	Waivers	According to the CMS waiver website, the Texas Consolidated Waiver Program [Waiver ID 'E7'], was terminated in December 2011. However, between January 2012 and September 2013, the state continued to report about 50 members per month. TX indicated this is a defect of the new TIERS system, which did not correctly suspend reporting for this waiver. Their production team has addressed this and will be removing this population from TMSIS reporting, since TX is no longer making changes to the MSIS process.	4/16/2015
TX	IP	Procedure Code	Texas uses the following procedure codes: "MXXX" and "KXXX"; these are codes on the National Heritage Insurance Company (NHIC) Procedure Master File. NHIC previously used these codes for: MXXX: Medicaid prior approval; KXXX: Chronically Ill Disabled Children (CIDC) Inpatient Prior Authorization.	12/10/2004
TX	IP	TPL	Texas sometimes receives claims with erroneous Other Third Party Payment (or Third Party Liability/TPL) amounts that are so large they won't fit in the Other Third Party Payment (or Third Party Liability/TPL) field. Texas will 9-fill the field and it will be converted to "0" in the MSIS Valids file, appearing that there wasn't any Other Third Party Payment (or Third Party Liability/TPL) paid.	12/10/2004
TX	LT	Admission Date	Admission date is missing on almost all claims.	3/16/2012
TX	LT	Leave Days	Leave days are missing starting in Q1FY2005.	3/16/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
TX	LT	NPI	State reports NPIs in the billing provider ID field instead of legacy provider IDs.	3/16/2012
TX	LT	Patient Status	Patient Status is missing on most LT claims.	12/10/2004
TX	LT	Provider Taxonomy	Texas reports provider taxonomy codes on very few claims.	3/16/2012
TX	OT	Crossovers	Crossover claims are reported with $0 Medicaid payments.	3/20/2012
TX	OT	Managed Care Capitation	In 2006/2007 there were many more person months of enrollment in PCCM than PCCM capitation claims. It is possible that PCCM is included in the capitation payments for other types of managed care.	3/21/2011
TX	OT	Managed Care Capitation	TX submits a few (+/- 3,000) HMO capitation claims with a type of claim of FFS instead of capitation. These represent PACE capitation payments.	3/20/2012
TX	OT	Managed Care Encounters	Encounter claims reporting increased by more than 75% between Q4FY2011 and Q1FY2012.	3/20/2012
TX	OT	MSIS ID	There are a few claims with missing MSIS IDs.	3/21/2011
TX	OT	NPI	State reports NPIs in the billing provider ID field instead of legacy billing providers in approximately 50 percent of claims.	3/16/2012
TX	OT	Revenue Code	The OPD claims do not have UB-92 revenue codes.	3/21/2011
TX	OT	TPL	Other Third Party Payment (or Third Party Liability/TPL) is not on most claims because it is carried at the header level.	12/10/2004
TX	RX	Compound Drugs	TX reports compound drugs with the word 'COMPOUND' in the NDC field.	3/16/2012
TX	RX	NDC	Claims without NDCs do not have the service code in the NDC field. That field is blank filled for those claims. The state hoped to correct this starting in FY2008.	3/21/2011
TX	RX	Quantity	Over 90% of TX's FFS and encounter records in the RX file show more than 1,000 in the Quantity field. Mathematica is inquiring whether the state is trying to 8- or 9-fill this field.	2/10/2014
UT	_All	MSIS ID	From 1999 Q1 forward, about 7-10% of the MSIS OT claims have not matched the MSIS EL files for the same quarter. Some of these claims may be for foster children. So far the state has no explanation and haven't been able to correct the problem.	9/25/2007
UT	Claims	MSIS ID	MSIS IDs that the state reports in its claims files (IP, LT, OT, RX) do not use a standard numbering scheme. Most claims have a 10-byte numeric field, others have a 9-byte alpha-numeric, 9-byte numeric, and others have a 10-byte alphanumeric. It has not been determined whether the reporting of IDs is consistent within or across claims or eligibility file. However, none of these other numbering schemes exceed more than two percent of files.	5/17/2013
UT	Claims	Service Tracking Claims	Starting in Q1FY2004, the HMO's began providing services on a FFS basis. The state reimburses the plans for those services plus	7/11/2005

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
			a 9% administrative fee and they are reported in the MSIS files as service tracking claims.	
UT	Eligibility	0-filling	Through Q4 FY08, UT reports some individuals with the Waiver Type and ID fields 0-filled that should either have a valid waiver code or the field should be 8-filled. The state fixed this as of Q1 FY09.	7/13/2011
UT	Eligibility	1115 Waivers	Utah's section 1115 Waiver program is its Primary Care Network, approved for implementation in July 2002. The program expands Medicaid coverage to cover adults up to 150 percent FPL and pregnant women with assets exceeding the allowable levels for Medicaid. MSIS reporting began in October 2002. While the pregnant women's group qualifies for full benefits, the adults receive a reduced benefit package. Childless adults included in this waiver can be identified by state-specific eligibility groups PC2 and PC4.	3/21/2011
UT	Eligibility	1115 Waivers	UT had a Hurricane Katrina waiver approved on March 20, 2006. The state continued to report a small number of individuals to this waiver through Q4 FY08 (Waiver ID '07') even though the waiver expired in June 2006. This appears to have been fixed by Q1 FY09.	4/6/2012
UT	Eligibility	1115 Waivers	Between July and December 2012, enrollment in the Utah Primary Care Network PCN 1115 Waiver [Waiver ID '06'] steadily declined from about 16,200 to 12,100 [-25.4%]. The waiver was renewed in June 2010 and again in January 2013. The state indicated that this was an expected decline in the program. The waiver has capped enrollment and was closed during this period. This is part of the regular cyclical cycle of a program subject to open enrollments.	10/28/2014
UT	Eligibility	CHIP	Utah reports enrollment in its S-CHIP program in MSIS. The state does not have an M-CHIP program.	3/21/2011
UT	Eligibility	CHIP	Starting in Q2 FY07, the count of S-CHIP children in MSIS diverged from the count reported to the CMS SEDS system (26% difference). The MSIS count significantly decreased, while the SEDS count significantly increased. The data sources continued to show differences in Q3-4 FY07, but were consistent again in Q1 FY08 forward.	4/6/2012
UT	Eligibility	Dual Eligibility Codes	Utah provides full Medicaid benefits up to 100 percent FPL for its aged and disabled recipients. As a result, many eligibles in MAS/BOE 31 and 32 receive full Medicaid benefits. Utah reports they do not buy into Part A Medicare coverage for duals.	NA
UT	Eligibility	Dual Eligibility Codes	Between 85 - 90 percent of persons age 65 and older are reported as dual eligibles, a somewhat lower than expected proportion. This improved to about 97% in Q1 FY07 (and forward) when UT made improvements to its dual code reporting. However, the problem resurfaced in FY09. The state will be asked to investigate and try to fix in future reporting.	7/13/2011

MSIS State Data Characteristics/Anomalies Report

State	File Type	Rec/Issue Type	Issue	Recorded
UT	Eligibility	Dual Eligibility Codes	From Q1 FY07 - Q4 FY09, UT reported a small number of individuals (between 5 - 50 individuals) with a single '0' value in months 2-3 of each quarter. These individuals were also assigned to MASBOE 31-32 and reported with a zero-filled state-specific code. It is unclear if these individuals should have either had the dual code field 0-filled as well, or maybe been assigned dual code 03 or 06 (since these dual codes are also mapped to MASBOE 31-32 and have a 0-filled state code). In Q2 FY11, the dual code assignment for these individuals changed to 9-filled.	7/13/2011
UT	Eligibility	Dual Eligibility Codes	2008-Current: UT continues to have problems with comparisons of its MSIS dual eligibility data (specifically those with Dual Codes 03, 04, and 06) versus what's reported in MMA. The state has been asked to explain the source of these discrepancies. Meanwhile, the state has historically had issues with reporting Dual Codes 03 and 06. Through FY08, individuals in these dual codes were reported with a 0-filled state-specific eligibility group. This was corrected as of Q1 FY09 (even though it still appeared, when compared to MMA, that these groups were not being fully reported in MSIS). Meanwhile, all reporting of Dual Codes 03, 04, and 06 was missing for Q2 FY09, although it appears that reporting to Dual Code 04 shifted to Dual Code 08 for that one quarter. (The problem with missing reporting did not appear in the Q3-Q4 FY09 eligibility files.) The comparison to MMA improved by FY11 for these codes but diverged for code 08. However, the total counts for both full and partial duals remains consistent.	9/16/2011
UT	Eligibility	Managed Care	BHP: From the start, UT included BHP reporting in MSIS. However, enrollment mistakenly dropped to 1,700 per month in Q2 FY05, compared to 178,000 per month in Q1 FY05. This shortfall continued until Q1 FY06. (This drop did not occur in the June 2005 managed care data.) FY06 BHP reporting in MSIS returned to the expected levels and was very consistent with the June 2006 BHP numbers in the CMS data. Then, in Q1-3 FY07, reporting unexpectedly dropped across all BHP plans before resuming to regular levels of reporting in Q4 FY07.	3/28/2011
UT	Eligibility	Managed Care	During Q1-4 FY07, a very small number of individuals (<5) with BHP enrollment each month had the corresponding Plan ID 0-filled. This reporting was down to one individual in Q4 FY07, and we didn't ask the state to review since there were so many other MC issues in FY07. This issue was fixed in Q1 FY08 forward.	3/28/2011
UT	Eligibility	Managed Care	HMO: In FY04, UT corrected its managed care reporting by removing most of its HMO reporting, although a low level of HMO enrollment continued (in error). Then in FY05, UT stopped reporting HMO enrollment altogether (except for one person in the Healthy U plan). Very low levels of HMO enrollment for some HMO plans in MSIS resumed in FY06 (although the last byte of the Plan IDs was not always the same compared to the Plan IDs reported in FY04). The levels were similar to FY04 and were also in error. In addition, in FY06, UT began mistakenly	7/1/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			reporting enrollment in several S-CHIP plans in MSIS (for current Medicaid children who used to be in S-CHIP). Then, in Q1 FY07, UT started incorrectly reporting HMO enrollment of over 100,000 individuals per month across several plans. In FY08, UT greatly improved this reporting and HMO enrollment levels were reduced to low levels (~500 enrollees each month). The state indicated that the remaining enrollment is due to enrollees in several S-CHIP plans, yet most of the enrollees are reported to BOE 2 instead of BOE 4. We've asked the state to continue researching this enrollment to find some resolution to this remaining HMO enrollment.	
UT	Eligibility	Managed Care	Long-Term Care: From the start, UT has reported a Long Term Care Capitation demonstration (Plan ID 330211132000). However, enrollment in this plan was erroneously reported to plan type 01 (HMO) through Q1 FY05 and then dropped completely from Q2-Q4 FY05 in MSIS. Reporting resumed in Q1 FY06, but started decreasing at the end of FY07 and completely disappeared by Q3 FY08. The state confirmed that this was expected.	7/13/2011
UT	Eligibility	Managed Care	PCCM: Although CMS data show UT as having a PCCM plan (IHC Health Plan), PCCM enrollment is not reported in MSIS until Q1 FY08. (This plan was incorrectly reported as HMO through Q4 FY04.) However, the count of enrollees reported to this plan in MSIS was not consistent with the count reported to the June CMS managed care report. This was fixed as of Q1 FY09.	7/13/2011
UT	Eligibility	Managed Care	UT was instructed to not report its non-risk based PIHPs Molina, Molina Plus, and Healthy U as managed care, although the Molina plans were to be reported as of Q4 FY09 when both Molina plans switched to risk-based arrangements. The state did begin reporting the Molina plans, but as of July, not September (it had previously indicated that the switch would take place as of 9/1/09). CMS reports these plans in its annual managed care report.	1/12/2012
UT	Eligibility	Managed Care	Transportation: CMS data show UT as having a transportation managed care plan. We were receiving the capitated claims for this plan in MSIS; however, enrollment for this plan is not reported in MSIS eligibility files until Q1 FY08 (Plan ID '870570096006', Plan Type '08').	4/6/2012
UT	Eligibility	Managed Care	Starting in Q4 FY11, about 96,000 (of the 100,000) individuals reported to Plan ID '942938348014' (Valley Mental Health; Plan Type 03 Behavioral) shifted to a new Plan ID '87600316005'(OPTUM). Claims were submitted starting in June and enrollment in MSIS started in July 2011 even though enrollment shows up in the 2011 June CMS managed care report.	10/22/2014
UT	Eligibility	Managed Care	Utah does not report its Healthy Outcomes Medical Excellence (HOME) plan (Plan ID '129991113012') in its eligibility files. In Q3 FY2011, enrollment was about ~2,500. The state indicated on 12/10/2013 that enrollment information for this plan, which	10/22/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			is grouped under the name 'Other/Home/DDD', is not readily available and that information would come from a different state agency (Department of Workforce Services) rather than the Department of Health. Limited programming staff and resources keep this a lower priority; the state suggested to leave it as-is.	
UT	Eligibility	Managed Care	Medicaid enrollees residing in Utah's four most populous counties [Weber, Davis, Salt Lake, and Utah County] must be enrolled in managed care. Those residing outside of these counties are in FFS systems, but could enroll in managed care if such programs were available to them.	10/28/2014
UT	Eligibility	MASBOE	In Q4 FY08, UT reported one individual each month to MASBOE 4A. The state fixed this as of Q1 FY09.	7/13/2011
UT	Eligibility	MASBOE	UT indicated that enrollment increases of ~30% in MASBOE 34 during FY09 appeared to be accurate. It also indicated that a rise and fall in enrollment in UT's Primary Care Network PCN 1115 Demonstration (reported to MASBOE 55) appeared to be accurate. However, it did confirm that an apparent shift in enrollment of ~3,600 persons between MASBOE 31 and 32 (poverty-related aged and disabled) and MASBOE 21 and 22 (medically needy aged and disabled) during August-September 2009 should require correction. Despite this, the state did not fix this in its resubmitted version of the Q4 FY09 file.	7/13/2011
UT	Eligibility	MASBOE	2002-Present: By mistake, UT had been reporting its section 1115 expansion group of pregnant women to MASBOE 35, instead of MASBOE 55. They are in state group P82. The state fixed this assignment starting in Q1 FY08.	4/6/2012
UT	Eligibility	Private Health Insurance	UT reports some enrollees with a 9-filled Health Insurance data field. The count started low (< 500 in FY04), and grew to about 1,900 in FY07 and forward. Most of these individuals are also partial duals. Cause unknown.	3/28/2011
UT	Eligibility	Race/Ethnicity	The number of missing race in the new race variable continues to increase. This appears to be due to a considerable number of enrollees in the old 'White' not being mapped to the new race variable properly and being coded as having zero races reported. The state said there are several intake system that feeds into their MMIS and unfortunately race is not an essential data element. So if these systems provide unknown for race then we would get unknown.	11/4/2014
UT	Eligibility	Restricted Benefits Flag	Some enrollees in UT's Primary Care Network section 1115 waiver program receive a reduced benefit package of Medicaid services (while others--high risk pregnant women--receive the full Medicaid benefits package). Through FY05, UT's MSIS data, however, mistakenly showed that ALL of the restricted benefits waiver enrollees were assigned a Restricted Benefits Flag = 1 (full benefits). Beginning in Q1 FY06 forward, UT started assigning RBF '5' (other) for this group, except for a few (<5) who were identified as duals.	3/28/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
UT	Eligibility	Restricted Benefits Flag	Some eligibles outside of MAS/BOE 31 and 32 received RBF = 3 (restricted benefits based on dual eligibility status). This no longer applied, as of Q1 FY09.	7/13/2011
UT	Eligibility	Restricted Benefits Flag	In FY06, about 2,000 aged/disabled full benefit duals and about 1,800 aged/disabled non-duals were all assigned RBF 3. This reporting improved starting in Q1 FY07; however, about 1,900 full benefit duals were still assigned to RBF 3. This improved again in FY08.	4/6/2012
UT	Eligibility	SSI	Utah requires a separate Medicaid application for its SSI recipients. As a result, the number of MAS/BOE 11 and 12 eligibles was lower than the number receiving SSI.	NA
UT	Eligibility	TANF/1931	UT had an error in its TANF data processing in November - December 2004 (Q1 FY05) causing a significant drop in the TANF enrollee count. The TANF data continued to be unreliable through Q4 FY05 and the state started 9-filling this data element in Q1 FY06 forward, although a small number of individuals were reported each month with TANF flag = 1. These individuals should have the TANF flag 9-filled as well. All enrollees were correctly 9-filled by FY11.	3/28/2011
UT	Eligibility	Waivers	UT's New Choices Waiver was implemented in April 2007; however, enrollment in this waiver was not reported in MSIS until October 2007 (Waiver ID '11' and Waiver Type '3'). Prior to October, enrollees in this waiver can be identified each month with state eligibility codes 'QN' and 'WN' in bytes 1-2.	3/28/2011
UT	Eligibility	Waivers	We expect that UT's enrollment reporting to its managed care transportation plan (Plan Type 08 and Plan ID '870570096006') would be consistent with the count of enrollees reported with enrollment in UT's Non-Emergency Transportation Waiver (Waiver ID '10' and Waiver Type '2') since the transportation service is provided under the authority of this waiver. There are about 150,000 individuals reported with the managed care enrollment each month, but only about 16,000 (mostly adults) are shown with enrollment in the waiver. The state indicated that many of these enrollees in the managed care plan are not captured in the waiver enrollment data since many of them are enrolled in more than 3 waivers. Since MSIS only captures enrollment up to three waivers, the waiver hierarchy established by CMS has the transportation plan below several other types of waivers (including the Freedom of Choice 1915(b) waiver--Waiver ID '08'), which means it may get dropped from MSIS reporting for these enrollees. Therefore, the count of enrollees with managed care enrollment in MSIS should be either equal to or much higher than the count of enrollees in the transportation waiver since MSIS does not fully capture the waiver enrollment.	4/5/2011
UT	Eligibility	Waivers	CMS approved a new waiver (UT Autism 1915(c) waiver) on 9/25/2012 and the state began enrolling individuals in this waiver in December 2012. However, in Q1 and Q2 FY13, the state did not report this waiver to a unique Waiver ID. The state did report its members to state-specific eligibility group 'AUT'.	10/28/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
			Enrollment to SSEG 'AUT' was 49 in Q1 and 185-242 in Q2. The state corrected this for Q2 only by reporting the Autism waiver to Waiver ID '12' and Waiver Type '3'. It is reported incorrectly only for Q1 M3. Those enrolled in the Autism waiver were also enrolled in one or more of the state's three 1915(b) waivers [Freedom of Choice, Prepaid Mental Health, and Non-Emergency Transportation], but the Autism waiver does not operate concurrently with those waivers.	
UT	IP	Patient Status	There are no FFS Non-crossover Original Claims with a PATIENT-STATUS = '30' (Still a Patient).	4/22/2011
UT	LT	Admission Date	The ADMISSION-DATE and PATIENT-STATUS are missing on nearly all nursing home/institutional claims, because Utah does not retain the data on the input record.	4/22/2011
UT	LT	Covered Days	In Q1FY2009 UT switched from monthly to weekly and bi-weekly bills, increasing the number of LT claims.	6/9/2009
UT	LT	FFS Claims	The number of Original FFS LT claims and the total Medicaid Amount Paid for them declined substantially between Q2 and Q3FY2009. The State reported about 27,900 Original FFS claims for Q2FY2009 with Total Expenditures of $53 million. It reported only 13,500 claims for Q3FY2009 with expenditures of $20.8 million. In Q4FY2009, both of these values returned to Q2FY2009 levels.	1/30/2012
UT	OT	Capitation	Behavioral capitation ratio is 2:1 due to the way the state reports payments	12/23/2013
UT	OT	Capitation	Enrollment reporting for OPTUM PLANID 876000316005 started in July of 2011 (Q4).	4/3/2014
UT	OT	Capitation	UT 2012Q3, plan id 942938348009 should be plan id 942938348014.	8/12/2014
UT	OT	EPSDT	Most claims for children have a Program Type of 1 (EPSDT).	12/10/2004
UT	OT	Managed Care	Starting in July 2003, UT switched 2 of its 3 HMO plans to a 'no-risk' basis. So basically services are being paid on a FFS basis by administered by the plans. One plan has shifted to submitting individual FFS claims, but the other 2 (Molina and Healthy U) do not. UT resubmitted the 2004 Q1-4 EL files to remove all the HMO enrollees and the OT capitation claims. It is adding Service Tracking claims with the expenditures from the 2 plans. It will continue with this until it is able to submit individual FFS claims. The Type of Service on these service tracking claims is Other Services as they include a bundle of services.	3/21/2011
UT	OT	Managed Care Capitation	LT managed care capitation claims are reported with a Type of Service of HMO capitation due to the comprehensive nature of the services provided.	NA
UT	OT	Managed Care Capitation	There are not any PCCM capitation claims in the OT file as they are paid on a FFS basis.	5/27/2005

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State	File Type	Rec/Issue Type	Issue	Recorded
UT	OT	Managed Care Encounters	There is one plan id 870293014001 that is reported on encounters only that should be cross walked to 870293014007 in 2012Q4 and 2013Q1	10/13/2014
UT	OT	Service Tracking Claims	Some of Utah's managed care plans operate under a "Non-risk Capitation" reimbursement arrangement. If a beneficiary's total cost of care exceeds their cap payments, the State pays the difference to the MCO. These payments appear as service tracking claims in the OT file and are considered "rate adjustments".	2/6/2012
UT	OT	Specialty Code	SPECIALTY-CODE is missing for about 13% of FFS Non-crossover Claims with TYPE-OF-SERVICE = '08' (Physician).	4/22/2011
UT	RX	Date Prescribed	All FFS Original Claims have a DATE-PRESCRIBED = 9-filled. All FFS Original Claims have a PRESCRIPTION-FILL-DATE formatted as 'YYYYMM'.	4/22/2011
VA	Claims	Adjudication Date	In encounter claims, adjudication date is the claim's date of last activity date. In non-encounter claims, the claim's remittance advice payment date is used as the adjudication date in the claim's MSIS extract record. In addition, each month's MSIS claims extract run around the third weekend of each month. Each month's extract process picks up those claims from the preceding month that were not included in the preceding month's claims extract process.	6/18/2012
VA	Eligibility	0-filling	In Q1 FY10, VA incorrectly 0-filled the plan type, plan ID, waiver type, and waiver ID fields for several enrollees. In some cases, individuals with MASBOE 00 did not have these fields 0-filled, and in other cases, individuals with MASBOE > 00 had these fields 0-filled. We asked the state to improve this reporting but they responded that they could not. This is because 0-filling of the MASBOE field is done based on eligibility segments while the plan type, plan ID, waiver ID, and waiver type fields are 0-filled based on eligibility and enrollee segments.	9/1/2011
VA	Eligibility	1115 Waivers	In FY08 - 09, VA reported all of its Family planning-only enrollees to plan type 01. The state contact explained that this reporting is incorrect and these persons should be FFS. This reporting was corrected in Q1 FY10.	6/8/2011
VA	Eligibility	1115 Waivers	Enrollment in VA's 1115 family planning waiver increased from approximately 7,000 in Q2 FY11 to approximately 15,000 in Q1 FY12. This increase was expected due to program changes.	5/2/2012
VA	Eligibility	1115 Waivers	Effective 10/1/11, VA's family planning program transitioned from a waiver to the state plan. However, the state continued to report family planning enrollees to MAS 5 with waiver enrollment through Q3 FY12. The state made this fix in Q4 FY12 and started assigning FP enrollees to MAS 3.	9/27/2012
VA	Eligibility	CHIP	Until the fall of 2002, Virginia only had a child S-CHIP program, and was reporting all of its S-CHIP eligibles into MSIS. Effective September 2002, the state has a child M-CHIP program as well, and many children appear to transfer from S-CHIP to M-CHIP.	1/29/2010

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State	File Type	Rec/Issue Type	Issue	Recorded
			The M-CHIP expansion provides Medicaid to children of all ages with household income up to 133% FPL.	
VA	Eligibility	CHIP	In Q4 FY08, MSIS reported 16 percent more S-CHIP enrollees than SEDS did. We asked the state for more information about this discrepancy but did not receive a reply.	3/22/2011
VA	Eligibility	CHIP	VA began reporting S-CHIP adults in Q4 FY05 (state group '005' reported to MASBOE 00). This group is part of the section 1115 S-CHIP waiver (not a Medicaid waiver) that extends coverage to pregnant women with income 133-200% FPL. Premium assistance coverage for children was also implemented in August 2005.	3/22/2011
VA	Eligibility	CHIP	Starting in Q1 FY14, Virginia reported individuals with MASBOE = 00 (not eligible) to CHIP Flag = 1 (Eligible but no CHIP). In Q1 FY14, the number of individuals reported with MASBOE = 00 and CHIP Flag = 1 increased from 137 to 328. By Q2 FY14, the issue was still present and had worsened from 621 to 812 individuals. Previously, in Q2 FY13, there was 1 individual reported with MASBOE = 00 and CHIP Flag = 1, but it was corrected by the next quarter. Then the issue reemerged in Q1 FY14. DMAS indicated that this is how CHIP-CODE should be assigned for all the new MAGI aid categories (010 - FAMIS Deemed Newborn <1 year old). Currently the code defaults to '00' MAS/BOE when the RS-ELIG-AID-CAT-PGM NOT = '01', which a couple of them had benefit program is '07' – FAMIS, they would default to '00'.	4/8/2014
VA	Eligibility	County Codes	Virginia assigns special FIPS codes 510 - 840 and 975 to 997 to cities that are independent entities.	NA
VA	Eligibility	County Codes	There were approximately 2,700 enrollees with county code 000 in the Q1 FY10 file. The state indicated that it reports out-of-state enrollees to this code.	9/23/2011
VA	Eligibility	County Codes	Virginia assigns county codes 983 - 997 to institutions in the state. Virginia also assigns county code 975, which is not a FIPS code. VA DMAS uses county code 975 for assessments when there is not an existing record in the MMIS. This county code appears in MSIS files when the state fails to update the county code when a person subsequently becomes Medicaid eligible.	12/21/2011
VA	Eligibility	Dual Eligibility Codes	Between Q1 and Q2 FY12 and again between Q1 and Q2 FY13, the number of enrollees with dual code 06 (qualified individual 1) decreased from approximately 10,500 to approximately 9,000. This enrollment then increased to approximately 10,000 in Q3 FY12. The state indicated that this type of fluctuation is expected annually because QI-1 members must renew this enrollment each year. Some individuals do not renew within the right timeframe and experience a break in coverage.	5/2/2012
VA	Eligibility	Managed Care	VA started reporting PACE enrollment (Plan Type 06) in Q2 FY08.	7/1/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
VA	Eligibility	Managed Care	From month 1 to month 2 of Q4 FY07, PCCM enrollment dropped from about 64,000 enrollees per month to about 50,000 enrollees. The state explained that the PCCM program was discontinued in the Lynchburg region of the state and these enrollees were transitioned to managed care, thus explaining the increase in HMO enrollment through early FY08.	8/5/2008
VA	Eligibility	Managed Care	Each month from Q2 FY07 through Q4 FY09, Virginia reported several thousand (5,000-11,000) HMO enrollees with 0-filled plan IDs. The state corrected this reporting in Q1 FY10.	7/8/2011
VA	Eligibility	Managed Care	In 2006, VA reported about 320,000 enrollees in a transportation managed care plan in the CMS June managed care report; however, the state did not include this enrollment in its MSIS eligibility files. VA indicated that this plan is not a true managed care plan (no capitated payments) and should not have been reported in the CMS report. This enrollment was not included in the 2007 CMS report but did appear in the June 2008, 2009, and 2010 reports.	1/11/2012
VA	Eligibility	Managed Care	Enrollment in VA's PCCM managed care plans (plan type 07) started decreasing in November 2011 and ended completely in Q3 FY12 when the state ended its PCCM program on 5/1/12.	5/2/2012
VA	Eligibility	MASBOE	2001 - current: Beginning in Q4 FY 2001, Virginia extends full Medicaid benefits to aged and disabled persons to 80 percent FPL (state groups 29, 39, and 49).	NA
VA	Eligibility	MASBOE	After July 2000, the state began bypassing the 1931 rules for children. Virginia now determines eligibility for children based on the more simplified poverty-related provisions (MAS 3). The state has continued to use the 1931 rules to determine eligibility for adults, but they are unable to separate 1931 eligibles from other transitional assistance recipients. Both groups are under one state-specific eligibility group that is mapped to MAS 4.	NA
VA	Eligibility	MASBOE	2007: In FY07, VA started showing a seam effect across several MASBOE groups between the last month of one quarter and the first month of the next quarter. Generally, enrollment is highest in month one of each quarter and lowest in month three.	9/20/2007
VA	Eligibility	MASBOE	All Years: Virginia has an outreach program to children in September of each year. Enrollment is often retroactive three months.	3/21/2011
VA	Eligibility	MASBOE	Effective April 2009, CMS approved a SPA in VA that lifts the 5-year waiting period for immigrants.	3/21/2011
VA	Eligibility	MASBOE	All Years: Virginia is a 209(b) state. As a result, SSI recipients are required to fill out separate applications for Medicaid, and are required to meet stricter standards. Because of this, the total number of persons in MASBOE 11 and 12 may be less than the number of SSI recipients reported by the SSA. In addition, VA appears to report most SSI disabled >65 years to MASBOE 11. Finally, VA has a state administered SSI supplement.	9/23/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
VA	Eligibility	MASBOE	VA confirmed that it uses state specific eligibility group 059 for Medicaid Buy-In enrollees. Through FY09, VA mapped these persons to MASBOE 32. At our request, the state remapped this group to MASBOE 42 starting in Q1 FY10.	9/23/2011
VA	Eligibility	MASBOE	From October 2013 to March 2014, MASBOE = 22 (Medically Needy Blind/Disabled) decreases from 3,429 to 2,609 and MASBOE = 17 (Receiving Cash Unemployed Adult) increases from 6,953 to 8,292. We have asked the state whether these shifts were expected and if so, what the explanation was.	4/8/2014
VA	Eligibility	MASBOE	From April 2013 to September 2013, the number of individuals reported to MASBOE = 22 (Medically Needy and Blind/Disabled) decreased from 3,991 to 2,970. The MASBOE 22 category is cross walked to the Virginia's MMIS Benefit Aid Categories 038, 048, 058, and 068. DMAS's responded that the shift in MASBOE 22 had to do with the new SLMB aid categories. Some of these members were moved from Medically Needy into other related aid categories not associated with MASBOE 22 and some members didn't meet a spend down for the period because they did not incur enough in medical expenses to meet their spend down liability. DMAS also put SLMB Plus aid categories into effect and this may also account for part of the shift from MASBOE 22 grouping.	6/26/2014
VA	Eligibility	Restricted Benefits Flag	All medically needy persons except aliens and MFP enrollees receive restricted benefits code 5.	3/8/2010
VA	Eligibility	Restricted Benefits Flag	See waiver section for anomaly related to VA's Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program and RBF 'A' reporting.	7/8/2011
VA	Eligibility	Restricted Benefits Flag	A small number of aged and disabled full duals (roughly 10-20 each month) are mapped to restricted benefits code 2 (emergency services only for unqualified aliens). Generally, we would not expect unqualified aliens to have dual status, but VA informed us that these individuals are correctly enrolled 6 months at a time for emergency dialysis. It is possible to have Medicare TPL and have an unqualified alien status.	9/23/2011
VA	Eligibility	Restricted Benefits Flag	A small number of aged and disabled non-duals (roughly 20-30 each month) were previously mapped to restricted benefits flag 3 (restricted, dual eligibility). Generally, we would not expect non-duals to be receiving restricted benefits because of dual status. The state explained that Medicare payment and dual status were entered separately in the MMIS system and in these cases there was inconsistent information in the two subsystems. The state eliminated this issue in Q1 FY10, but began reporting these individuals with restricted benefits flag 9 (unknown). After investigation, the state determined that these individuals were not eligible for Medicaid and should have been assigned restricted benefits flag 0. Only non-duals with RBF 9 were not Medicaid enrollees. In Q4 FY12, the state stopped reporting any individuals to RBF 9.	9/23/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
VA	Eligibility	Restricted Benefits Flag	In July 2008, VA implemented a Money Follows the Person (MFP) program. MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. Starting in Q4 FY08, VA reported MFP enrollees to RBF code 8 in MSIS.	9/23/2011
VA	Eligibility	Restricted Benefits Flag	VA implemented a Disease Management program in October 2006 (Q1 FY07) that was approved by CMS as an alternative benefit package. Current enrollees that were determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes were able to opt out of traditional Medicaid into this new "Healthy Returns" program to receive additional benefits tailored to their conditions (with the exception of four groups of individuals - persons in managed care, dual eligibles, persons who lived in institutions, and those who had third party insurance). VA paid an administrative fee to the service provider but paid for services on a fee-for-service basis. VA was not able to report this enrollment in MSIS; however, the state estimated enrollment at about 5,800 (Sept 2008). VA expected to have changes made to its system to allow reporting to RBF 7 to begin in January 2009, but this reporting did not appear through Q1 FY10. When we asked the state to provide a timeline for including this reporting, the state replied that this program was not included in the Q1 FY10 file "because the disease management program is no longer active."	9/23/2011
VA	Eligibility	Retroactive/ Correction Records	VA only looks at changes made to birthdate, sex, and SSN when submitting correction records.	NA
VA	Eligibility	State-Specific Eligibility	Each quarter, VA typically shows a larger than expected shift of reporting to state-specific eligibility codes. This is caused by individuals moving between "A" (active) and "C" (canceled) in byte 4 of the code. (Bytes 1-3 of the code remain the same.) We talked to the state about this reporting and were ensured that all individuals reported with either an A or a C are still enrolled in Medicaid that month. The classification is mostly used for internal uses.	3/21/2011
VA	Eligibility	TANF/1931	TANF data are not reliable in Virginia. The state began 9-filling the TANF field in Q1 FY 2003.	NA
VA	Eligibility	Waivers	From October 2004 until October 2009, VA used 3 different waiver IDs for its Medallion 1915(b) waiver. This waiver includes PCCM and MCO programs. VA used Waiver ID 'M1' for persons who live in areas with PCCM coverage, waiver ID 'M2' for persons who live in areas with 'MCO' coverage, and waiver ID 'M3' for persons who live in areas with both PCCM and MCO coverage. We asked VA to stop using waiver ID 'M3,' and to report these persons to 'M1' if they were PCCM enrollees or 'M2' if they were MCO enrollees. VA made this change in Q1 FY10.	6/8/2011
VA	Eligibility	Waivers	Between Q2 and Q3 FY10, enrollment in VA's family planning waiver (waiver ID 'F1') increased from approximately 5,200 to	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			approximately 5,700. Enrollment in this waiver further increased to approximately 6,200 in Q4 FY10.	
VA	Eligibility	Waivers	From Q1 FY08 through FY09, VA incorrectly reported enrollment in its Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant to waiver ID 'B3'. This is a grant program and not a Medicaid waiver. We asked VA to stop reporting enrollment to this waiver ID and to identify these enrollees using RBF 'A' instead. VA did so in Q1 FY10. However, while approximately 60 enrollees were included in the waiver each month in Q4 FY09, only around 30 enrollees were reported with RBF 'A' each month in Q1 FY10. VA indicated that this decrease in enrollment occurred because a coding error was fixed, and that retro/correction records were used to fix this error in the previous two quarters.	4/6/2012
VA	Eligibility	Waivers	In Q1 FY10, VA reported approximately 1,500 children who were assigned BOE 4 or 8 with enrollment in the Virginia Elderly or Disabled with Consumer Direction Waiver (waiver ID 'A3'). When asked about this, the state indicated that these children were disabled. We requested that VA assign BOE 2 to disabled children in future files. However, the state indicated that "Children who are otherwise eligible for Medicaid even with Long-term care (LTC) benefits are not considered disabled members unless they have had a disability determination by SSA. Many of these children do not and if they have been determined disabled by SSA, they are placed in other covered groups." The state therefore indicated that these children cannot be moved to BOE 2. The state further indicated that "Children are not sent for disability determinations through SSA unless the child is not eligible in the Families and Children covered group or is aging out of this covered group." Therefore, we expect to continue to see children reported with BOE 4 or BOE 8 in this waiver.	4/6/2012
VA	Eligibility	Waivers	VA had some ongoing section 1915(c) waiver link issues. In FY08, about 40 percent of individuals not enrolled in HCBS waivers have type 6/7 claims. Poor linkage continued in FY09. VA researched this issue and found a coding error in the generation of claims OT files. The state corrected this issue beginning in the claims OT file for Q4 FY11.	4/6/2012
VA	Eligibility	Waivers	See managed care anomaly for information about fluctuations in enrollment in VA's Mediallion - MCO waiver (waiver ID 'M2') between Q1 and Q3 FY12.	5/2/2012
VA	IP	Crossovers	The percent of crossover claims is much higher than typical but may be due to the state's managed care structure. 57% of Medicaid enrollees are in comprehensive managed care (June 2009 Medicaid managed care enrollment report) but no duals are enrolled. Therefore, duals likely make up a significant portion of the FFS claims.	3/22/2011
VA	OT	FFS Claims	As of Q2 FY2012, state reports 20% of its dental claims with Plan IDs.	6/18/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
VA	OT	Managed Care Encounters	From Q2 of 2010 to Q2 2011 approximately 20 percent of original FFS claims had a plan ID on them. It is unclear if these claims are encounter claims mistakenly submitted as FFS or if they are FFS claims.	7/12/2011
VA	OT	Provider ID	The servicing and billing provider ID numbers are usually the same. When available they are putting the attending provider ID in the servicing field.	12/10/2004
VA	RX	NDC	Virginia does not have the capacity of using HCPCS inputs on pharmacy claims. Universal codes are used for DMEs without NDCs. Pharmacy claims without NDCs can be compounds or other unidentifiable items.	12/10/2004
VT	Eligibility	1115 Waivers	In October 2005, VT implemented another 1115 waiver (VT Long Term Care Plan/Choices for Care) that focused on improvements to the LTC system and increased access to HCBS. A small Medicaid expansion population was included (state group WM reported to MASBOE 51 and waiver ID L2). It consists of individuals not previously enrolled in Medicaid who are in moderate need of non-institutional services. They only qualify for a limited benefits package. Reporting to this group began in Q1 FY06.	5/11/2010
VT	Eligibility	1115 Waivers	Beginning in 1995, Vermont implemented an 1115 waiver program -- Vermont Health Access Plan (VHAP) -- that extends eligibility with full benefits to 300% FPL for children and 185% for parents. Aged and disabled enrollees with income to 175% FPL qualify under the 1115 waiver for prescription benefits. In addition, many of these aged & disabled enrollees also get Medicare cost-sharing benefits under QMB only, SLMB only, or QI provisions. These enrollees were rolled into the 1115 Global Commitment waiver ID 'G6' towards the end of 2005.	4/19/2011
VT	Eligibility	1115 Waivers	Parts of VT's "Global Commitment to Health" 1115 waiver (approved 9/05) began to be implemented in Q1 FY06. This waiver has many components. To start, it appears that most Medicaid expansion enrollees in the old VHAP 1115 waiver transferred to this waiver. In addition, the waiver allows VT to convert its entire Medicaid population to a public MCO. Finally, the waiver includes a new ESI Premium Assistance program for working adults with access to insurance, as well as premium assistance in the Catamount Health program for the uninsured.	4/19/2011
VT	Eligibility	1115 Waivers	Effective December 22, 2009 (Q1 FY10), CMS approved an amendment to the Global Commitment waiver that included an enrollment expansion. The amendment expanded eligibility up to 300% (FPL) under the ESI premium assistance program and the private product Catamount premium assistance program (causing some expansion to state groups ZA, ZB, and ZC). (Prior to this approval, VT was covering these individuals up to 300% out of State funds). Approval was also given to expand/extend pharmacy benefits for low income Medicare beneficiaries from 175% to 225% FPL. These new VHAP enrollees (included in	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			Waiver ID 'G6') are reported in MSIS starting in Q1 FY10 to state-specific groups VF, VI, VL, VO and to MASBOE 51.	
VT	Eligibility	CHIP	Vermont reports its S-CHIP eligibles into MSIS. The state does not have an M-CHIP program.	3/22/2011
VT	Eligibility	Dual Eligibility Codes	Starting in Q1 FY08, VT included new groups of partial duals (state-specific groups PQ, PS, & QI) in its MSIS reporting; however, due to an error in the state's system, the dual codes were not correctly assigned for these individuals (many were 0-filled). PQ enrollees should be assigned to dual code 01; PS enrollees should be assigned to dual code 03; and, QI enrollees should be assigned to dual code 06. VT corrected MASBOE and dual assignments for these groups in the Q1 FY 2009 file.	5/11/2010
VT	Eligibility	Dual Eligibility Codes	Most QMB only, SLMB only, and QI-1 eligibles are reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate). Other dual eligibles in the 1115 program were assigned dual code 09, beginning in FY03.	3/22/2011
VT	Eligibility	Dual Eligibility Codes	Starting in Q2 FY06 (January 2006), with the implementation of Part D, some enrollees shifted from dual code 09 (pharmacy + waiver) to dual codes 01 and 03 (and 06 in the MMA file). However, they remained in the section 1115 waiver (presumably the program provided drug wraparound benefits). Enrollment in dual code 09 continued for those in the 1115 waiver who did not meet the partial dual financial requirements.	3/22/2011
VT	Eligibility	Dual Eligibility Codes	VT did not start reporting to dual code 06 until Q1 FY08 in MSIS (MMA shows enrollees reported to this dual code prior to FY08).	4/19/2011
VT	Eligibility	Dual Eligibility Codes	VT's reporting of dual codes in MSIS does not compare well to MMA. Counts of duals in 03 were inconsistent, but greatly improved in Q1 FY07. Counts of duals in code 09 were inconsistent, but greatly improved in Q1 FY10. Counts of duals in 04 and 08 have never compared well. We've talked with the state several times about reviewing why these sources are different and they explain that the MMA files are able to access a greater level of detailed enrollee information and the state is not able to produce the same counts. Differences will continue to exist. Mathematica has communicated this issue to the CMS MSIS/MMA team.	5/15/2011
VT	Eligibility	HCBS Waiver	Vermont reports individuals in its LTC Waiver program who may begin or end their participation without completing the month. The state will report that enrollment even if only one day of the month is covered.	3/22/2011
VT	Eligibility	Managed Care	Prior to 2000, VT placed enrollees in capitated managed care plans; however, when its two HMO plans (Blue Cross and Kaiser) left the program, it transitioned everyone into PCCM plans. This resulted in a shift in managed care reporting in MSIS from Plan Type = 01 (HMO) to Plan Type = 07 (PCCM) starting	5/11/2010

State	File Type	Rec/Issue Type	Issue	Recorded
			in Q1 FY00. By Q3 FY00, no one was reported in MSIS with HMO enrollment. Then, in October 2005 (Q1 FY06), VT implemented its new 1115 waiver, Global Commitment to Health (GC waiver). The state considers these waiver enrollees to be in HMO-like managed care, with two major exceptions, the PC Plus enrollees and VHAP Rx enrollees, discussed below. Under the waiver, CMS pays a capitation fee to the state of VT to act as a public HMO for GC enrollees. From Q1-4 FY08, VT assigned GC enrollees in HMO-like managed care to Plan Type 01 (HMO) and Plan ID 'GC11W0019411' in MSIS (although this reporting was incorrect since the state duplicated HMO enrollment for enrollees instead of 8-filling some of the fields leaving the total HMO enrollment count much larger than the total Medicaid population). Since capitation claims are not submitted for these enrollees and most of the services appear as FFS, the state removed this HMO enrollment effective Q1 FY09 (on our request). Also part of the GC waiver, the PC Plus enrollees, who are assigned to a specific primary care doctor who is paid $5/month for administration and case management, are assigned to Plan Type 07 and mapped to Waiver ID 'G4' from October 2005 forward (these enrollees are counted as HMO enrollees in the annual CMS June data). VHAP Rx enrollees are not in any managed care arrangement and are mapped to Waiver ID 'G6' from October 2005 forward.	
VT	Eligibility	Managed Care	When running edits for FY 2008, CMS noticed that VT has not been submitting Plan IDs for PCCM plans (leaving the Plan ID field blank for these enrollees). A QA tab for the FY 2009 files showed that VT was entering Plan IDs for all but a small percentage of enrollees in PCCM plans (about 0.14 percent had blank plan IDs).	5/11/2010
VT	Eligibility	Managed Care	Starting in 2007 forward, the MSIS data do not compare well to CMS' June managed care data due to differences in counting HMO enrollment for the Global Commitment waiver enrollees (there was a smaller problem with the comparison in 2006 due to GC's phase-in throughout that year). And, as discussed in another anomaly, the difference in 2008 was particularly large due to duplication of HMO enrollment reporting in MSIS.	4/19/2011
VT	Eligibility	Managed Care	VT started a PACE program in April 2007; however, the state did not include this enrollment reporting in MSIS through Q4 FY07. These enrollees can be identified by Waiver ID 'L4' (part of VT's LTC 1115 waiver). The state fixed this assignment in Q1 FY08 and assigned Plan ID 'PACEVT000191'. The state phased out its PACE program in 2013.	4/6/2012
VT	Eligibility	MASBOE	2006: Starting in Q2 FY06 (January 2006), with the implementation of Part D, some 1115 waiver enrollees changed status. While they continue to be reported to MAS 5, the state added in a set of new state-specific codes (VD-VN) for enrollees that used to be VSCRIPT and VHAP Pharmacy who now have Medicare Part D coverage.	11/14/2008

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State	File Type	Rec/Issue Type	Issue	Recorded
VT	Eligibility	MASBOE	2006: VT began to shift its VHAP 1115 Medicaid expansion population to the Global Commitment to Care 1115 in Q1FY06. This shift can be detected in MSIS waiver data, but did not have an impact on the MASBOE counts.	11/14/2008
VT	Eligibility	MASBOE	All Years: Through FY07, VT did not report enrollees to MASBOE 31 - 32 because all QMB only, SLMB only, and QI1 eligibles were reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits (wraparound benefits after Part D), but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate). Their enrollment continued in 2006, even after the implementation of Medicare Part D. Starting in FY08, VT included some new state-specific groups (PQ, PS, QI) that were reported to MAS 2, but should have been mapped to MAS 3 since these individuals are receiving cost-sharing benefits only and no Pharm Plus benefits. The state moved these enrollees to MAS 3 in Q1 FY 2009.	5/11/2010
VT	Eligibility	MASBOE	In Q1 FY06, VT started reporting enrollees (<100 individuals) to state eligibility group "WM". They are mapped to MASBOE 51-52. This aged/disabled group is part of VT's section 1115 Long Term Care waiver (Choices for Care waiver administered by the Department of Aging and Independent Living). These enrollees are assigned RBF 5 as they are eligible for only three specific Home Health care services and not full Medicaid benefits.	3/22/2011
VT	Eligibility	MASBOE	All Years: Beginning in 1995, Vermont implemented an 1115 waiver program -- Vermont Health Access Plan (VHAP) -- that extended eligibility with full benefits to 300% FPL for children and 185% for parents. Aged and disabled enrollees with income to 175% FPL qualified under the 1115 waiver for prescription benefits. In addition, many of these aged & disabled enrollees also received Medicare cost-sharing benefits under QMB only, SLMB only, or QI provisions. Beginning in Q1 FY06, Medicaid expansion groups in this waiver shifted to VT's new Global Commitment to Care 1115 waiver. Effective Q1 FY10, CMS approved an amendment to VT's 1115 waiver that included an expansion of pharmacy benefits for low income Medicare beneficiaries from 175% FPL to 225% FPL (Waiver ID G6). These new VHAP enrollees caused an increase in reporting to MASBOE 51.	4/19/2011
VT	Eligibility	MASBOE	Through FY09, VT reported several hundred persons age 65 and older each month to BOE 2 (disabled). The state fixed this assignment starting in Q1 FY10 causing a shift from MASBOE 12 to 11.	4/19/2011
VT	Eligibility	MASBOE	Effective 7/1/11 (Q4 FY11), VT implemented a new SPA to expand coverage to qualified alien children and/or pregnant women who are lawful permanent residents in the United States and who have not met the 5-year waiting period. A low number of individuals are covered (state-specific codes RC, R4, RP, and R7).	11/15/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
VT	Eligibility	Private Health Insurance	In Q1 FY08, VT started reporting implemented its new ESI/Catamount Health Assistance Plan (CHAP) as part of the Global Commitment 1115 waiver. These enrollees are reported to state-specific eligibility codes ZA, ZB, and ZC and are assigned Health Insurance flag "3" if a state subsidy is involved.	4/19/2011
VT	Eligibility	Race/Ethnicity	VT reports about 40 percent of its enrollees with unknown race/ethnicity information. The state does not require that enrollees provide this information.	NA
VT	Eligibility	Race/Ethnicity	Through FY06, VT zero-filled the new expanded Race Codes 1-4 and Ethnicity data elements that were required starting in FY05 (although VT does continue report to the old combined race/ethnicity data element). Although VT does not collect multiple race/ethnicity information in its system, starting in Q1 FY07 the state started crosswalking the old data element to the new, expanded data elements to populate these new fields.	2/2/2009
VT	Eligibility	Restricted Benefits Flag	VT does not assign any individuals to RBF 2 and is not able to do so at this time. The state is aware of this missing information from its reporting and hopes at some point in the future to be able to add it. This will probably not occur until a new eligibility system is implemented (the system is scheduled for an upgrade at some point in the future, but no timeline has been established, yet).	3/22/2011
VT	Eligibility	Restricted Benefits Flag	Restricted benefits flag 5 ("other") is assigned several different groups of enrollees. Some RBF 5 enrollees are in Vermont's section 1115 demonstration, which provides aged and disabled enrollees with pharmacy benefits only. In FY06, VT started reporting state-specific eligibility group "WM" (MASBOE 51-52) with RBF 5 as they are part of VT's section 1115 waiver (Choices for Care waiver administered by the Department of Aging and Independent Living) and are eligible for only three specific Home Health care services and not full Medicaid benefits. In addition, persons in MASBOE 55 are assigned restricted benefits code 5 when they switch from FFS to the "Primary Care Plus" program. This program has some restrictions which have changed over the years, such as no dental coverage and higher copays.	5/15/2011
VT	Eligibility	Restricted Benefits Flag	In Q1-4 FY08, VT started reporting to new state-specific groups PQ, PR, and QI. These enrollees receive cost-sharing benefits only and should have been assigned to RBF 3 instead of RBF 5. The state started assigning these enrollees to RBF 3 in Q1 FY 2009.	4/6/2012
VT	Eligibility	Restricted Benefits Flag	CMS awarded Vermont a Money Follows the Person (MFP) demonstration grant in 2011 and the state started transitioning individuals during the first half of 2012. Vermont, however, is not able to report MFP enrollment to MSIS (RBF '8') as the state's system is not able to identify MFP program recipients in the system that feeds the MSIS file creation. The state is not able to make this fix until some point in the future when they implement a new data system.	7/29/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
VT	Eligibility	Retroactive/ Correction Records	Even though VT often submits a larger number of correction records, relatively few make changes to key variables. For example, 97 percent of the 61,478 correction records included in Q2 FY04 for Q1 FY04 did not change any key variables.	NA
VT	Eligibility	Retroactive/ Correction Records	Vermont submits a small number of correction records that are very old. The number of such records is small and the state does not think this practice has an effect on its data.	4/19/2011
VT	Eligibility	SSN	VT is submitting what appear to be valid SSNs (9 digit numeric data) for over 99 percent of Medicaid enrollees each quarter. We generally expect to see the SSN field 8-filled for at least 2-3 percent of enrollees, given that SSNs are not always available for some enrollees, such as newborns, younger children, or undocumented aliens. VT has about 0.2 percent of its records 8-filled. However, VT responded that the state requires applicants/enrollees to obtain SSNs for newborns and younger children in the first 7 days of life which contributes to the high number of SSNs being reported.	4/4/2008
VT	Eligibility	TANF/1931	In April 2008, VT made some changes to its funding streams for TANF enrollees causing many TANF enrollees to be reclassified as "Reach-Up", the state's financial assistance and work program for low income families with children. Some, but not all, of Reach Up is Vermont's TANF financial assistance-work program. Families in the Reach Up program are funded by TANF funds, some are funded with State funds claimed for TANF MOE, and some families' grants are funded with state funds that are not claimed as TANF or TANF MOE. This shift from TANF to Reach Up caused the ACF enrollment data to decrease starting in 2008; however, the state did not make any changes to how TANF clients are reported in MSIS, causing a large difference in enrollment counts. At this time, the state is not able to report MSIS counts to match the ACF counts.	4/6/2012
VT	Eligibility	Waivers	In 2006, when VT started reporting its Global Commitment to Health waiver enrollment in MSIS, the state used several waiver IDs (G1-G6) to designate different subgroups enrolled under the waiver; however, some waiver enrollees in MAS 5 did not fall into one of these categories and were not reported with waiver enrollment. In addition, starting in Q1 FY08, VT started reporting its ESI/Catamount Health Assistance Plan (CHAP) enrollees (state groups ZA, ZB, ZC) but did not assign them any waiver enrollment. Therefore, starting in Q1 FY09, VT started using a new waiver ID (G7) as a 'catch-all' to show waiver enrollment for all of these Global Commitment waiver enrollees that did not fall into of the original G1-G6 subgroup codes.	4/19/2011
VT	Eligibility	Waivers	VT reports about 250 enrollees a month to both the state's VHAP Rx waiver (Waiver ID 'G6'), which provides only drugs, and the HCBS Aged and Disabled Waivers (Waiver ID 'L2') which provides only a few HCBS. The state confirmed that they have some individuals that are enrolled in the pharmacy program that	6/28/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			are also separately eligible for limited HCBS care under VT's long term care waiver.	
VT	Eligibility	Waivers	VT offer HCBS to enrollees under its global 1115 waiver, which is unique compared to most other states that offer HCBS under section 1915(c) waivers.	7/30/2014
VT	IP	Covered Days	In Q1FY2009, IP covered days field contains unreliable information. Researchers who need this information are encouraged to use an alternative method of computing covered days by taking the difference between service end date and service begin date.	3/16/2011
VT	IP	DRG	The state does not use DRGs.	3/16/2011
VT	LT	Adjustments	Across the four quarters of 2009, the percentage of original claims submitted increased steadily from 18%, 26%, 45%, and 93% from Q1 to Q4, respectively.	NA
VT	LT	Adjustments	In Q1FY2009, more than 80% of the claims submitted were adjustments compared to 7% in Q4FY2008 along with a substantial increase in total claims counts. Count of original claims remained steady however.	NA
VT	LT	Leave Days	VT reports very few leave days.	12/5/2005
VT	OT	HCBS Waiver	In Q1FY2009, 31% increase in total amount paid, and 18% increase in average amount paid for HCBS services over Q4FY2008. Total amount paid and average amount paid gradually is going down to previous level in subsequent quarters.	NA
VT	OT	Revenue Code	VT uses state specific Revenue Codes for Home Health and Hospice services and not service codes	3/23/2006
VT	RX	Crossovers	All QMB-only, SLMB-only, and QI-1s in Vermont's section 1115 demonstration qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).	3/22/2011
VT	RX	Date Prescribed	The fill date is reported in both the Fill Date and Prescribed Date fields.	4/12/2005
WA	_All	MSIS ID	WA is implementing a new MMIS system effective January 2010. The state is planning to send a cross reference file cross-walking the former MSIS-IDs to the new MSIS-IDs. The new system in the beginning will mostly be just a transition of the old system without a lot of changes except that they plan to include more encounter claims and in a more timely fashion.	5/29/2008
WA	Claims	All	FFY 2014 Q4 LT and OT files did not include data from RDA. The state is resubmitting the files. RDA is a division in the Department of Health and Social Services in Washington State. They provide some data that appears in the LT and OT files, although it is unclear if they are responsible for the adjudication. On the OT file, it likely impacted the HCBS claims and their absence.	5/20/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
WA	Claims	CHIP	S-CHIP FFS claims and managed care claims have declined significantly since FFY 2014 Q1. During this same time, S-CHIP enrollment has increased.	6/9/2015
WA	Claims	Data System Change	WA implemented a new MMIS in Q1FY2009. The state first converted its old system to the new and will soon implement phase 2 of its transition, which will correct problems that had occurred in its old system.	NA
WA	Claims	HCBS Waiver	WA reported claims in the IP and LT files with a program type of 6 and 7 in Q1 and Q2FY2010 files.	10/26/2011
WA	Claims	Managed Care Plan IDs	The 7 leading bytes (all 0) in the eligibility Plan ID field need to be dropped in order to link with the claims.	NA
WA	Eligibility	0-filling	Beginning in FY99, about 25 - 300 current enrollees each month had the TANF, RBF, and plan type fields 0-filled by mistake. The state's research shows that these individuals should not have been reported in the MSIS data and the state intended to make this fix when it implemented its new MMIS (Q1 FY10 file). However, in Q1 FY10, there were differences in zero-filling between the MASBOE and health insurance, dual, managed care, TANF, CHIP, and waiver fields. In Q2 FY10, there was a difference in zero-filling between the MASBOE and health insurance fields. The state resolved these issues in the Q3 FY10 file.	4/6/2012
WA	Eligibility	1115 Waivers	Effective Q4 FY 2001, Washington extended family planning benefits to adults in a section 1115 demonstration.	3/22/2011
WA	Eligibility	1115 Waivers	Through Q2 FY09, WA should have reported enrollees in state-specific eligibility groups 'SCP0' and 'STP0' to MASBOE 55 (rather than 35); as having a restricted benefits flag = 6; and with waiver ID 'TC'/waiver type 'F'. The state had previously been inconsistent with how these groups were reported. It appears that the state was unable to fix this issue in the FY10 files. In these files, approximately 8,000 - 9,000 individuals assigned state-specific code '1098' under the new MMIS were reported with restricted benefits flag 6, MASBOE 45, and no family planning waiver enrollment. We asked the state to clarify if these are the same individuals who would have been assigned state-specific groups 'SCP0' and 'STP0' under the old MMIS and to correct this reporting in future files. The state indicated that these individuals were reported to state-specific groups 'SCZ,' STZ,' 'SCY,' and 'STY' under the old MMIS and that these individuals are not part of the family planning waiver. We are unsure who these individuals are and if this reporting is correct, but CMS preferred not to ask the state further questions about this issue.	4/6/2012
WA	Eligibility	All	In the state's Q2 FY14 submission, about 182,000 individuals are not reported with a T-MSIS eligibility group. The state indicated that these individuals were not eligible and they are reported with MASBOE 00.	11/17/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
WA	Eligibility	CHIP	Washington operates an S-CHIP program, but did not begin reporting enrollment in this program in MSIS until Q1 FY10. Pregnant women are reported as unborn children in SEDS reporting, but not in MSIS reporting. The state does not have an M-CHIP program.	12/27/2011
WA	Eligibility	CHIP	In Q4 FY11, the total person-months of S-CHIP enrollment reported by WA was around 94,000 in MSIS and around 112,700 in SEDS. We asked the state to explain this difference.	9/28/2012
WA	Eligibility	CHIP	Starting in Q1 FY12, Washington began reporting monthly field values for its S-CHIP enrollees in MASBOE 00. However, about 6,300 individuals in CHIP flag 3 were moved to MASBOE 35 and assigned RBF 2 (restricted benefits based on alien status). These 6,300 individuals with CHIP flag 3, MASBOE 35, and RBF 2 are all in state specific eligibility group "1096". WA improved its reporting by Q4 FY 12.	2/15/2013
WA	Eligibility	CHIP	In October 2013, there were 1,870 individuals with CHIP Flag 1 (Elig w no CHIP) and MB 00 (not elig), and by December 2013, there were 9,795 individuals reported with this pattern. By June 2014, this reporting had improved to 5,212. The state has responded that these enrollees are in a new RAC – "1209 - Categorically Needy MAGI Pregnancy Medicaid; Income =<193% FPL; for pregnant women who are not federally qualified due to citizenship/alien status" added as part of ACA. They have indicated they will correct their reporting going forward by reporting RAC 1209 as CHIP CODE 3.	6/26/2014
WA	Eligibility	CHIP	WA reports between ˜27,000 and ˜30,000 individuals with CHIP flag 3, MASBOE 34, and state specific eligibility groups "1206" or "1207", which are newly added CHIP RACs as part of ACA who are in S-CHIP. They have indicated they will be correcting the MASBOE for these individuals going forward.	3/3/2015
WA	Eligibility	CHIP	S-CHIP enrollment increases from Sept to Oct from 30,124 to 37,896. We are asking the state for potential explanations for this increase.	5/29/2015
WA	Eligibility	County Codes	In Q3 FY10, WA began reporting a small number of enrollees with county code 50 which is not a valid FIPS code. Due to the small number of enrollees with this county code, we did not ask the state to explain this reporting at that time. However, in Q4 FY12, there was a large increase in the number reported to this county (up from 38 in Q3 FY12 to 945 in Q4). WA responded that if a valid county code of their addresses within WA does not exist, their system codes them as 40050, which translates to a 050 MSIS county code. Clients with an Oregon address are coded as County Code 050 (20050 in the state system) and those in Idaho are also coded as 050 (30050 in the state system). The state is changing the logic in their system to only consider valid WA FIPS county codes when populating this field and to coding OR and ID clients as 000 as indicated in the data dictionary. By Q1 FY13, the state had ceased reporting to County Code 050, and Washington confirmed they have ceased	5/7/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			reporting to this code. They instead report OR and ID clients as 000.	
WA	Eligibility	Data System Change	WA implemented a new MMIS as of the Q1 FY10 file submission.	9/29/2010
WA	Eligibility	Date of Birth	In Q1 FY13, 78 individuals were reported with missing/invalid DOBs (almost half of these people were in MB 34). However, this number was back down to 8 by Q2 FY13, and had increased again to 29 in Q1 FY14.	10/14/2013
WA	Eligibility	Dual Eligibility Codes	From month 1 to month 2 in Q3 FY07, the number of enrollees assigned to dual code 08 dropped from about 10,000 to about 8,500 (a 16 percent drop). The decrease occurred across several MASBOE groups and continued through Q4 FY07. In addition, WA's monthly MMA file showed a similar drop in the reporting to dual code 08 during this time period. The state determined that many of these 08s moved to 02, but is uncertain of the cause unless it was related to a FPL adjustment that occurred around this time.	12/17/2007
WA	Eligibility	Dual Eligibility Codes	Between Q4 FY09 and Q2 FY10, the following fluctuations in enrollment in dual eligible groups occurred. The state explained that these changes were due to an effort to properly classify dual eligible enrollees into specific programs rather than using the generic other full benefit dual category. - Between Q4 FY09 and Q1 FY10, enrollment in QMB+ increased from approximately 94,000 to approximately 106,000. - Between Q4 FY09 and Q1 FY10, enrollment in SLMB+ increased from approximately 1,000 to approximately 1,300. - Between Q4 FY09 and Q1 FY10, enrollment in QI-1 increased from approximately 4,300 to approximately 5,100. Then, in Q2 FY10, enrollment in this dual group decreased to approximately 4,600. - Between Q4 FY09 and Q1 FY10, enrollment in the other full benefit dual group decreased from approximately 4,400 to approximately 1,100. Then, in Q2 FY10, enrollment in this dual group increased to approximately 1,500.	1/6/2012
WA	Eligibility	Dual Eligibility Codes	In Q3 FY10, approximately 100 partial dual enrollees were reported with restricted benefits flag 1.	3/2/2012
WA	Eligibility	Dual Eligibility Codes	Between Q2 and Q3 FY10, the number of dual eligibles reported with dual code 06 (QI-1) increased from approximately 5,100 to approximately 6,300 and the number of dual eligibles reported with dual code 08 (other full duals) increased from approximately 2,200 to approximately 7,600. We asked the state if the increase in other full dual enrollment was expected.	5/4/2012
WA	Eligibility	Dual Eligibility Codes	In Q1 and Q2 FY10, MSIS reporting of enrollment in some dual categories differed noticeably from that of MMA reporting. The state explained that these differences were due to the timing of submissions. After the MMA submission but prior to the MSIS submission, the state undertook an effort to properly classify dual eligible enrollees into specific programs rather than using the generic other full benefit dual category. - In December	5/4/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			2009, 1,329 other full duals were reported in MSIS while 5,815 other full duals were reported in MMA. Additionally, in March 2010, 2,197 other full duals were reported in MSIS while 5,590 other full duals were reported in MMA. - In Q1 and Q2 FY10, a few individuals were reported as QDWIs in MSIS, but no QDWIs were reported in MMA. - In Q2 FY10, 1,380 SLMB+ individuals were reported in MSIS, but only 1,205 SLMB+ individuals were reported in MMA. In Q3 FY10, an increase in dual code 08 enrollees in MSIS caused the difference between sources to skew in the other direction (with about 7,600 other full duals reported in MSIS and about 5,600 other full duals reported in MMA). Similar differences continued in subsequent quarters.	
WA	Eligibility	Dual Eligibility Codes	The difference between WA's counts of SLMB+ enrollment in MSIS and MMA increased from 10% in September '10 to 19% in March '11.	5/4/2012
WA	Eligibility	Dual Eligibility Codes	Between Q1 and Q2 FY11, enrollment in dual code 06 (qualified individual 1) decreased from approximately 7,000 to approximately 6,300.	5/7/2012
WA	Eligibility	Dual Eligibility Codes	Starting in Q2 FY13 through Q1 FY14, the comparisons between MMA and MSIS for QDWI dual eligibles (Dual Code = 05) has become increasingly divergent, ranging from a difference of 13 to 29%. Washington has indicated it will improve this reporting in future submissions.	6/9/2014
WA	Eligibility	Family Planning	All enrollees in Washington's Family Planning waiver are assigned to MASBOE 55 (Adults enrolled in 1115 demonstration waiver), even though some of them are under age 21. The state indicated that it will work on moving those Family Planning waiver enrollees under age 21 to be assigned to MASBOE 54, but as of Q1 FY14, it was not yet corrected and the state again said they will be updating the logic to consider Date of Birth in deriving MASBOE 54 for Family Planning enrollees under the age of 21.	6/9/2014
WA	Eligibility	Family Planning	Between December 2013 and June 2014, enrollment in Washington's Take Charge Family Planning (Waiver ID 'TC') decreased by 64% (60,056 to 21,720). The state explained that this decrease is due to clients moving into new programs such as AHAC (ACA) from Jan 2014 onwards.	11/17/2014
WA	Eligibility	HIC Numbers	More than 96 percent of Washington's non-dual eligibles have the HIC number 9-filled. The HIC number should be 8-filled for non-dual eligibles.	NA
WA	Eligibility	Managed Care	2009: WA PCCM counts declined from about 74,000 in January to about 14,000 in February. According to WA, this was due to the ending of a chronic care management contract and the PCCM numbers were expected to remain stable going forward.	10/14/2009
WA	Eligibility	Managed Care	The Department of Social and Health Services administers the BHP program and provided only one plan ID in MSIS (until the new MMIS was implemented for the Q1 FY10 file) in contrast to	4/4/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			what is reported in CMS data. WA's DSHS Mental Health Division contracts with county-operated Regional Support Networks (RSNs) who provide community-based MH services. The RSNs receive a monthly payment based on each Medicaid-eligible person within the RSN area. WA confirmed that it provides these community-based mental health services to individuals receiving both full benefits and partial benefits (e.g. partial duals and family planning enrollees).	
WA	Eligibility	Managed Care	In June 2010, WA reported 14,156 PCCM enrollees in MSIS but only 6,381 PCCM enrollees in the CMS Medicaid Managed Care Report. A similar inconsistency occurred in the June 2009 comparison and a smaller inconsistency representing a 23% difference between counts occurred in the June 2011 comparison. Washington indicated that these differences were due to the inclusion of chronic care management enrollees in PCCM reporting in MSIS.	3/2/2012
WA	Eligibility	Managed Care	In February 2007, WA's PCCM enrollment increased from about 3,500 to over 60,000 enrollees per month when the state started Chronic Care management for FFS clients. After identifying clients who would benefit from chronic care management, the state pays the provider a fee to provide these services. The state expected that the enrollment would remain up at this level or go a little higher. However, PCCM enrollment did not increase in WA's June 2007 managed care data at CMS. The explanation for this discrepancy is that CMS reports WA's chronic care management program (59,997 enrollees as of June 30, 2008) as Disease Mgmt PAHP.	4/6/2012
WA	Eligibility	Managed Care	Enrollment in WA's behavioral health managed care plan had consistently been ~10 percent greater than corresponding enrollment in the Medicaid waiver it is based on (waiver ID 'MH', waiver type '2'). After the new MMIS was implemented, in the Q1 and Q2 FY10 files, enrollment in the behavioral health managed care plan type was equal to enrollment in the waiver. However, the state 8-filled the plan IDs for this enrollment for most enrollees. Therefore, CMS asked the state to use a generic plan ID for those behavioral managed care enrollees for whom it did not have specific plan ID information in future files. The state responded that, due to previous instructions from CMS, it would continue to 8-fill the plan IDs until more specific plan ID information became available. In Q3 FY10 through Q2 FY11, differences between behavioral managed care and waiver enrollment reappeared, but these resolved by Q4 FY11. Additionally, the state began reporting specific managed care plans for most of these enrollees for June 2010.	5/4/2012
WA	Eligibility	Managed Care	Prior to 2011, WA was reporting tribal health PCCMs and chronic care management in this category in MSIS. Between April and September 2011, WA's PCCM enrollment decreased from approximately 12,500 to approximately 5,700 because WA had decided that they would stop reporting chronic care management. PCCM enrollment stayed at about 5,000 through	9/28/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			Q1 –Q3 FY 2012, while it rebounded to about 6,900 in Q4 FY 2012. The increase in Q4 FFY12 was due to the expansion of managed care to Blind/Disabled population. The American Indian/Alaskan Native portion of this population were given the option of PCCMs. If there is a PCCM clinic in their area, these individuals were assigned to that clinic with the option of enrollment with an MCO or to stay FFS.	
WA	Eligibility	Managed Care	WA's HMO enrollment (Plan Type 01) increased by about 60,000 individuals during Q4 FY12. These enrollees were reported to several new Plan IDs. The state has indicated that the increase in HMO enrollment is due to the adding of Basic Health clients to their roles as well as the SSI population moving from FFS to Managed Care delivery systems. Managed Care in WA is currently increasing by 1000 – 1500 clients per month and they are not able to determine if these are new clients or those moving from FFS to MC.	3/18/2013
WA	Eligibility	Managed Care	Washington's PCCM enrollment decreased from approximately 12,500 to about 5,700 between April and September 2011, and stayed at about 5,000 between Q1 –Q3 FY 2012. It then rebounded to about 6,900 in Q4 FY 2012. It increased again by 18% from Sept 2012 to October 2012. The decrease in PCCM enrollment between April and September 2011 was due to the ending of the CMMH and CMCM programs. The state responded that the increase in 2012 could be the result of new MC programs introduced in MC system in the last couple of years such as HOBD, HOFC, etc.	4/23/2014
WA	Eligibility	Managed Care	PCCM increases between Q4 FY14 and Q1 FY15, increasing from 21,088 in September 2014 to 25,322 in December 2014. We are asking the state why this increase occurred.	5/29/2015
WA	Eligibility	MASBOE	2007 - 2008: WA reported a 14-15% decline in both MASBOE 14 and MASBOE 15 (primarily state groups C200 and C100) during Q3-4 FY07. The state verified this decrease, but was unable to provide a cause. Reporting to MASBOE 14 rebounded somewhat in FY08.	9/22/2008
WA	Eligibility	MASBOE	2006 - 2008: MASBOE 55 (1115 waiver expansion/adult) enrollment declined 18 percent from September 2006 to March 2007. These are individuals who only qualify for family planning benefits. The state indicated that this happened at a time when the Take Charge application was moved from the web to the mainframe so all the family benefit enrollment would be in the same database. Some enrollees were found to be receiving family planning benefits through more than one program, so the state closed some enrollment in the family planning only waiver, thus causing the decline in MASBOE 55 through FY08.	8/31/2009
WA	Eligibility	MASBOE	All Years: Washington enrollment data for SSI recipients (MASBOE 11 - 12) are higher than expected relative to SSA data. This may occur because of a state-administered SSI supplement. It also appears most SSI disabled >65 years are reported to MASBOE 11.	12/27/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
WA	Eligibility	MASBOE	WA stated that large fluctuations in enrollment by MASBOE between Q4 FY09 and Q1 FY10 were due to MASBOE mapping changes for some groups. These changes were discussed as part of the state's implementation of its new MMIS.	12/27/2011
WA	Eligibility	MASBOE	From FY 1999 to FY2008, enrollment generally declined from month 1 to month 3 in every quarter, and then increased substantially in month 1 of the next quarter, resulting in a "seam effect." The state started delaying its file submissions in FY08, which helped make the data more complete, thereby smoothing out the seam effect.	4/6/2012
WA	Eligibility	MASBOE	In February 2011, enrollment in MASBOE groups 11, 12, 44, and 45 increased while enrollment in MASBOE groups 14, 15, 41, and 42 decreased. The state indicated that these fluctuations were due to changes made to MASBOE mappings. (They said the changes were expected and attributable to new, more specific state-specific eligibility codes called RAC codes. RAC codes are the basis of the state's eligibility groups, and they assign MAS/BOE according to RAC codes. The old RAC codes were MAS 4 and the new ones are MAS 1, causing the shift. There is an outstanding question to the state on specifically which RAC codes were added and whether they are separate from the codes that were added with the implementation of the state's new MMIS.)	5/4/2012
WA	Eligibility	MASBOE	In Q4 FY12, there was a decrease in reporting to MASBOE 34 when Washington fixed its CHIP reporting and moved about 5,000 individuals to MASBOE 00.	2/15/2013
WA	Eligibility	MASBOE	Between Q4 FY13 and Q3 FY14, some unexpected fluctuations in MASBOE reporting occurred. The state has responded that these shifts were an expected outcome as enrollees' eligibility has changed beginning in October 2013. MASBOE 14 (Cash Child) enrollment decreased from 63,313 in Sept 2013 to 4,416 in October 2013, before increasing to 9,854 in Nov 2013 and 20,002 in Dec 2013, and decreasing again to 1,896 to Mar 14. MASBOE 15 (Cash Adult) enrollment decreased from 25,085 in Sept 2013 to 1 in October 2013, before reporting ceased altogether in Nov and Dec 2013, before reporting resumed in Jan 2014, increasing to 562,797 by Sept 2014. MASBOE 44 (Other Child) increased from 138,524 in Sept 2013 to 195,800 in Oct 2013, decreasing to 57,810 by Sept 2014. MASBOE 45 (Other Adult) also increased from 87,522 in Sept 2013 to 110,843 in Oct 2013, decreasing to 36,216 by Sept 2014.	6/26/2014
WA	Eligibility	MASBOE	In Q1 FY14, there were 14,881 individuals assigned to MASBOE 14 who were reported as being 21-44 years old and in this same time period, there were 4,677 individuals assigned to MASBOE 14 who were reported as being 45-64 years old(out of a total of 20,002 individuals reported to MASBOE 14 overall). The state has responded that the data will be corrected going forward.	6/26/2014
WA	Eligibility	MASBOE	In FY14, there were large fluctuations in BOEs 4 and 5 between Q1 and Q3. The state responded that these fluctuations were	9/30/2014

State	File Type	Rec/Issue Type	Issue	Recorded
			expected and provided the following explanation: Prior to the state's implementation of MAGI in Oct. 2013, they "delinked" medical coverage from cash assistance (TANF), which moved a large number of adults and children from medical coverage group F01 (MAS 1, BOE 4 and 5) to F04 (MAS 4, BOE 4 and 5) in Q4 FY13. Additionally, medical coverage group F02 (MAS 4, BOE 4 and 5) was not supported in the new system. As these individuals completed renewals over the next year (Q1 – Q4 FY14) through the new www.wahealthplanfinder.org portal, their coverage changed again. F02/F04 adult enrollees (MAS 4, BOE 5) converted to N01/N05 (MAS 1, BOE 4 or 5) coverage depending on their income. F02/F04 child enrollees (MAS 4, BOE 4) shifted to N11 coverage (MAS 3, BOE 4) at renewal.	
WA	Eligibility	MASBOE	In Q1 FY14, the state reported 4,677 individuals in MASBOE 14 to the 45-64 age group. Because these individuals were assigned to BOE 4 (Child), we would expect them to be under the age of 18. We asked the state to improve this reporting.	9/30/2014
WA	Eligibility	Private Health Insurance	Between Q4 FY09 and Q1 FY10, the number of individuals with health insurance flag 2 (third party insurance) dropped from approximately 90,000 to approximately 77,000. The state indicated that this drop in third party health insurance enrollment was expected.	1/6/2012
WA	Eligibility	Race/Ethnicity	The numbers of individuals reported as "American Indian or Alaskan Native," "Asian," or "Hawaiian/Pacific Islander" in the combined race/ethnicity field have consistently differed from the number in the individual race fields. WA fixed this problem as of Q1 FY10.	4/6/2012
WA	Eligibility	Race/Ethnicity	Through Q2 FY06, WA generally reported about 44,000 enrollees as being Asian (Race Code 4 = 1) and 4,000 enrollees as being Hawaiian/Pacific Islander (Race Code 5 = 1). However, in Q3 FY06 forward, there was a change in reporting when the count of Asians decreased to about 27,000 and the count of Hawaiians/Pacific Islanders increased to about 17,000. This occurred because the state made a correction to its method of race code processing.	4/6/2012
WA	Eligibility	Race/Ethnicity	Between Q4 FY09 and Q1 FY10, the percentage of individuals with unknown race in the combined race/ethnicity field increased from 9.66 percent to 33.22 percent. The state indicated that this high percentage was a function of the state's eligibility system and could not be addressed. However, the percentage decreased to 19.28 percent in Q3 FY10.	5/4/2012
WA	Eligibility	Race/Ethnicity	WA's ethnicity reporting fluctuated between Q4 FY09 and Q3 FY10. In Q4 FY09, approximately 102,000 enrollees were reported as Hispanic or Latino (ethnicity code 1) and no enrollees were reported with unknown ethnicity. Next, in Q1 and Q2 FY10, over 99 percent of enrollees were reported with unknown ethnicity. The state initially indicated that this could not be addressed. However, in Q3 FY10, approximately 203,000 enrollees were reported as Hispanic or Latino (ethnicity code 1)	5/4/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			and approximately 215,000 enrollees were reported with unknown ethnicity. The state indicated that the increase in the Hispanic/Latino population was due to more accurate reporting under its new MMIS.	
WA	Eligibility	Restricted Benefits Flag	WA reported some enrollees with RBF=2 in 2002 and 2003, but then only October-December 2004. RBF=2 enrollment was not captured in MSIS again until Q1 FY08.	8/4/2008
WA	Eligibility	Restricted Benefits Flag	WA's Money Follows the Person (MFP) program was approved in March 2008 (Q2 FY08). MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. Until Q3 FY09, WA failed to report MFP enrollment (via RBF code 8), although a previous submission of Q2 FY08 that did include them had a count of ~30 persons per month.	9/29/2010
WA	Eligibility	Restricted Benefits Flag	WA assigns restricted benefits flag (RBF) 5 to persons in the medically needy group. Previously, the state also assigned RBF 5 to women in MASBOE 35 who only qualify for family planning benefits in the post-partum period, as well as women in MASBOE 55 covered by a section 1115 family planning only waiver. However, effective Q2 FY06, WA began assigning RBF code 6 to family planning only enrollees.	3/22/2011
WA	Eligibility	Restricted Benefits Flag	WA had trouble properly reporting restricted benefits in its Q1-Q2 FY09 eligibility files. Analyses of these files revealed that all enrollees outside of MASBOE 31-32 with an RBF=3 were partial duals in a previous month but not in the current month.	9/23/2011
WA	Eligibility	Restricted Benefits Flag	From Q3 FY10 through Q2 FY11, WA reported an increasing number of partial duals with restricted benefits flag 1 (full benefits) and full duals with restricted benefits flag 3 (individual is only entitled to restricted benefits based on dual eligibility status). If these numbers increase, we will ask the state about this in the future.	5/7/2012
WA	Eligibility	Restricted Benefits Flag	In Q4 FY12, the state made a correction to its RBF 8 reporting that caused enrollment to increase from about 330 to 700.	3/25/2013
WA	Eligibility	Waivers	Beginning in Q1 FY05, WA incorrectly reported persons in MASBOE 00 ("not enrolled") as having Waiver ID 88 (they were correctly assigned to Waiver Type 0). All "not enrolled" beneficiaries should have all three monthly Waiver IDs coded as "00" (individual is not eligible for Medicaid during the month). This problem was corrected by Q1 FY09.	3/22/2011
WA	Eligibility	Waivers	Since waiver reporting began in Q1 FY05, WA has not reported enrollment in its 1915(c) waivers because the state did not capture this waiver information in its MMIS. Also, the state did not report expected enrollment in its 1915(b) waivers -- instead the state indicated that: (1) the Selective Hospital Contracting Program (waiver ID 'SC') expired on June 30, 2007; (2) its Disease Management program (waiver ID 'DM') morphed into	1/6/2012

State	File Type	Rec/Issue Type	Issue	Recorded
			the Chronic Care Management program operating under 1932(a) authority and was implemented on January 1, 2007; and (3) the Washington Healthy Options program operates under 1932(a) authority and was implemented on January 1, 2002. In October 2009, the state indicated that it would be able to begin reporting its 1915(c) waivers within 18 months (~April 2011). However, the state's MMIS transition was delayed and the state now expects to begin submitting 1915(c) waiver enrollment data in December 2013.	
WA	Eligibility	Waivers	There were major changes in waiver reporting between Q1 and Q2 FY14. Enrollment in the state's Integrated Community Mental Health Program (MSIS Waiver ID 'MH') increased 34% from December 2013 to March 2014, from ˜1,098,700 to ˜1,472,300. The state confirmed that the overall increases in the Integrated Community Mental Health Program (Waiver ID 'MH') are due to the overall increase in enrollee numbers was due to ACA.	1/26/2015
WA	Eligibility	Waivers	There were major changes in waiver reporting between Q1 and Q2 FY14. Enrollment in the Take Charge Family Planning waiver (MSIS Waiver ID 'TC') decreased 45%, from ˜60,100 to ˜32,800. The state confirmed that clients have transitioned from the Waiver to managed care for full scope family planning benefits. The state has noted that as of January 2014, Take Charge enrollment is just over 5000 clients, noting decreases every month. The state is conducting an evaluation to understand why there are still about 5,200 clients still on Take Charge.	1/26/2015
WA	IP	Family Planning	There were no claims with a Program Type of 2 (Family Planning) as FP services are always incidental to other IP services. The professional component is billed in the OT file.	12/10/2004
WA	IP	NPI	None of the managed care encounters have information reported in the NPI filled. Washington was not reporting these because they viewed MCOs as the billing provider for encounter claims. We reviewed the data dictionary definition and they will begin providing the caring institution NPI beginning in FFY 2015 Q1 data submission.	1/22/2015
WA	IP	Revenue Code	Roughly 25% of IP Medicaid managed care claims do not have ancillary codes. This would indicate that 25% of the records are for accommodation only and do not bill services. Question posed to state.	1/22/2015
WA	LT	Covered Days	There was a 20% jump in the number of original FFS claims in the Q1FY2010 LT claims file submission. The state reported this was expected because prior to the new system, nursing homes were limited to billing once per month and there was often a one month lag between month of service and month of submission. The nursing homes are now allowed to bill in a more timely fashion and more frequently. The number of claims should even out again over time.	9/20/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
WA	LT	Diagnosis	Washington does not report diagnosis codes on most nursing home claims. With the advent of Provider One, diagnosis codes should begin appearing as of the Q1FY2010 claims files.	9/20/2011
WA	LT	Leave Days	Washington does not cover Leave Days.	8/22/2005
WA	LT	Leave Days	Medicaid FFS leave days is zero. Expect to see a small number of long term care claims to have leave days. Question posed to state.	1/22/2015
WA	LT	Patient Status	About half of the Medicaid encounter claims have patient status = 30, which is lower than expected. Most of the DX for these claims are for acute care and rehab services, which will have shorter lengths of stay. It would appear that the longer term care would be under the FFS payments.	1/22/2015
WA	LT	Type of Service	There are no original, non-crossover claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under). According to the State, its Mental Health Division is still working on adding this coding system (having Type of Service 04). Previously, all inpatient psychiatric facility claims were lumped together, not broken out by age category.	3/22/2011
WA	LT	Type of Service	No payments are reported for ToS = 02 and ToS = 04 (mental health treatment for the aged and inpatient treatment for under 21 populations respectively). While the total number of claims is small, it is still a question. Question submitted to state regarding reimbursement issues.	1/22/2015
WA	OT	Capitation	Washington's capitation payments for comprehensive managed care (type of claim = 2, type of service = 20) do not approximate a 1:1 ratio of claims per person month of enrollment in various quarters during FY 2011-2012. Capitation claims fluctuate from 1:1 ratio to 1:1.5 ratio.	2/27/2013
WA	OT	Crossovers	Washington's OT files for FY 2011 Q1 through FY 2012 Q4: crossover claims fluctuate from approximately 300,000 claims per quarter to approximately 900,000 claims per quarter. A vast majority of those crossover claims - between approximately 60% and 78% show Medicaid Amount Paid equal to zero.	2/27/2013
WA	OT	HCBS Waiver	The state is not planning on adding waiver related claims until March 2012. In Jan 2011 they plan to add some of the missing medical payments for chemical assistance, refugee assistance, etc.	NA
WA	OT	HCBS Waiver	There are seven agencies that administer waiver claims. Some these claims are not submitted as individual claims into MSIS. Washington is converting to a new MMIS in January 2010 and within the following 18 months plan to revise the new system so it can submit all waiver services as individual claims. In the meantime here is the status of these agencies claims: 1: Able to submit individual claims - 13-Division of Alcohol and Substance Abuse; 14- Aging; 16-Children's Administration; and probably 17: Juvenile Rehabilitation Agency. Agency 11-Division of	7/8/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			Developmental Disability submits a combination of individual claims and Service Tracking claims. Finally those agencies who only submit Service Tracking claims include 12-Mental Health Disables; 15-Economic Services Administration.	
WA	OT	Managed Care	Until Q3FY2009 WA reported encounter claims with a Type of Service of HMO capitation.	NA
WA	OT	Managed Care	Washington State Managed Care plans numbers required further review. The issues fell into three categories. 1) The managed care plan had a high ratio of OT and RX claims relative to enrollees. Based on discussion with state. Some of the programs were being terminated, and claims were clearing after enrollees removed. The numbers looked ok, and they felt that they were high based on natural variation. They noted they would take another look at the numbers, but requested we look across quarters to verify. 2) A number of managed care programs had capitation payments, but no enrollees or payments. There are three reasons. First, one of the programs was being terminated, and thus winding down. The second was that four of the programs were beginning and claims would be expected in FFY2014 second quarter. The remaining plans are home health plans and do not have claims or enrollees. 3) They confirmed that behavioral health plans do not include inpatient claims. Did note that it is possible that these claims might be included in the LT managed care file.	12/24/2014
WA	OT	Managed Care	There are four managed care plans that have high OT ratios (the number of claims on the OT file compared to the enrollees is high, above 10:1 in these cases). Spoke with the state regarding this issue on the FFY 2014 Q1 report. The state indicated that the numbers looked right, that there are natural fluctuations. WA also indicated they would review to confirm. There are five managed care plans that are of concern. 105010105 105010204 105010205 201599904 201609404 F/u Question posed to the state regarding the outstanding claims.	1/22/2015
WA	OT	Managed Care Capitation	Their disease management program is for case management only and the capitation claims are submitted with a Type of Service of PCCM Capitation.	10/15/2008
WA	OT	Managed Care Capitation	The capitation payments made to MC plans that use FQHC's do not include the supplemental FQHC payment. That supplemental payment is made directly to the FQHC's and is a monthly rate for everyone enrolled in an FQHC plan. The state will submit those individual supplemental payments with a Type of Claim = 5 (supplemental payment) starting in 2005. They are coded with TOS=20 instead of TOS=12.	3/22/2011
WA	OT	Managed Care Capitation	As of FY 2011 Q1, WA still does not report any capitation payments for their BHO program.	8/27/2012
WA	OT	Managed Care Plan IDs	There is a very long list of Plan IDs for HMO that probably in many cases are rendering provider IDs and not Plan IDs.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
WA	OT	Service Code	2009 files: Over 20% of FFS claims have state-specific codes, over 10% are mixed alpha numeric, over 10% are all numeric.	3/25/2011
WA	OT	Supplemental Claims	WA uses Type of Service = 20 (Capitated Payments to HMO, HIO, or PACE Plan) on hundreds of thousands of Type of Claim = 5(supplemental payments). On many of those claims report a plan ID number associated with clinics and physicians and not managed care plans.	6/1/2012
WA	OT	Type of Service	There are no claims classified as Home Health from Q2FY2004 to Q4FY2009.	9/4/2005
WA	OT	Type of Service	There may be some services not included in the MSIS submission but are planned for inclusion in 2011/2012. These include services administered by the Social Service Payment System and include some medical payments such as outpatient DC Treatment, SSI evaluations, pre-ordered psych evaluations, State hospital and Special Commitment Center medical and dental. It also includes some chemical dependency services, some refugee and immigration assistance.	10/25/2009
WA	OT	Type of Service	The Medicaid original encounter claims saw a change in distribution regarding type of service. Starting in FFY2014 Q1 and continuing in Q2, outpatient services (ToS = 11) increased to about 16% of all OT claims from zero in prior quarters. Physician services (ToS = 8) and other services (ToS = 19) saw decreases in their share of total claims. This appears to be a corrections, but question posed to state to confirm the shift.	1/22/2015
WA	RX	HCBS Waiver	Drugs provided under the bundled rate for people who are institutionalized under the mental health (MH) and DDD waiver programs are not separately reported. However, the non-bundled drug claims are submitted in the RX files as individual claims.	12/10/2004
WA	RX	Managed Care Encounters	Plan ID field on RX TOC=3 are filled with provider ID/NPI	8/27/2012
WA	RX	Medicaid Amount Paid $0	WA resubmitted FY 2011 Q2 RX file after previous version had passed. The S3 version appears to have over 16% of records with $0 Medicaid paid.	12/5/2013
WA	RX	NPI	None of the Medicaid managed care claims have information reported in the NPI field. Question posed to state.	1/22/2015
WA	RX	Provider Taxonomy	Reporting from WA's new MMIS will not report Taxonomy codes on RX claims.	8/27/2012
WI	_All	Data System Change	WI implemented a new MMIS in Q1FY2009.	3/19/2013
WI	_All	MSIS ID	WI will be switching to new MSIS IDs in Q1 FY09 and will be providing a xreference file for use with the MAX files.	NA
WI	_All	MSIS ID	Wisconsin is not an SSN state, but submits its MSIS EL files using SSN rules. The state assigns Temp IDs to people who don't have a SSN (usually babies) and then when the enrollee gets a SSN the state uses that for the MSIS ID. Wisconsin uses	7/8/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			the SSN with an additional byte on the end as a permanent MSIS ID number. The extra byte is "0" unless someone else has previously enrolled in the system with the same SSN.	
WI	Claims	Managed Care Encounters	WI confirmed that through at least FFY2013Q2 the values reported as AMOUNT-CHARGED on managed care encounters represents the amount billed by the provider to the managed care organization rather than the amount paid by the managed care organization to the provider as specified in the data dictionary. The state indicated that the amount paid by the managed care plan to the provider was not available in the state's decision support system (DSS) but was available in the interChange system. Through at least FFY2014Q1 there is no indication that this has been fixed.	12/30/2014
WI	Eligibility	1115 Waivers	Wisconsin also had an 1115 waiver extending Family Planning benefits, effective Q2 FY 2003 that expired 12/31/10.	NA
WI	Eligibility	1115 Waivers	Effective February 2008 (Q2 FY08), WI amended its Medicaid and CHIP plans to implement a new BadgerCare Plus program that replaces all of BadgerCare as well as family coverage under the Medicaid program. The new program extends eligibility to all children (regardless of income), increased the income limit for parents and caregivers (from 185% FPL to 200% FPL) and pregnant women (from 185% FPL to 300% FPL), and added new eligibility for young adults (ages 18-20) aging out of foster care (regardless of income) and some farmers and self-employed workers. Some BC+ enrollees are covered by state funds only (pregnant women and children in families with incomes between 250-300% FPL) and are not included in MSIS reporting. Therefore, only pregnant women and children with income to 250% FPL are included in WI's MSIS data. (Generally, children with income from 100-150% FPL are M-CHIP while children with income from 150-250% FPL are S-CHIP enrollees. Adults with income from 130-200% FPL are M-CHIP adults.)	4/8/2009
WI	Eligibility	1115 Waivers	In 1999, WI implemented a major 1115 demonstration called BadgerCare which extends coverage to low-income adults and children. Some, but not all, of the 1115 children and adults are M-CHIP enrollees.	3/22/2011
WI	Eligibility	1115 Waivers	Wisconsin's Badger Care 1115 waiver ID 'B1' expired in February 2008 and was rolled into the new waiver ID 'A1.' In Q1 FY2009, about 41,000 individuals were incorrectly reported to the expired waiver ID 'B1.' The fix was made by Q2FY09.	9/6/2011
WI	Eligibility	1115 Waivers	Effective September 2002, Wisconsin added a SeniorCare (Pharm Plus) section 1115 demonstration extending prescription drug benefits to low income aged with an income<200% FPL not otherwise qualified for full Medicaid benefits (reported to MASBOE 51). SeniorCare continued after the implementation of Medicare Part D and allowed its participants (about 70,000/month) to delay enrollment in Part D without penalty. Therefore, Pharm Plus enrollment and expenditures did not decline in WI in 2006. WI wanted the waiver to continue	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			because the Pharm Plus program has no premiums, smaller copays than Part D, and no gaps in prescription drug coverage.	
WI	Eligibility	1115 Waivers	Under BadgerCare+, WI had a new 1115 waiver approved 12/08 to cover childless adults. Implementation of this waiver was delayed from January 2009 to July 2009. Enrollment, however, was suspended in October 2009. The expansion groups began reporting to MSIS in Q4 FY09 and enrollment increased sharply through Q1 FY10.	4/27/2012
WI	Eligibility	CHIP	WI discontinued using CHIP (Title XXI) funds for adults effective May 1, 2008; however, the state continued to report M-CHIP adults to CHIP flag 2 through Q4 FY08 instead of moving them to flag 1. The CHIP flag assignment was corrected in Q1 FY09.	2/17/2010
WI	Eligibility	CHIP	In Q4 FY07, WI shifted some of its adult 1115 enrollees from state group B4 (BadgerCare adults with family income greater than 100% and less than 150% of the federal poverty level) to GP (BadgerCare custodial parent of a child less than 19 years with income less than 100% FPL). This caused the number of adult M-CHIP enrollees to drop from 38,000/month in Q3 FY07 to 30,000/month in Q4 FY07 (cause unknown). Adult M-CHIP enrollment reported in SEDS changed even more dramatically in Q4 FY07, dropping from 66,000/month in Q3 FY07 to 27,000/month in Q4 FY07. Thus, both sources became reasonably consistent for the first time with regard to adult M-CHIP enrollment. In Q1 FY08, however, the sources became inconsistent again when both MSIS and SEDS showed significant drops in adult enrollment, but the drop in SEDS was much larger.	3/22/2011
WI	Eligibility	CHIP	Wisconsin reported a small number of M-CHIP children until FY1999 Q3, when enrollment increased substantially. Children were covered to 250% FPL by 2007. M-CHIP children (B1, B2, B3) were reported under MAS/BOE 54 through January 2008, since they were part of the state's 1115 Badger Care demonstration.	7/8/2011
WI	Eligibility	CHIP	Both M-CHIP and S-CHIP child person months of enrollment in MSIS are higher in Q1 FY09 than in the SEDS system. The state indicated that WI was having some problems with reporting SEDS at the implementation of its new MMIS system. The SEDS team has been working to correct those problems and the state believes that future reporting in SEDS will be more reliable.	4/6/2012
WI	Eligibility	CHIP	In May 2007, CMS approved an amendment for WI to add an S-CHIP program (effective retroactively back to October 2006), expanding coverage to uninsured unborn children, who are ineligible for Medicaid, with family income up to 185% FPL. At first, WI choose not to include this S-CHIP enrollment information in MSIS; however, it started to include this enrollment in MSIS in Q2 FY08 (January 2008) as part of the other changes related to BC+ that occurred that quarter. Note that pregnant women are reported in S-CHIP data for the unborn children group. It appears most unborn children are in	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			the nonqualifying pregnant alien groups (BS and BT) and the pregnant immigrant groups (F1, F2, F3, F4).	
WI	Eligibility	CHIP	WI amended its CHIP plan to shift children with income from 150-250% FPL from M-CHIP to S-CHIP effective January 2008. In the first month of Q2 FY08 (January), WI began reporting S-CHIP enrollment to MSIS. To start, a small number of pregnant S-CHIP enrollees were reported to state eligibility codes F1, F2, F3, and F4 in MSIS data. Then, in February, reporting to these codes ended and the state switched to state codes BS and BT for pregnant aliens. Also in February, S-CHIP children began to be reported to BG, BH, and TC. These changes occurred when the CHIP enrollees moved under the new BadgerCare Plus coverage. The new BC+ program in February 2008 also caused increases in M-CHIP enrollment and for the MAS assignment to change from MAS 5 to MAS 3 for these child and adult enrollees.	4/6/2012
WI	Eligibility	CHIP	Effective from Q2 FY 2001, Wisconsin began to cover adults under its SCHIP program. M-CHIP adults were reported into MAS/BOE 55 through January 2008 (see discussion below regarding BadgerCare Plus). M-CHIP adult (B4, B5, B6) counts in MSIS were lower than the SEDS counts because BadgerCare adults with income<100 percent FPL (state group GP) are not considered to be M-CHIP enrollees in MSIS. These individuals were covered from the start of WI's BadgerCare Plan as 1115 Medicaid enrollees. It is not clear why WI is reporting them as SCHIP adults in SEDS - beginning in 2009, <19 CHIP is also reported in SEDS. In Q4 FY07, it appears that the adult SEDS count made a large correction bringing it more consistent with the MSIS count (within 9%). And, beginning in 2009, both M-SCHIP and S-SCHIP child person months of enrollment in MSIS are higher in Q1 FY09 than the SEDS system. The state indicated that they were having some problems with reporting SEDS at the implementation of the new data system but was able to get them corrected and consistent again with MSIS.	4/27/2012
WI	Eligibility	CHIP	Starting from at least Q1FY11, about 900 SCHIP individuals are assigned to MASBOEs other than 00. This is most likely caused by WI's 6-byte eligibility codes, in which a person may be assigned up to 3 2-byte codes, in any combination. MASBOE is assigned based on the first 2-bytes; however, if an individual has a SCHIP code in bytes 3-4 or 5-6, they will be assigned CHIP=3. These SCHIP codes are BG, BH, BS, BT, C3, HG, TC, TF, TG, 7G, 7X, and 7Z. WI confirmed that these are SCHIP and indicated they will modify their eligibility codes in future files (Q2FY14) to correctly map them to MASBOE 00.	1/20/2015
WI	Eligibility	County Codes	As of Q1 FY09, WI reports about 2,000 individuals to county code '078,' which is a valid FIPS code for Menominee County.	1/23/2012
WI	Eligibility	Dual Eligibility Codes	Effective Q1 FY 2003, Wisconsin assigned dual code 09 to persons in its Pharmacy Plus Program not qualifying under other dual codes. WI continued to provide Pharm Plus coverage to aged duals and nonduals after January 2006.	4/8/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
WI	Eligibility	Dual Eligibility Codes	In Q1 FY2009, WI incorrectly assigned about 300-500 individuals to invalid dual code '99.' The state is unable to correctly assign these individuals to a valid dual code or report that they are not eligible duals (0-fill). This reporting was corrected in Q2 FY2009.	9/6/2011
WI	Eligibility	Dual Eligibility Codes	Starting in Q1 FY09, Wisconsin reports about 9,000 full duals to MASBOE 31 (through Q4 FY08 these enrollees were only assigned to MASBOE 32). The state indicates that their dual code assignment is correct.	1/27/2012
WI	Eligibility	Dual Eligibility Codes	In Q1 FY2009, Wisconsin implemented a new MMIS system, which allows individuals to be assigned to up to three benefit groups at the same time (noted in bytes 1-2, 3-4, and 5-6 of the state specific eligibility field). Individuals are given a dual code assignment based on their primary eligibility group (bytes 1-2); this dual code assignment is not always consistent with what we'd expect based on the other two assigned benefit groups. For example, WI reports many full benefit duals to MAS 3, even though they do not extend full benefits to the ABD population up to 100% FPL. Because of this logic, about 15,000 individuals transferred from dual code 02 in Q4 FY08 to dual code 08 in Q1 FY09. This change was the result of a change in MSIS logic, not Medicaid policy. WI's data is expected to show trends consistent with Q1 FY09 forward.	2/28/2012
WI	Eligibility	Family Planning	In FY2009, the counts for family planning waiver enrollment (Waiver ID=D1, Waiver Type=F), state specific eligibility group (FB, FQ, FS, FT, PB, PF, PQ, or PT), and RBF flag 6 were not equal. This occurs because WI's new MMIS system assigns RBF based on the first of three possible eligibility groups; if the two subsequent eligibility groups indicate family planning waiver enrollment, RBF 6 will not be assigned. The state is unable to correctly report corresponding family planning waiver counts through FY2009.	9/6/2011
WI	Eligibility	Family Planning	Effective 12/31/10, WI moved its family planning waiver (waiver ID 'D1') to a state plan amendment. Waiver ID 'D1' covered Med Stats FS and PF. Med Stat FS was no longer reported to waiver ID 'D1' as of 12/31/10; however, Med Stat PF was still active until 12/31/2012. Waiver ID 'D1' was reported to MSIS through Q1FY13 (Dec 2012) (about 3,000). As of Q1FY14, about 14,000 people with RBF 6 were reported to MASBOE 54 and about 65,000 people with RBF 6 were reported to MASBOE 55. WI indicated that they would remap these people to MASBOEs 34-35.	1/25/2013
WI	Eligibility	Managed Care	Through Q1 FY08, Plan IDs 63 and 67 were reported in MSIS to Plan Type 06 (PACE), and while the state indicated that these plans were going to be set up as PACE, that change never occurred. Therefore, these plan IDs should have been reported to type 01 (HMO). This reporting was fixed starting in Q2 FY08.	9/1/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
WI	Eligibility	Managed Care	Effective Q1 FY09, WI implemented a new MMIS and started using a completely new set of managed care Plan IDs in its MSIS reporting.	9/2/2009
WI	Eligibility	Managed Care	Plan ID 69 switched from a PACE plan to an HMO effective March 31, 2001, but continued to be reported as PACE in MSIS. Therefore, starting in April 2001 (Q3 FY01), this plan should have been reported as an HMO as well. (Plan ID 65 continues to provide PACE services and should continue to be reported to plan type 06 in MSIS through Q4 FY08. WI stopped offering any PACE effective Q1 FY09.)	3/22/2011
WI	Eligibility	Managed Care	Each month, several thousand eligibles (primarily SSI aged and disabled) receive Plan Type 08. These eligibles are enrolled in a voluntary managed care program in Milwaukee County called "The Independent Care Plan" or "iCare." This plan provides medical and social services to individuals with physical, developmental, or emotional disabilities and can also take care of short-term physician-ordered nursing home stays with prior written approval. These stays are typically for rehabilitative purposes. Reporting to Plan Type "08" increased significantly during FY05 and continued to increase in FY06 when WI added similar plans in other counties (Plan IDs 41, 42, 43, 44, and 66). In June 2005, 8,438 enrollees were reported to Plan Type 08, and by June 2006, this number had increased to 16,863. These plans are reported as HMOs in CMS managed care data.	4/6/2012
WI	Eligibility	Managed Care	WI had incorrectly been reporting PACE plans to plan type 01 instead of plan type 06. We expect this correction to be made starting in FY 2011.	1/25/2013
WI	Eligibility	Managed Care	In Q4FY11, there was an increase of about 650,000 in plan type '08' (other). WI explained that they implemented Transportation Manager code changes in February and ran the file in March, causing the increase since Transportation Manager also have PLAN-TYPE=08.	11/10/2014
WI	Eligibility	Managed Care	In November 2012 (Q1FY13), Plan Type '01' (HMO) enrollment decreased by about 145,000. Then in April 2013 (Q3FY13), enrollment increased by about 21,000 and in August 2013 (Q4FY13) enrollment increased by another 97,000. WI explained that at the end of October, one of their existing MCOs did not want to continue participation and about 175,000 members moved from an HMO plan to Fee for Service, then some returned to HMO in March. More continued to move back to HMO in August when 3 MCOs (69004631, 69006530, and 69009027) could absorb the new members.	1/20/2015
WI	Eligibility	Managed Care	In September 2012 (Q4FY12), there was an increase of about 252,000 in Plan Type '08' (Transportation Manager). WI confirmed the counts and explained that the first submission was very large compared to other months.	1/20/2015
WI	Eligibility	Managed Care	In August 2013 (Q4FY13), enrollment in plan type 08 increased by about 132,000. During this time, enrollment in 69009030 and	1/22/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
			69009055 disappeared and enrollment in 69009070 increased. WI changed Transportation providers, causing this change. In July, services were provided by Logisticare (69009030 and 69009055) and in August, services were provided by MTM (69009070).	
WI	Eligibility	MASBOE	All Years: Several disabled groups who qualify for full benefit Medicaid coverage are reported to MASBOE 32, these include state groups m3-m9 and includes enrollees in nursing homes, community waivers, and those in brain injury waivers; some pay premiums.	NA
WI	Eligibility	MASBOE	All Years: Wisconsin has a state-administered SSI supplement program, which explains why the counts in MAS/BOE 11 - 12 are higher than the number of federal SSI recipients.	NA
WI	Eligibility	MASBOE	All Years: WI reported several thousand persons over age 65 to MASBOE 42 (other blind/disabled). These enrollees should have been reported to MASBOE 41 (other aged). This was fixed starting in Q1 FY08. However, In Q1FY09, WI began reported about 1,000 individuals over 65 to MASBOE 42 again.	10/6/2008
WI	Eligibility	MASBOE	2008: When WI started using new state-specific eligibility codes in February 2008, a large number of children (<19 years) were assigned to state codes X6 and X7 and mapped to MASBOE 45 and 15 by mistake. The children in code X6 should have been mapped to code X8 and MASBOE 44, while the children in code X7 should have been mapped to code X9 and MASBOE 14. Starting in July 2008 (Q4 FY08), the state fixed this reporting in MSIS. (This error in reporting also caused a dip in total children enrollment and corresponding increase in total adult enrollment from Feb - June.)	4/8/2009
WI	Eligibility	MASBOE	1999 - 2008: In 1999, WI implemented a major section 1115 demonstration called BadgerCare which extends coverage to low-income adults (including single adults), as well as children. Some, but not all, of the 1115 children and adults are M-CHIP enrollees.	3/22/2011
WI	Eligibility	MASBOE	2002 - Present: Effective September 2002, Wisconsin added a SeniorCare program (Pharm Plus) to its section 1115 demonstration extending prescription drug benefits to low income aged with an income<200% FPL not otherwise qualified for full Medicaid benefits (reported to MASBOE 51). Wisconsin's 1115 waiver also extends FP benefits, effective Q2 FY 2003.	3/22/2011
WI	Eligibility	MASBOE	In Q1 FY2009, about 41,000 individuals were reported as enrolled in an 1115 waiver (Waiver Type '1') and about 2,000 were enrolled in a Pharmacy Plus waiver (Waiver Type '6') but were not reported to MAS 5. This occurs because WI's new MMIS system assigns MASBOE based on the first of three possible eligibility groups; if the two subsequent eligibility groups indicate 1115 waiver enrollment, MAS 5 will not be assigned. The state is unable to correctly report all individuals assigned to 1115 waivers to MAS 5 through FY2009.	9/6/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
WI	Eligibility	MASBOE	In Q1 FY2009, Wisconsin implemented a new MMIS system, which allows individuals to be assigned to up to three benefit groups at the same time (noted in bytes 1-2, 3-4, and 5-6 of the state specific eligibility field). Individuals are given a MASBOE assignment based on their primary eligibility group (bytes 1-2); this MASBOE assignment is not always consistent with what we'd expect based on the other two assigned benefit groups. Because of this logic, WI's MSIS data reported several very large shifts in MASBOE counts from Q4 FY08 to Q1F09 (see 8/22/11 email to Clarice Burrell). These shifts were the result of the change in MMIS logic, not changes in Medicaid policy. WI's data is expected to show trends consistent with Q1 FY09 forward.	2/28/2012
WI	Eligibility	MASBOE	1999 - 2008: Beginning in Q3 99, Wisconsin starts to show substantial enrollment for M-CHIP children (MAS/BOE 54) in its 1115 Badger Care program. Enrollment for adults in MAS/BOE 55 generally starts in Q499. Effective Q2 FY 2001, M-CHIP adults are also reported to MAS/BOE 55 (although WI stopped using Title XXI funds for this group effective May 1, 2009 these adults continued to be reported as CHIP adults in MSIS through Q4 FY08).	4/6/2012
WI	Eligibility	MASBOE	2008: In Q1 FY08, WI reported a small number of individuals to MASBOE 99 (8 individuals in January, 13 in February, and 14 in March), an invalid code. These individuals were assigned to new state-specific eligibility codes BA, BE, BJ, BL, and X6 and were given valid codes in other monthly fields. The state did not explain who was in this group, but in Q2 FY08, the state fixed this reporting so that no one was assigned to MASBOE 99 or to any of these state codes. It is assumed these individuals should not have been included in the Q1 FY08 file.	4/6/2012
WI	Eligibility	MASBOE	2008: There were several changes in child and adult MASBOE reporting when WI implemented BadgerCare Plus in February 2008 (reporting for aged and disabled stayed the same). The state also sent a new state-specific eligibility code crosswalk to show the new coverage groups. MASBOE 35 showed a significant increase as it now includes caretaker relatives (includes M-CHIP adults) and expanded coverage for pregnant women. There were also large increases in reporting to MASBOE 14-15 since BC+ raised the income limit for Section 1931 from about 40% up to 100% FPL. (Many individuals who previously qualified for Medicaid under the medically needy rules, 1115 rules, or the poverty-related rules were shifted to MASBOE 14-15, causing drops in reporting to MASBOE 16-17, 24-25, and 54-55.)	4/6/2012
WI	Eligibility	MASBOE	In Q4FY11 (July and August), MASBOE 35 decreased by about 23,000. The state explained that eligibility codes 3B and 4B ended as 7/31/11, causing the decrease in MASBOE 35. Also, in Q4FY11 (August), MASBOE 55 increased by about 25,000, caused by the addition of new eligibility codes 7B, 7C, and 7L.	10/15/2014

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State	File Type	Rec/Issue Type	Issue	Recorded
WI	Eligibility	Private Health Insurance	Wisconsin reported about 16 percent of its eligibles with private health insurance, which is somewhat higher than other states report. The state has confirmed that this proportion is correct. Effective September, 2002, the proportion increased even more, with the implementation of the Pharmacy Plus Program. The proportion increased to 22% by 2005.	NA
WI	Eligibility	Restricted Benefits Flag	Wisconsin assigned Restricted Benefits Flag 5 ("other") to enrollees who are infected with TB and eligible for TB-related services only. These persons are assigned state-specific eligibility code TR and are mapped to MAS/BOE 44 - 45. Beginning in September 2002, Flag 5 was also assigned to prescription drug only enrollees in MAS/BOE 51. Beginning in January 2003, RBF 5 was assigned to enrollees of the Family Planning Waiver, who were mapped to MAS/BOE 54 - 55. Starting in Q1 FY05, the state started assigning RBF flag 6 for family planning only enrollees. WI began covering FP services through a SPA 1/1/13; however, they still reported RBF 6 to MASBOEs 54-55 as of Q1FY14. WI said they would remap these individuals to MASBOE 34-35.	NA
WI	Eligibility	Restricted Benefits Flag	WI has a Medicaid state plan amendment to implement an alternative benefit package or benchmark- equivalent coverage, under the provisions of the 2005 Deficit Reduction Act approved by CMS. This "BadgerCare Plus (BC+) Benchmark Plan" was implemented in February 2008 (Q2 FY08) along with the broader BC+ program that extended eligibility to several groups. Enrollees in the Benchmark coverage include pregnant women 200-250% FPL and are assigned RBF 7.	3/22/2011
WI	Eligibility	Restricted Benefits Flag	WI's Money Follows the Person (MFP) program was approved in October 2007 (Q1 FY08). MFP enrollees are individuals with long term care needs who are transitioning from an institution to the community. Qualified home and community based services for these individuals qualify for enhanced FFP. MFP enrollees are assigned RBF code 8 in MSIS starting in Q3 FY08.	4/6/2012
WI	Eligibility	Restricted Benefits Flag	Each quarter, WI reports about 20,000 individuals in MASBOEs 31 and 32 to RBF 1. It appears that the state may have extended full benefits to the aged and disabled up to a certain FPL (perhaps 84%, or 94% for those who are married). The only evidence of this is found in the US Directory of Health Benefits. We continue to bring this up with the state.	5/29/2013
WI	Eligibility	Restricted Benefits Flag	In August 2011, RBF 7 decreased by about 7,000. WI explained that eligibility codes 4B and C2 ended as of 7/31/11, causing the decrease.	5/19/2015
WI	Eligibility	SSN	Wisconsin 8-fills the SSN field when the recipient is assigned a pseudo-MSIS ID. This explains the larger-than-expected number of persons with 8-filled SSNs. The state assigns permanent SSNs and MSIS IDs in the next quarter, using a retroactive change.	4/6/2012
WI	Eligibility	State-Specific Eligibility	WI implemented a new set of state-specific eligibility codes in February 2008 as part of its BadgerCare Plus program.	4/8/2009

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State	File Type	Rec/Issue Type	Issue	Recorded
WI	Eligibility	State-Specific Eligibility	Individuals in WI are eligible for multiple benefit plan simultaneously. With the new MMIS system implemented in Q1 FY2009, WI will report the primary benefit plan to bytes 1-2 of the state specific eligibility code field and will report two secondary benefit plans to bytes 3-4 and 5-6, if applicable. WI prioritizes the plans based on a hierarchy used in claims reporting. All subsequent fields (MASBOE, RBF, Dual Code, etc.) are assigned to an individual based on the primary plan designation. In cases where the beneficiary is a child eligible for both Medicaid and SCHIP, WI will report Medicaid as the primary plan and use Chip Code = 3 to indicate subsequent eligibility for SCHIP.	4/6/2012
WI	Eligibility	State-Specific Eligibility	Through Q4FY08, WI reported all Medicaid Buy-In (MBI) participants to state-specific eligibility groups "M3-M9", or "MP". Beginning in Q1FY09, with the state's implementation of a new eligibility system and a switch to an expanded eligibility group code (which can be up to 6 bytes), MBI participants are reported with codes "M3-M9", "MP" in any part of the eligibility group code (bytes 1-2, bytes 3-4, or bytes 5-6). To match the numbers in the finder file, all eligibility codes with M3-M9 or MP in any of the 6 bytes should be counted. WI started coding M3-M9, MP in bytes 1-2 in Q1FY11, moving all MBI enrollees to MASBOE 42. In Q4FY12, the state returned to coding M3-M9, MP in any of the 2 byte spots (1-2, 3-4, or 5-6); therefore, MBI enrollees were assigned to MASBOEs other than 42.	1/25/2013
WI	Eligibility	TANF/1931	Wisconsin is unable to identify TANF recipients. The field is 9-filled for all eligibles.	NA
WI	Eligibility	Waivers	WI's Q1 FY09 eligibility file shows some enrollment decreases in several of WI's 1915(c) waivers (waiver IDs 'F1', 'G1', 'P1', and 'R1'). The state indicated this was due to Family Care Expansion into additional counties.	11/11/2009
WI	Eligibility	Waivers	No enrollment was reported for all of WI's 1915(c) and 1915(b)(c) waivers through 2006 because the state did not capture much of its waiver enrollment in its MMIS. In 2006, WI had two 1915(c) waivers in place for aged and disabled, one for enrollees with physical disabilities, one for people with traumatic brain injuries, three for people with IID/DD, and one for people with mental illness or severe emotional disturbance. WI also had two 1915(b)(c) Family Care waivers in place in 2006, one for counties inside Milwaukee and the other for counties outside Milwaukee. Starting in Q3 and Q4 FY08, WI began to report enrollment in 1915(c) waivers – specifically, waiver IDs "F1", "G1", "H1", "O1", "P1", "R1", and "S1". However, there are still several 1915(c) and 1915(b) waivers that are not included in WI's MSIS reporting.	4/6/2012
WI	Eligibility	Waivers	WI reports eligibility and claims data for waiver ID 'G1' (WI Community Integration Program) differently. Enrollment data (eligibility) is submitted for quarter. For example, Q4FY13 covers July - Sept 2013. However, WI submits yearly claims data for	2/24/2015

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State	File Type	Rec/Issue Type	Issue	Recorded
			the previous year in March, when it is reconciled. This data shows up in Q4 of the next year. For example, Q4FY13 claims data covers all of 2012 data.	
WI	IP	Crossovers	In 2011 WI began to use the lesser-of payment methodology for inpatient crossover claims causing the average amount paid for crossover claims to decrease and percentage of crossover claims paid zero to increase.	12/30/2014
WI	IP	Crossovers	Until FFY2013Q3 WI reported the amount that Medicare applied towards coinsurance and deductible as the MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT in MSIS rather than reporting the amount that Medicaid paid towards the Medicare coinsurance and deductible as specified in the MSIS data dictionary. This was corrected in FFY2013Q3.	12/30/2014
WI	IP	Medicaid Amount Paid	WI had large modifications to hospital rates retroactive to July 2008, and subsequent rate modifications again in May 2009. These retroactive adjustments occurred during Q3FY2009. As a result, there is a large increase in the number of Void/Resubmittals, and total Medicaid paid for original claims during this quarter.	3/22/2011
WI	LT	Managed Care Encounters	In FFY2013Q2 WI reported about 7,000 claims for nurse practitioner services as LT encounters. Those encounters should have been reported in the OT file. This is the only quarter that this occurred in.	12/24/2014
WI	OT	Adjustments	The void adjustment claims have the span dates on the claim header, while the originals and resubmissions have the line item service date.	12/10/2004
WI	OT	Diagnosis	Until Q1FY2009, Wisconsin's system required diagnosis codes on all claims regardless of Type of Service, including dental, lab, and x-ray.	12/10/2004
WI	OT	HCBS Waiver	Through at least Q4FY2010, WI only reports their HCBS waiver claims in the Q4 file each year. These are claims for Q1-Q4. This has an impact on the Type of Service and Program Type distributions.	3/19/2013
WI	OT	Managed Care	On July 1, 2011, the Wisconsin Department of Health Services implemented a new non-emergency transportation broker for most members enrolled in Wisconsin Medicaid, the BadgerCare Plus Standard Plan, and the BadgerCare Plus Benchmark Plan.	NA
WI	OT	Managed Care Capitation	The PHP capitation rate is very high as it is used to cover Aged/Blind/Disabled managed care services.	12/15/2004
WI	OT	Managed Care Capitation	Wisconsin changes the date of service to match the date of payment since the HMO capitation claims are made prospectively and their system won't allow payment for a service before it is rendered. This means that if a capitation payment for April is made in March, the dates of service will be changed to March resulting in the capitation payments always being one	10/1/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			month prior to the managed care enrollment. Also, this results in the adjustments not linking to the original claims by date of payment. The variation in capitation claims adjudicated per month became more unbalanced in 2007 and through at least 2009 indicating that WI began submitting the true adjudication date regardless of date of service.	
WI	OT	Managed Care Capitation	In Q1FY2009 WI reported about twice as many original HMO capitation claims as person months of enrollment in an HMO. The extra original HMO capitation claims actually represent the resubmittal portion of a claim adjustment for dates of service prior to Q1FY2009. In the Q1FY2009 OT file there were between 16,000 and 30,000 original claims and a similar number of void claims for each preceding month of service through December 2007.	12/3/2012
WI	OT	Managed Care Encounters	In 2009 WI reported all service codes on encounters with service code flag = 6 (HCPCS) though many were actually all-numeric CPT codes and should have been reported with service code flag = 1 (CPT).	2/23/2012
WI	OT	Managed Care Encounters	Through WI's Q4FY09 submissions between 25 and 50 percent of encounters are reported with plan IDs that do not match enrollments. In Q1FY10 WI corrected this for the majority of encounters claims.	3/19/2013
WI	OT	Revenue Code	Until Q1FY2009, UB-92 code 001 occurred on many outpatient hospital claims as Wisconsin used it for rate reimbursement.	4/19/2011
WI	OT	Service Code	Until about 2003, Wisconsin had two Service Codes that can have different meanings but are not distinguishable on the MSIS claims. These codes are W0500 and W0520.	4/19/2011
WI	OT	Type of Service	In Q4 of each year the total amount paid for TYPE-OF-SERVICE = 13(Home Health) and 30 (Personal Care Services)) decreases by about 99% compared to the prior three quarters. The state explained that in Q4FY11 the state stopped paying for these services when billed by an individual because they were causing duplicate payments when a home health or personal care agency also submitted claims for the same services. It is not clear whether this is related to the annual increase in Q4 of each year and decrease in Q1-3.	5/13/2013
WI	RX	Family Planning	WI stopped reporting family planning claims in the RX file in Q1FY2009 and began reporting them again in the RX file in Q4FY2012.	5/17/2013
WI	RX	Managed Care Encounters	Through Q4FY2010 most of the data elements on the few encounters reported by WI in the RX file are 8-filled. WI stopped reporting managed care encounters in the RX file in Q1FY11.	3/19/2013
WI	RX	Medicaid Amount Paid Total	On February 1, 2008 pharmacy benefits were carved out of WI Badgercare managed care benefits becoming FFS benefits. The number of FFS RX claims and total expenditures increased substantially in Q2FY2008 and continued to rise through	5/14/2013

State	File Type	Rec/Issue Type	Issue	Recorded
			Q4FY2009 when they began to level off. By Q2FY2009 there were no RX encounters.	
WV	_All	CHIP	WV's legacy MMIS system does not contain separate CHIP claims or enrollment data and they cannot integrate it into MSIS with their current resources. WV plans on integrating separate CHIP data into the replacement MMIS that is scheduled to go live in July 2015. This likely means that separate CHIP data will first be reported by WV to T-MSIS.	10/13/2014
WV	Claims	Adjustments	There are a few claims in the file with the incorrect adjustment indicator.	7/23/2007
WV	Claims	MSIS ID	WV assigned an MSIS ID in both the claims and eligibility files to newborns that did not yet have a Medicaid ID that is composed of 9 zeros and the year and month of birth. This means that all babies born in the same month share a MSIS ID. The state has been asked to correct this starting with the 2007 or 2008 files.	NA
WV	Claims	MSIS ID	In accounting for newborn deliveries, the state appears to have created temporary IDs that look like month/year values, in the form 000000000YYYYMM often (but not always) corresponding to the admission date or the service begin date, instead of using the mother's ID. This has resulted in claims belonging to different newborns as being attributed to the same beneficiary.	3/22/2011
WV	Eligibility	CHIP	West Virginia first reported its M-CHIP enrollment in June 1999, but the state's program phased out by the end of FY2000. The state has an S-CHIP program, but does not report its S-CHIP enrollment in MSIS.	3/22/2011
WV	Eligibility	Dual Eligibility Codes	No dual codes 02, 03, 04, or 06 were included in MSIS through Q4 FY05. The state began reporting QMB-plus enrollees (dual code 02) in the MSIS file starting in Q1 FY06, shifting about 5,000 duals from code 08 to 02. Enrollees in dual codes 03 and 06 were added to MSIS starting in Q2 FY06 causing an increase in total dual reporting. However, most of the information for codes 03 and 06 is pulled from the monthly CMS buy-in file, which only contains a limited number of data elements (HIC, SSN, PIN, Name, Sex, DOB, Coverage Date, Coverage Type) causing other data fields in MSIS to be 9-filled when the data is not available. These enrollees are assigned to state-specific eligibility groups "SLMB" and "QI" and are not included as valid codes in the MASBOE crosswalk. Also in Q2 FY06, WV was able to start identifying dual code 04 enrollees, however, these enrollees were already being reported in MSIS and just shifted over from 08s.	2/18/2011
WV	Eligibility	Dual Eligibility Codes	We asked the state to review its dual coding for SSI recipients as we feel the state should be reporting more dual eligibles to dual code 02 (QMB plus) than what is currently reported in the monthly MMA data. WV currently reports about 4,500 enrollees to dual code 02 in MMA compared to the approximately 28,000 SSI recipients (reported to MASBOE 11-12) reported as duals in MSIS. We feel most of these SSI recipients should be reported	4/6/2012

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State	File Type	Rec/Issue Type	Issue	Recorded
			to dual code 02 since it is likely they have income less than 100% FPL. The state, however, indicated that in WV SSI enrollees do not need to apply for QMB status as they automatically start having premiums paid so there is no additional benefit to going through the QMB application process. After discussions with CMS, it was agreed that since these enrollees are captured as 08s in the state's system and the state would prefer to keep the coding as 08 in MSIS, these enrollees will remain assigned dual code 08.	
WV	Eligibility	Dual Eligibility Codes	In Q1FY14 and Q2FY14, about 500 individuals were assigned invalid dual code 99. These were individuals in MASBOE 48 and assigned SSG 'Z039'. The state indicated in their response to the review that they will correctly assign these individuals dual code 00. The issue was corrected in Q4FY14.	5/26/2014
WV	Eligibility	Dual Eligibility Codes	WV began reporting T-MSIS Eligibility Group in Q2FY14. WV was reporting QI and SLMB duals to T-MSIS Eligibility Group 99. In the future, WV will assign QI duals to 26 and SLMB duals to 25.	10/27/2014
WV	Eligibility	Dual Eligibility Codes	In Q2FY14-Q4FY14, WV assigned about 1,000 other full benefit duals (Dual Code '08') to MASBOE 35. The state explained that these were the new MAGI population (SSG FCMGAD) and confirmed that the counts were correct.	11/4/2014
WV	Eligibility	Managed Care	From Q1 to Q2 FY2010, PCCM enrollment (Plan Type 09) dropped by about 3,000, while HMO enrollment (Plan Type 01) rose by a similar amount. The State explained that in January 2010, the 3 HMOs in WV expanded to more counties thus reducing the PCCM enrollment count and increasing the HMO member count.	7/11/2011
WV	Eligibility	Managed Care	In Q1FY15, PCCM enrollment increased from about 3,400 in July 2014 to about 6,100 in December 2014. WV indicated that this increase should not have happened - the additional enrollees should have been assigned Plan Type '07' (they are HMO enrollees (Plan Type '01')). WV indicated that they need to add Plan ID '3810027240' (WV Family Health Plan) to their system.	2/4/2015
WV	Eligibility	MASBOE	2005: From January to February 2005 (Q2 FY05), reporting to MASBOE 3A (state-specific eligibility group RMPG) dropped from 528 enrollees to 176 enrollees. While unusual, these numbers are small and the state was not able to provide any explanation.	NA
WV	Eligibility	MASBOE	2003 - Current: Enrollment in MASBOE 11 and 12 is about 10-15 percent higher than the number of SSI recipients reported by SSA (FY03 - FY06). This may be caused by persons receiving state supplemental SSI benefits for special needs administered by the state. The state also appears to report most disabled, 65+ years to MASBOE 11. In addition, it was determined in FY03 that WV had been including some aged nursing home enrollees in MASBOE 11 by mistake. This was corrected in Q1 FY03, causing enrollment in MASBOE 11 to drop, with an increase in MASBOE 41.	12/18/2007

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State	File Type	Rec/Issue Type	Issue	Recorded
WV	Eligibility	MASBOE	During FY08, some pregnant women previously reported to UEG 45 (state-specific group 'CMEP') were shifted to UEG 35 (state-specific group 'FCMFPP'), causing a major increase in enrollment by year end.	2/8/2011
WV	Eligibility	MASBOE	Between Q4FY13 month 3 (Sept 2013) and Q1FY14 month 3 ((Dec 2013), there was an increase in enrollment of about 6,000 individuals in MASBOE 15. The increase primarily occurred in state specific eligibility code FCMGPC. The state explained that this increase was due to the MAGI deployment in WV on 10/1/2013.	5/26/2014
WV	Eligibility	MASBOE	Between Q1FY14 month 3 (December 2013) and Q2FY14 month 3 (March 2013), there was an increase of about 8,000 in MASBOE 44. The increase occurred mostly in SSG FCMGKS. The state explained that this increase was the result of Medicaid Adjusted Gross Income (MAGI) eligibility expansion.	10/27/2014
WV	Eligibility	MASBOE	From April 2014 to December 2014, several trends occurred in WV's MASBOE reporting. MASBOE 34 steadily increased, from about 12,700 to about 42,200 (mostly in SSG FCMGKF) MASBOE 35 steadily increased, from about 134,900 to about 161,000 (mostly in SSG FCMGAD) MASBOE 22 steadily decreased, from about 12,400 to about 3,100 (mostly in SSG FDMS) MASBOE 25 steadily decreased, from about 4,700 to about 200 (mostly in SSG FCMAOR) MASBOE 44 steadily decreased, from about 168,000 to 132,100 (mostly in SSG FCMQCA) WV confirmed these changes and explained that it was due to MAGI expansion - moving members from old codes to new codes or members not qualifying for the old categories but qualifying for the new MAGI category.	2/4/2015
WV	Eligibility	Private Health Insurance	Most of the enrollees with 9-filled private insurance codes are partial duals.	2/21/2010
WV	Eligibility	Race/Ethnicity	WV reports a very small number of individuals (<5) each quarter with Ethnicity Code = 1 (Hispanic/Latino). This count seems small, but the state confirmed that the count is consistent with the data in its system. We have asked for an explanation for the perpetually low count of Hispanic/Latino enrollees, but the state has not yet responded.	4/6/2012
WV	Eligibility	Restricted Benefits Flag	In Q2 FY07, WV started assigning RBF 7 to individuals enrolled in the state's new alternative benefit packages (or benchmark equivalent coverage) that had been approved by CMS as a Medicaid state plan amendment under the provisions of the 2005 Deficit Reduction Act. Implementation occurred in March 2007 and extended enrollment to existing Medicaid enrollees that can now receive enhanced benefits if they agree to sign a membership agreement. These enrollees are generally healthy adults and children, including individuals receiving TANF. In MSIS, these enrollees are assigned to various child/adult MASBOE groups, including 14, 15, 17, 25, 34, 44-45. Disabled and elderly individuals, however, are not eligible for this new alternative benefit package. Enrollment counts in MSIS (RBF =7)	8/3/2009

State	File Type	Rec/Issue Type	Issue	Recorded
			started low in Q2 FY07 because the state provided limited coverage in only two counties. As expected, enrollment counts picked up in Q1FY08 when the state extended coverage to additional counties in October 2007. In addition, the state expected that eventually about 50% of child and adult Medicaid enrollees would be able to participate in this new coverage, which is consistent with the proportion we see enrolled in WV's Q4 FY08 data. WV terminated the program in December 2013 and stopped reporting to RBF 7 in Q2FY14. Enrollment was about 153,000.	
WV	Eligibility	Restricted Benefits Flag	WV reports a very small number of individuals (<5) each quarter with RBF=2. This count seems small, but the state confirmed that the count is consistent with the data in its system. It is also consistent with their confirmed race/ethnicity data. We have asked several times for an explanation but the state has not been able to provide one. WV has never successfully reported RBF=2. Through FY06, WV did not assign RBF 2 to any enrollees, although we expect that WV would have some undocumented immigrants that qualify for emergency services under WV's Medicaid program. In Q1 FY07, WV started reporting to RBF 2; however, this assignment was incorrect. These individuals should have been assigned to either RBF 1 or 7. RBF 2 should be assigned to enrollees in state specific groups that end with: MIIS, MIIR, or MIIU. WV fixed the RBF 2 assignment starting in Q1 FY08 and enrollment increased. In FY10, enrollment in RBF 2 once again dropped off.	4/6/2012
WV	Eligibility	Restricted Benefits Flag	WV received a MFP grant in July 2011 and we expected for tentative awards to be announced in September 2011; however, no RBF 8 were reported as of Q1FY14. The state indicated in the Q1FY14 review that they would make the necessary modifications to identify and include MFP record. WV started including RBF 8 on the Q2FY14 review.	5/26/2014
WV	Eligibility	Restricted Benefits Flag	In Q2FY14-Q3FY14, WV began incorrectly assigning RBF A (PRTF Grant) to 250 individuals per month. The state does not have a PRTF Grant and has indicated that they will stop assigning RBF A. WV stopped reporting RBF A in Q4FY14.	10/27/2014
WV	Eligibility	Restricted Benefits Flag	During Medicaid expansion, effective 1/1/14, newly eligible members in the expansion group are enrolled in a new Alternative Benefit Plan (Medically Frail). The main differences between the existing traditional Medicaid Plan and the ABP are limitations set for OT, PT, and Home Health. Members of the Medically Frail ABP are assigned RBF 7 and reporting began in Q4FY14.	11/4/2014
WV	Eligibility	Retroactive/ Correction Records	Since the state started reporting retro/correction records in FY06, about 25 records each quarter are reported with blanks in the "Type of Record" and "Federal Fiscal Year/Qtr" fields. This reporting was fixed starting in Q2 FY09.	3/22/2011
WV	Eligibility	SSN	It appears that WV is submitting valid SSNs for over 99 percent of Medicaid enrollees, which is higher than generally expected	3/22/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			since SSNs are not always available for some enrollees, such as newborns, younger children, or undocumented aliens. However, the state expressed that it has been putting extra efforts into obtaining valid SSNs for most of the Medicaid population and confirmed that it believes these data in MSIS are reliable.	
WV	Eligibility	State-Specific Eligibility	Starting in Q1 FY05, WV made some changes to its MASBOE crosswalk that resulted in shifts in MASBOE reporting. The MASBOE mapping changed for several groups, but the biggest shift occurred with state group FCMQCA moving from MASBOE 34 to MASBOE 44. Over 130,000 children are reported to this state group (about 87% of WV's total child Medicaid enrollees). This was an unusual change, but WV confirmed that this group qualifies under the "Qualified Child" waiver deduction that states, "For children covered under Section 1902(a) (10) (i) (III) and 1905(n) of the Social Security Act, the State of West Virginia will disregard an amount equal to the difference between 100% of the current Federal Poverty Level and 100% of the AFDC payment standard plus $1.00 for the same family size."	8/2/2007
WV	Eligibility	TANF/1931	Effective FY 2001, the TANF flag is 9-filled for all eligibles. In FY 1999 and FY 2000, the TANF flag was 9-filled for all eligibles in MAS/BOE 14 - 15. All other eligibles, including those in MAS/BOE 16 - 17, received TANF flag 1, indicating that they did not receive TANF benefits.	NA
WV	Eligibility	Waivers	WV's 1915(b) waiver is a combined MCO and PCCM program so that enrollees receive services through either one of these types of managed care. Therefore, the sum of enrollees reported with HMO or PCCM enrollment is about equal to the total count of enrollees in WV's 1915(b) waiver (waiver ID 'MH').	8/25/2010
WV	IP	Family Planning	There are no claims with Program Type of 2 (Family Planning).	3/22/2011
WV	IP	MSIS ID	WV had been assigning newborns a temporary ID that is 9 zeros + MMYY of birth until 2008. This means that babies born in the same month all have the same MSIS ID. They are not assigned a permanent ID until they get a SSN. Starting with 2008, the state is submitting newborns with a unique system ID. However this number will still be converted to a different MSIS ID when they get their SSN as SSN is the first 9 bytes.	3/22/2011
WV	IP	Service Tracking Claims	The amount paid on IP service tracking claims is greater than the amount paid as FFS.	10/15/2008
WV	OT	Service Tracking Claims	In Q1FY2004 WV started submitting some managed care capitation claims as service tracking claims.	3/16/2008
WY	Eligibility	1115 Waivers	WY implemented a Family Planning-only section 1115 waiver in January 2009 (state-specific group 'A20'). From Q2 FY09 to Q1 FY10, WY reported these persons to RBF 5 and MASBOE 45, but did not report waiver enrollment to the Waiver ID and Waiver Type fields. Starting in Q2 FY10, WY corrected this reporting by assigning these enrollees to RBF 6, MASBOE 55 and new Waiver	8/15/2011

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State	File Type	Rec/Issue Type	Issue	Recorded
			ID 'F1' and Waiver Type 'F'. WY also reportedly plans to move this program to the State Plan instead of a waiver. However, the waiver has been extended to 9/30/2014.	
WY	Eligibility	All	Disease Management: As of 2004, Wyoming has run a state Medicaid Health Management Program. The 'Healthy Together' program is a total population health management program aimed at improving health outcomes and reducing costs for Medicaid enrollees with chronic illnesses. At minimum, clients receive education and educational materials to encourage self-management, then depending upon the severity of the illness, clients receive one-on-one support from a health coach or case manager.	10/10/2012
WY	Eligibility	CHIP	Wyoming has an S-CHIP program but does not report its S-CHIP enrollees into MSIS. WY has no M-CHIP program.	NA
WY	Eligibility	County Codes	In July 2012, the number of Medicaid enrollees assigned County Code 007 increases from 2,000 to 6,000; during this same time, enrollees with County Code 021 decreases from approximately 13,000 to 9,000. We have asked the state to verify the cause of this shift but did not receive a response.	2/16/2013
WY	Eligibility	Managed Care	Wyoming implemented its first PACE program in February 2013. This plan was not reported as a managed care plan in the EL files through Q3 FY 2014. However, PACE enrollees can be identified via state-specific eligibility group codes P11-P28. The state said that the plan was originally paid via gross adjustment, but was "recently" transitioned to direct billing (per response received in January 2015). We have asked the state to report PACE enrollees to plan type '6'.	11/6/2012
WY	Eligibility	Managed Care	Wyoming plans to develop a patient-centered medical home (PCMH) pilot project in FY 2013.	11/6/2012
WY	Eligibility	MASBOE	All Years: WY reports SSI disabled age 65+ to MASBOE 11.	NA
WY	Eligibility	MASBOE	Through Q3 FY 2011, WY was assigning one if its state-specific codes (S59) for Medicaid Buy-In participants to MASBOE 41 rather than MASBOE 42. This issue was corrected starting in Q4 FY 2011.	4/17/2012
WY	Eligibility	MASBOE	Between January and December 2014, enrollment in MASBOE 14 fell 61 percent, while enrollment in MASBOE 15 increased about 50 percent. We have asked the state to explain the reason for these results.	3/11/2015
WY	Eligibility	Race/Ethnicity	Through Q3 FY 2012, enrollees assigned to the "Hispanic Latino" category in the ETHNICITY-CODE field are also assigned to "American Indian / Alaskan Native" race in the RACE-CODE field. This issue was corrected as of Q4 FY12. As a result, starting in Q2 FY12, most (88 percent) Hispanic/Latino enrollees are reported with an unknown race.	4/17/2012
WY	Eligibility	Restricted Benefits Flag	WY has been assigning restricted benefits flag 5 (restricted--other) to a handful of Medicaid enrollees each month. They are	2/23/2011

State	File Type	Rec/Issue Type	Issue	Recorded
			reported to state codes S50, S51, and S54; however, the state is not sure what benefits they receive causing the assignment of flag 5. Additionally, in July 2011, WY began assigning RBF= 5 to about 100+ state-only (non-Medicaid eligible) individuals reported to state-specific eligibility group 'P02' and MASBOE = '00'. We have asked the state to make sure that the RBF and all other fields are 0-filled for those assigned 'P02'.	
WY	Eligibility	Restricted Benefits Flag	In Q2 FY 2010, reporting to RBF= 4 drops from about 1900 per month to 30 per month. It appears that these individuals (in state groups 'A19', A71', and 'A72') were switched to RBF = '1' but should continue to be reported to RBF= 4, as all are noted as "pregnant women" in WY's MASBOE crosswalk and reported to MASBOE 34-35. The state has agreed to make this change, but it did not appear to have been made through Q4 FY 2014.	9/25/2012
WY	Eligibility	State-Specific Eligibility	Enrollment in eligibility group 'P02', mapped to MASBOE 00, begins in July 2011. This group is mapped to MASBOE 00 and RBF= '5' with all other fields 8-filled. The state has said that P02 is a state-only group. We have asked the state to make sure all fields (other than the state-specific eligibility group of 'P02') are 0-filled for these individuals in the MSIS EL files.	4/17/2012
WY	Eligibility	TANF/1931	Wyoming TANF data are not reliable. The state began 9-filling the TANF flag in Q1 FY04.	NA
WY	Eligibility	Waivers	WY implemented a CMH waiver (ID #W6) in October 2006 and a small number of enrollees were reported starting in the Q2 FY07 file.	NA
WY	Eligibility	Waivers	In Q2 FY 2010, WY ceased reporting individuals to Waiver ID= 'W5'. Reporting to this waiver ID resumed as usual in Q3 FY 2010. The Q2 file was approved despite this omission. Individuals in this waiver can be identified using state codes 'B01' and 'B02'.	8/16/2011
WY	Eligibility	Waivers	According to CMS documentation, the 'WY Supports' 1915c waiver (CMS waiver #1060.R00.00) and the 'WY Comprehensive' 1915c waiver (CMS waiver # 1061.R00.00) were implemented on 4/1/2014. However, they are not reported in MSIS through Q4 FY 2014. We have asked the state to confirm whether these waivers are currently active and if so, when they will be able to begin reporting them.	3/11/2015
WY	Eligibility	Waivers	Enrollment in the 'WY Adult Developmental Disabilities' waiver (Waiver ID 'W1', Waiver Type '3', CMS Waiver # 0226.R04.00) fell sharply between July and December 2014. Our documentation shows an expiration date of 6/30/2014 for this waiver. We have asked the state whether the waiver has been renewed, and to explain what has caused this pattern.	3/11/2015
WY	IP	DRG	Wyoming does not use DRGs for reimbursement.	3/8/2012
WY	LT	Type of Service	There aren't any claims for Type of Service 02 (Mental Hospital for the Aged) though it is a covered service in their state plan.	NA

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State	File Type	Rec/Issue Type	Issue	Recorded
WY	OT	Crossovers	Through at least Q2FY2014 WY reported duplicate paid amounts on crossover claims, transposing a gross header-amount-paid onto multiple claim line/details inflating the MEDICAID-PAID-AMOUNT tenfold for crossover claims. While this represents a large discrepancy in the amount paid for crossover claims, Wyoming has the smallest Medicaid program of all states and does not have any managed care so it is not expected that accurate payments on crossover claims would be needed to do any rate-setting analysis at the federal level in the near future. The state has been asked to fix this in T-MSIS.	9/30/2014
WY	OT	Managed Care Capitation	There aren't any capitation claims as Wyoming doesn't have managed care.	3/8/2012
WY	RX	Taxonomy codes	For 2009Q9 to 2014Q2 less than 1 percent of taxonomy codes reported in the RX file represent the pharmacy or pharmacist's taxonomy. The state confirmed that the taxonomy reported in the RX file is the prescribing provider's taxonomy. The state has been asked to fix this in T-MSIS.	9/30/2014

NA = Not Available